The Orange Book

Management of Risk - Principles and Concepts

October 2004

HM TREASURY

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ISBN: 1-84532-044-1

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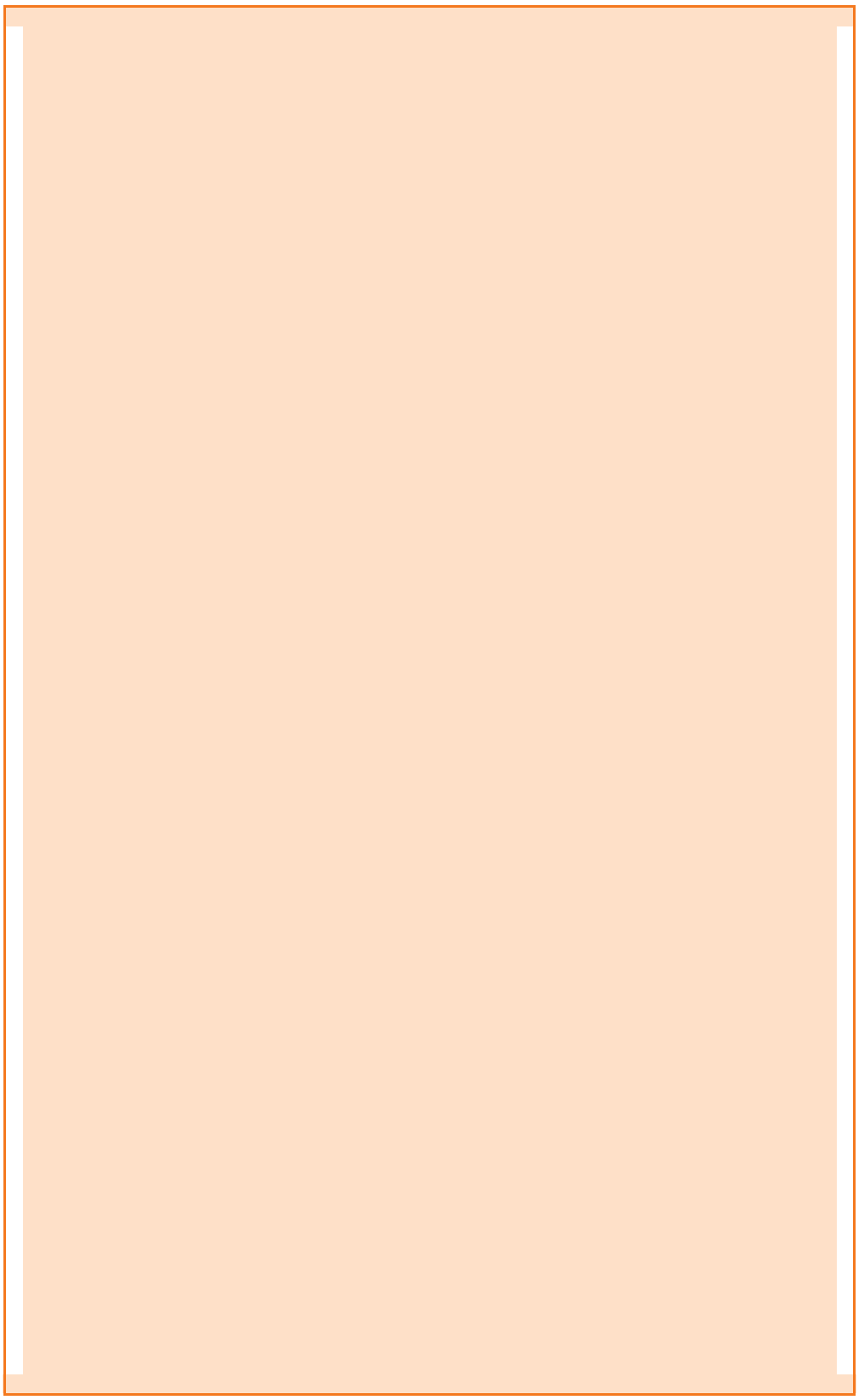

This guidance is intended to be useful to:

- those who are new to risk management and those who are tasked with providing training on risk management in their organisations, both of whom will find it useful as a key introductory document;
- those who are concerned with the review of risk management arrangements (such as Audit Committees) as a resource providing a comprehensive statement of principles against which actual risk management processes can be evaluated;
- senior staff whose leadership is vital if an appropriate culture is to be generated in which risk management can be effective;
- operational level staff who manage day to day risks in the delivery of the organisation's objectives and who will find it a practical support in the actual management of risk; and
- those who are experienced in risk management, for whom this guidance explores more difficult concepts such as risk appetite.

It will be equally of use whether the reader's focus of interest is with managing risk at strategic, programme or operational levels.

Mary Keegan

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HM Treasury

October 2004

1 OVERVIEW

1.1 It is a matter of definition that organisations exist for a purpose – perhaps to deliver a service, or to achieve particular outcomes. In the private sector the primary purpose of an organisation is generally concerned with the enhancement of shareholder value; in the central government sector the purpose is generally concerned with the delivery of service or with the delivery of a beneficial outcome in the public interest. Whatever the purpose of the organisation may be, the delivery of its objectives is surrounded by uncertainty which both poses threats to success and offers opportunity for increasing success.

1.2 Risk is defined as this uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. The risk has to be assessed in respect of the combination of the likelihood of something happening, and the impact which arises if it does actually happen. Risk management includes identifying and assessing risks (the "inherent risks") and then responding to them.

1.3 The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way which it can justify to a level which is tolerable. The amount of risk which is judged to be tolerable and justifiable is the "risk appetite".

1.4 Response, which is initiated within the organisation, to risk is called "internal control" and may involve one or more of the following:

- tolerating the risk;
- treating the risk in an appropriate way to constrain the risk to an acceptable level or actively taking advantage, regarding the uncertainty as an opportunity to gain a benefit;
- transferring the risk;
- terminating the activity giving rise to the risk.

In any of these cases the issue of opportunity arising from the uncertainty should be considered.

The level of risk remaining after internal control has been exercised (the "residual risk") is the *exposure* in respect of that risk, and should be acceptable and justifiable – it should be within the risk appetite.

1.5 None of this takes place in a vacuum. Every organisation functions within an environment which both influences the risks faced and provides a context within which risk has to be managed. Further, every organisation has partners on which it depends in the delivery of its objectives whether they be simply suppliers of goods which the organisation requires or direct partners in the delivery of objectives. Effective risk management needs to give full consideration to the context in which the organisation functions and to the risk priorities of partner organisations.

1.6 The management of risk at strategic, programme and operational levels needs to be integrated so that the levels of activity support each other. In this way the risk management strategy of the organisation will be led from the top and embedded in the normal working routines and activities of the organisation. All staff should be aware of the relevance of risk to the achievement of their objectives and training to support staff in risk management should be available.

Hierarchy of risk

Source: SU report Risk: improving government's capability to handle risk and uncertainty, Nov 2002

1.7 Managers at each level therefore need to be equipped with appropriate skills which will allow them to manage risk effectively and the organisation as a whole needs a means of being assured that risk management is being implemented in an appropriate way at each level. Every organisation should have a risk management strategy, designed to achieve the principles set out in this publication. The application of that strategy should be embedded into the organisation's business systems, including strategy and policy setting processes, to ensure that risk management is an intrinsic part of the way business is conducted.

1.8 This guide aims to provide an introduction to the range of considerations which apply in risk management, all of which can be applied at various levels ranging from the development of a strategic, organisation-wide risk policy through to management of a particular project or operation. It does so using a risk management model which is set out in the next section – each element of the model is explored in further detail. The guide focuses firstly on the "lifecycle" core of the model, then gives consideration to the wider based issues which form the overall risk management environment. It is important to note that this guide is *not* a detailed instruction manual for how to manage risk – its aim is simply to draw attention to the range of issues which are involved and to offer some general direction to help the reader think about how these issues may be addressed in the specific circumstances of their own organisation.

1.9 There is not a specific "standard" set for risk management in government organisations. This guide establishes *principles* of risk management, and the "Risk Management Assessment Framework"[1] provides a means of assessing the *maturity* of risk management. Organisations may choose to adopt particular standards (for example, the "Risk Management Standard" produced jointly by IRM, ALARM and AIRMIC[2] in the UK, or the Australian standard[3], CoSo[4], or the Canadian government sector standard[5]). More important than compliance with any particular Standard is ability to demonstrate that risk is managed in the particular organisation, in its particular circumstances, in a way which effectively supports the delivery of its objectives.

1 http://www.hm-treasury.gov.uk/media//7B1D9/risk_management_assessment_070104.pdf

2 http://www.airmic.com

3 http://www.riskmanagement.com.au/

4 http://www.erm.coso.org/Coso/coserm.nsf/vwWebResources/PDF_Manuscript/$file/COSO_Manuscript.pdf

5 http://www.tbs-sct.gc.ca/pubs pol/dcgpubs/Risk Management/siglist e.asp

2 THE RISK MANAGEMENT MODEL

Risk Management Model – developed from the model in the Strategy Unit's November 2002 report : *"Risk – improving government's capability to handle risk and uncertainty"*

Notes on the model

The management of risk is not a linear process; rather it is the balancing of a number of interwoven elements which interact with each other and which have to be in balance with each other if risk management is to be effective. Furthermore, specific risks cannot be addressed in isolation from each other; the management of one risk may have an impact on another, or management actions which are effective in controlling more than one risk simultaneously may be achievable.

The whole model has to function in an environment in which risk appetite has been defined. The concept of risk appetite (how much risk is tolerable and justifiable) can be regarded as an "overlay" across the whole of this model.

The model presented here, by necessity, dissects the core risk management process into elements for illustrative purposes but in reality they blend together. In addition, the particular stage in the process which one may be at for any particular risk will not necessarily be the same for all risks.

The model illustrates how the core risk management process is not isolated, but takes place in a context; and, how certain key inputs have to be given to the overall process in order to generate the outputs which will be desired from risk management.

3 IDENTIFYING RISKS

3.1 In order to manage risk, an organisation needs to know what risks it faces, and to evaluate them. Identifying risks is the first step in building the organisation's risk profile. There is no single right way to document an organisation's risk profile, but documentation is critical to effective management of risk.

3.2 The identification of risk can be separated into two distinct phases. There is:

- initial risk identification (for an organisation which has not previously identified its risks in a structured way, or for a new organisation, or perhaps for a new project or activity within an organisation), and there is;
- continuous risk identification which is necessary to identify new risks which did not previously arise, changes in existing risks, or risks which did exist ceasing to be relevant to the organisation (this should be a routine element of the conduct of business).

3.3 In either case risks should be related to objectives. Risks can only be assessed and prioritised in relation to objectives (and this can be done at any level of objective from personal objectives to organisational objectives). Care should be taken to identify generic risks which will impact on business objectives but might not always be immediately apparent in thinking about the particular business objective. When a risk is identified it may be relevant to more than one of the organisation's objectives, its potential impact may vary in relation to different objectives, and the best way of addressing the risk may be different in relation to different objectives (although it is also possible that a single treatment may adequately address the risk in relation to more than one objective). In stating risks, care should be taken to avoid stating impacts which may arise as being the risks themselves, and to avoid stating risks which do not impact on objectives; equally care should be taken to avoid defining risks with statements which are simply the converse of the objectives. A statement of a risk should encompass the cause of the impact, and the impact to the objective ("cause and consequence) which might arise.

Objective – to travel by train from A to B for a meeting at a certain time	
Failure to get from A to B on time for the meeting	**X** this is simply the converse of the objective
Being late and missing the meeting	**X** This is a statement of the impact of the risk, not the risk itself
There is no buffet on the train so I get hungry	**X** this does not impact on achievement of the objective
Missing the train causes me to be late and miss the meeting	This is a risk which can be controlled by making sure I allow plenty of time to get to the station
Severe weather prevents the train from running and me from getting to the meeting	This is a risk which I cannot control, but against which I can make a contingency plan

3.4 The individual risks which an organisation identifies will not be independent of each other; rather they will typically form natural groupings. For instance, there may be a number of risks which can be grouped together as "resources" and further risks which can be grouped together as "environmental". Some risks will be relevant to several of the organisation's objectives. These groupings of risks will incorporate related risks at strategic, programme and operational levels (see 1.6). It is important not to confuse a grouping of risks with the risks themselves. Risks should be identified at a level where a specific impact can be identified and a specific action or actions to address the risk can be identified. All risks, once identified, should be assigned to an owner who has responsibility for ensuring that the risk is managed and monitored over time. A risk owner, in line with their accountability for managing the risk, should have sufficient authority to ensure that the risk is effectively managed; the risk owner may not be the person who actually takes the action to address the risk.

3.5 It is necessary to adopt an appropriate approach or tool for the identification of risk. Two of the most commonly used approaches are:

- Commissioning a risk review: A designated team is established (either in-house or contracted in) to consider all the operations and activities of the organisation in relation to its objectives and to identify the associated risks. The team should work by conducting a series of interviews with key staff at all levels of the organisation to build a risk profile for the whole range of activities (but it is important that the use of this approach should not undermine line management's understanding of their responsibility for managing the risks which are relevant to their objectives);

- Risk self-assessment: An approach by which each level and part of the organisation is invited to review its activities and to contribute its diagnosis of the risks it faces. This may be done through a documentation approach (with a framework for diagnosis set out through questionnaires), but is often more effectively conducted through a facilitated workshop approach (with facilitators with appropriate skills helping groups of staff to work out the risks affecting their objectives). A particular strength of this approach is that better ownership of risk tends to be established when the owners themselves identify the risks.

3.6 These approaches are not mutually exclusive, and a combination of approaches to the risk identification process is desirable – this sometimes exposes significant differences in risk perception within the organisation. These differences in perception need to be addressed to achieve effective integration of risk management at the various levels of the organisation.

3.7 Increasingly both in the public and private sectors the importance of looking over the horizon and managing upcoming risk is now recognised. There can be considerable variation between organisations in their approach to horizon scanning because of differing organisational needs. A summary of horizon scanning issues, provided by the Civil Contingencies Secretariat of the Cabinet Office is at Annex C.

3.8 The table following is drawn from a 2004 review (by Treasury) of main departments' risks and offers a summary of the most common categories or groupings of risk with examples of the nature of the source and effect issues; it is intended to help organisations check that they have considered the range of potential risks which may arise; the table does not claim to be comprehensive - some organisations may be able to identify other categories of risk applicable to their work.

	Illustration /issues to consider
1. External (arising from the external environment, not wholly within the organisation's control, but where action can be taken to mitigate the risk) ***[This analysis is based on the "PESTLE" model – see the Strategy Survival Guide at www.strategy.gov.uk]***	
1.1 Political	Change of government, cross cutting policy decisions (e.g. – the Euro); machinery of government changes
1.2 Economic	Ability to attract and retain staff in the labour market; exchange rates affect costs of international transactions; effect of global economy on UK economy
1.3 Socio cultural	Demographic change affects demand for services; stakeholder expectations change
1.4 Technological	Obsolescence of current systems; cost of procuring best technology available, opportunity arising from technological development
1.5 Legal/regulatory	EU requirements / laws which impose requirements (such as Health and Safety or employment legislation)
1.6 Environmental	Buildings need to comply with changing standards; disposal of rubbish and surplus equipment needs to comply with changing standards
2. Operational (relating to existing operations – both current delivery and building and maintaining capacity and capability)	
2.1 Delivery	
2.1.1 Service/product failure	Fail to deliver the service to the user within agreed / set terms
2.1.2 Project delivery	Fail to deliver on time / budget / specification
2.2 Capacity and capability	
2.2.1 Resources	Financial (insufficient funding, poor budget management, fraud) HR (staff capacity / skills / recruitment and retention) Information (adequacy for decision making; protection of privacy) Physical assets (loss / damage / theft)
2.2.2 Relationships	Delivery partners (threats to commitment to relationship / clarity of roles) Customers / Service users (satisfaction with delivery) Accountability (particularly to Parliament)
2.2.3 Operations	Overall capacity and capability to deliver
2.2.4 Reputation	Confidence and trust which stakeholders have in the organisation
2.3 Risk management performance and capability	
2.3.1 Governance	Regularity and propriety / compliance with relevant requirements / ethical considerations
2.3.2 Scanning	Failure to identify threats and opportunities
2.3.3 Resilience	Capacity of systems / accommodation / IT to withstand adverse impacts and crises (including war and terrorist attack). Disaster recovery / contingency planning
2.3.4 Security	Of physical assets and of information
3. Change (risks created by decisions to pursue new endeavours beyond current capability)	
3.1 PSA targets	New PSA targets challenge the organisation's capacity to deliver / ability to equip the organisation to deliver
3.2 Change programmes	Programmes for organisational or cultural change threaten current capacity to deliver as well as providing opportunity to enhance capacity
3.3 New projects	Making optimal investment decisions / prioritising between projects which are competing for resources
3.4 New policies	Policy decisions create expectations where the organisation has uncertainty about delivery

4 Assessing Risks

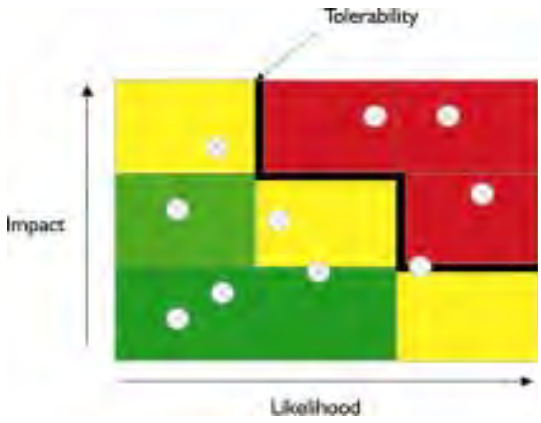
4.1 There are three important principles for assessing risk:

- ensure that there is a clearly structured process in which both likelihood and impact are considered for each risk;
- record the assessment of risk in a way which facilitates monitoring and the identification of risk priorities;
- be clear about the difference between, inherent and residual risk (see 1.2 and 1.4).

4.2 Some types of risk lend themselves to a numerical diagnosis - particularly financial risk. For other risks - for example reputational risk - a much more subjective view is all that is possible. In this sense risk assessment is more of an art than a science. It will be necessary, however, to develop some framework for assessing risks. The assessment should draw as much as possible on unbiased independent evidence, consider the perspectives of the whole range of stakeholders affected by the risk, and avoid confusing objective assessment of the risk with judgement about the acceptability of the risk.

4.3 This assessment needs to be done by evaluating both the likelihood of the risk being realised, and of the impact if the risk is realised. A categorisation of high / medium / low in respect of each may be sufficient, and should be the minimum level of categorisation – this results in a "3x3" risk matrix. A more detailed analytical scale may be appropriate, especially if clear quantitative evaluation can be applied to the particular risk - "5x5" matrices are often used, with impact on a scale of "insignificant / minor / moderate/ major/ catastrophic" and likelihood on a scale of "rare / unlikely / possible / likely / almost certain". There is no absolute standard for the scale of risk matrices - the organisation should reach a judgement about the level of analysis that it finds most practicable for its circumstances. Colour ("Traffic Lights") can be used to further clarify the significance of risks.

Simple risk/tolerability matrix



4.4 When the assessment is then compared to the risk appetite (see 4.5 below), the extent of action required becomes clear. It is not the absolute value of an assessed risk which is important; rather it is whether or not the risk is regarded as *tolerable,* or how far the exposure is away from tolerability, which is important.

4.5 At the organisational level risk appetite can become complicated (see section 5 for more detail), but at the level of a specific risk it is more likely that a level of exposure which is acceptable can be defined in terms of both a tolerable impact if a risk is realised, and tolerable frequency of that impact. It is against this that the residual risk has to be compared to decide whether or not further action is required. Tolerability may be informed by the value of assets lost or wasted in the event of an adverse impact, stakeholder perception of an impact, the balance of the cost of control and the extent of exposure, and the balance of potential benefit to be gained or losses to be withstood.

4.6 Thinking about risk frequently focuses on residual risk (ie- the risk after control has been applied which, assuming control is effective, will be the actual exposure of the organisation - see 1.4). Residual risk, of course, will often have to be re-assessed – for example, if control is adjusted. Assessment of the *anticipated* residual risk is necessary for the evaluation of proposed control actions.

4.7 Care should also be taken to capture information about the *inherent* risk. If this is not done the organisation will not know what its exposure will be if control should fail. Knowledge about the inherent risk also allows better consideration of whether there is over-control in place – if the inherent risk is within the risk appetite, resources may not need to be expended on controlling that risk. This need to have knowledge about both inherent and residual risk means that the assessment of risk is a stage in the risk management process which cannot be separated from addressing risk; the extent to which the risk needs to be addressed is informed by the inherent risk whereas the adequacy of the means chosen to address the risk can only be considered when the residual risk has been assessed.

4.8 Risk assessment should be documented in a way which records the stages of the process (an example is an Annex A). Documenting risk assessment creates a *risk profile* for the organisation which:

- facilitates identification of risk priorities (in particular to identify the most significant risk issues with which senior management should concern themselves);
- captures the reasons for decisions made about what is and is not tolerable exposure;
- facilitates recording of the way in which it is decided to address risk;
- allows all those concerned with risk management to see the overall risk profile and how their areas of particular responsibility fit into it;
- facilitates review and monitoring of risks.

4.9 Once risks have been assessed, the risk priorities for the organisation will emerge. The less acceptable the exposure in respect of a risk, the higher the priority which should be given to addressing it. The highest priority risks (the key risks) should be given regular attention at the highest level of the organisation, and should consequently be considered regularly by the Board. The specific risk priorities will change over time as specific risks are addressed and prioritisation consequently changes.

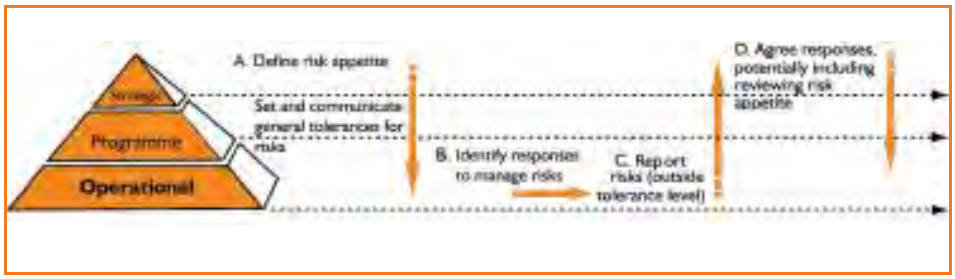
5 Risk Appetite

5.1 The concept of a "risk appetite" is key to achieving effective risk management and it is essential to consider it before moving on to consideration of how risks can be addressed. The concept may be looked at in different ways depending on whether the risk (the uncertainty) being considered is a threat or an opportunity:

- When considering threats the concept of risk appetite embraces the level of exposure which is considered tolerable and justifiable should it be realised. In this sense it is about comparing the cost (financial or otherwise) of constraining the risk with the cost of the exposure should the exposure become a reality and finding an acceptable balance;
- When considering opportunities the concept embraces consideration of how much one is prepared to actively put at risk in order to obtain the benefits of the opportunity. In this sense it is about comparing the value (financial or otherwise) of potential benefits with the losses which might be incurred (some losses may be incurred with or without realising the benefits).

It should be noted that some risk is unavoidable and it is not within the ability of the organisation to completely manage it to a tolerable level – for example many organisations have to accept that there is a risk arising from terrorist activity which they cannot control. In these cases the organisation needs to make *contingency plans* .

5.2 In either case the risk appetite will best be expressed as a series of boundaries, appropriately authorised by management, which give each level of the organisation clear guidance on the limits of risk which they can take, whether their consideration is of a threat and the cost of control, or of an opportunity and the costs of trying to exploit it. This means that risk appetite will be expressed in the same terms as those used in assessing risk. An organisation's risk appetite is not necessarily static; in particular the Board will have freedom to vary the amount of risk which it is prepared to take depending on the circumstances at the time. The model below sets out these concepts in more detail:

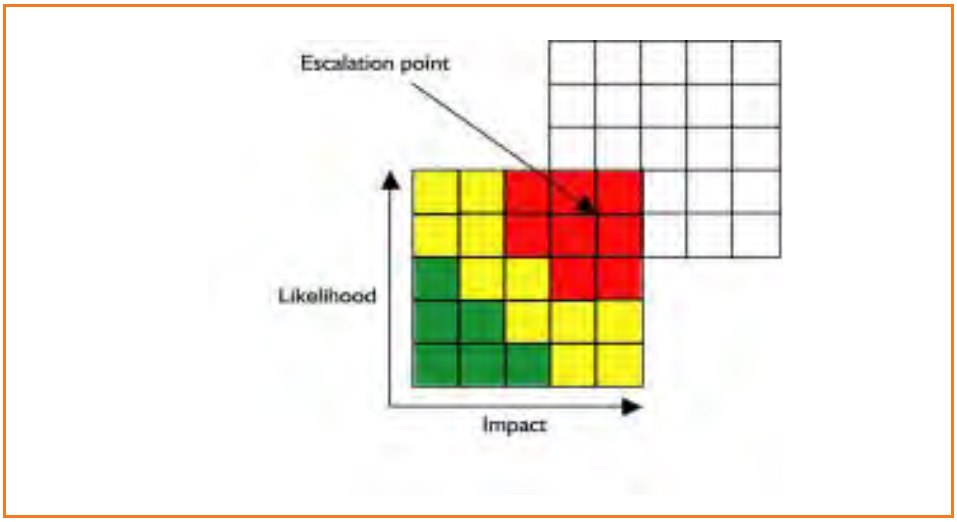


5.3 The concept of risk appetite can be further analysed thus:

- **Corporate Risk Appetite:** Corporate risk appetite is the overall amount of risk judged appropriate for an organisation to tolerate, agreed at board level (letter A in the model at 5.2). This may not be just one statement: OGC, for example, look at 5 key risk areas (policy/guidance risk; people and internal systems risk; propriety, regularity, finance and accountability risk; reputation risk; external risk) and make a statement on risk appetite for each. The Board and senior managers should judge the tolerable range of exposure for the organisation and identify general boundaries for unacceptable risk (or at least for risks that should always be referred to/ escalated up to the Board for discussion and decision when they arise). In doing this the Board may want to take Ministerial views on risk-taking into account;
- **Delegated Risk Appetite:** The agreed corporate risk appetite can then be used as a starting point for cascading levels of tolerance down the organisation, agreeing risk appetite in different levels of the organisation (letter B in the model above at 5.2). The effect of this is that what is considered a high level of risk at one level will be a lower level of risk to a higher level of management. This facilitates both a risk escalation process for the taking of risk decisions when delegated boundaries are met (see 5.4 below), and empowers people to innovate within their delegations;
- **Project Risk Appetite:** Projects that fall outside of day-to-day business of an organisation might need their own statement of risk appetite. Different types of projects might also require different levels of risk appetite, for example an organisation may be prepared to accept a higher level of risk for a project that would bring substantial reward.
  - different types of project could be:
    - Speculative (akin to venture capitalism in the corporate sector): with high risks but potentially high rewards, e.g. Invest to Save Budget projects; Pilot projects. It may be that the bulk of these projects are unsuccessful but important lessons are learnt;
    - Standard development projects: for example IT, procurement, construction, etc. (increasingly covered by OGC's Centres of Excellence programme at the time of issue of this document);
    - Mission critical' projects: where organisations need to be sure of success.

The level of risk appetite will obviously vary, with a speculative project prepared to take on higher levels of risk than a "Mission Critical" project.

5.4 Effective management and application of delegated risk appetite requires escalation processes**.** It is possible to set 'trigger points' where risks can be escalated to the next level of management as they approach or exceed their agreed risk appetite levels (letter C in the model at 5.2). The next level up in the hierarchy would then take appropriate action, which may mean managing the risk directly, or could mean adjusting the level of risk that they are happy for the level below to manage (letter D in the model at 5.2). It is also often the case that a higher level of management, with a wider portfolio of risk to manage, has more scope to accept higher risks in particular areas as they can offset them against other lower risks in their portfolio.



5.5 Further applications of the concept of risk appetite include:

- **Resource allocation:** Once the risk appetite level is set, it is possible to review if resources are targeted appropriately. If a risk does not correspond to the agreed risk appetite, resources could be focused on bringing it to within the tolerance level. Risks which are already within the agreed tolerance level could be reviewed to see if resources could be moved to more risky areas without negative effects. Customs, Inland Revenue, the Police and Fire Service all use risk-based resource allocations to prioritise allocation of resources;
- **Project initiation:** When taking the decision whether to initiate a new project, and when undertaking subsequent OGC Gateway reviews, risk appetite can be used as a guide on whether to proceed with the project and also to help identify and manage risks which may impede the success of the project.

6 ADDRESSING RISKS

6.1 The purpose of addressing risks is to turn uncertainty to the organisation's benefit by constraining threats and taking advantage of opportunities. Any action that is taken by the organisation to address a risk forms part of what is known as "internal control". There are five key aspects of addressing risk:

TOLERATE

The exposure may be tolerable without any further action being taken. Even if it is not tolerable, ability to do anything about some risks may be limited, or the cost of taking any action may be disproportionate to the potential benefit gained. In these cases the response may be to tolerate the existing level of risk. This option, of course, may be supplemented by contingency planning for handling the impacts that will arise if the risk is realised.

TREAT

By far the greater number of risks will be addressed in this way. The purpose of treatment is that whilst continuing within the organisation with the activity giving rise to the risk, action (control) is taken constrain the risk to an acceptable level. Such controls can be further sub-divided according to their particular purpose (see 6.2 below)

TRANSFER

For some risks the best response may be to transfer them. This might be done by conventional insurance, or it might be done by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks or risks to assets. The transfer of risks may be considered to either reduce the exposure of the organisation or because another organisation (which may be another government organisation) is more capable of effectively managing the risk. It is important to note that some risks are not (fully) transferable – in particular it is generally not possible to transfer reputational risk even if the delivery of a service is contracted out. The relationship with the third party to which the risk is transferred needs to be carefully managed to ensure successful transfer of risk (see section 10).

TERMINATE

Some risks will only be treatable, or containable to acceptable levels, by terminating the activity. It should be noted that the option of termination of activities may be severely limited in government when compared to the private sector; a number of activities are conducted in the government sector because the associated risks are so great that there is no other way in which the output or outcome, which is required for the public benefit, can be achieved. This option can be particularly important in project management if it becomes clear that the projected cost / benefit relationship is in jeopardy.

TAKE THE OPPORTUNITY

This option is not an alternative to those above; rather it is an option which should be considered whenever tolerating, transferring or treating a risk. There are two aspects to this. The first is whether or not at the same time as mitigating threats, an opportunity arises to exploit positive impact. For example, if a large sum of capital funding is to be put at risk in a major project, are the relevant controls judged to be good enough to justify increasing the sum of money at stake to gain even greater advantages? The second is whether or not circumstances arise which, whilst not generating threats, offer positive opportunities. For example, a drop in the cost of goods or services frees up resources which can be re-deployed.

6.2 The option of "treat" in addressing risk can be further analysed into four different types of controls:

PREVENTIVE CONTROLS

These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is that an undesirable outcome should not arise, the more important it becomes to implement appropriate preventive controls. The majority of controls implemented in organisations tend to belong to this category. Examples of preventive controls include separation of duty, whereby no one person has authority to act without the consent of another (such as the person who authorises payment of an invoice being separate from the person who ordered goods prevents one person securing goods at public expense for their own benefit), or limitation of action to authorised persons (such as only those suitably trained and authorised being permitted to handle media enquiries prevents inappropriate comment being made to the press).

CORRECTIVE CONTROLS

These controls are designed to correct undesirable outcomes which have been realised. They provide a route of recourse to achieve some recovery against loss or damage. An example of this would be design of contract terms to allow recovery of overpayment. Insurance can also be regarded as a form of corrective control as it facilitates financial recovery against the realisation of a risk. Contingency planning is an important element of corrective control as it is the means by which organisations plan for business continuity / recovery after events which they could not control.

DIRECTIVE CONTROLS

These controls are designed to ensure that a particular outcome is achieved. They are particularly important when it is critical that an undesirable event is avoided - typically associated with Health and Safety or with security. Examples of this type of control would be to include a requirement that protective clothing be worn during the performance of dangerous duties, or that staff be trained with required skills before being allowed to work unsupervised.

DETECTIVE CONTROLS

These controls are designed to identify occasions of undesirable outcomes having been realised. Their effect is, by definition, "after the event" so they are only appropriate when it is possible to accept the loss or damage incurred. Examples of detective controls include stock or asset checks (which detect whether stocks or assets have been removed without authorisation), reconciliation (which can detect unauthorised transactions), "Post Implementation Reviews" which detect lessons to be learnt from projects for application in future work, and monitoring activities which detect changes that should be responded to.

6.3 In designing control, it is important that the control put in place is proportional to the risk. Apart from the most extreme undesirable outcome (such as loss of human life) it is normally sufficient to design control to give a *reasonable assurance* of confining likely loss within the risk appetite of the organisation. Every control action has an associated cost and it is important that the control action offers value for money in relation to the risk that it is controlling. Generally speaking the purpose of control is to constrain risk rather than to eliminate it.

7 REVIEWING AND REPORTING RISKS

7.1 The management of risk has to be reviewed and reported on for two reasons:

- To monitor whether or not the risk profile is changing;
- To gain assurance that risk management is effective, and to identify when further action is necessary.

7.2 Processes should be put in place to review whether risks still exist, whether new risks have arisen, whether the likelihood and impact of risks has changed, report significant changes which adjust risk priorities, and deliver assurance on the effectiveness of control. In addition, the *overall risk management process* should be subjected to regular review to deliver assurance that it remains appropriate and effective. Review of risks and review of the risk management process are distinct from each other and neither is a substitute for the other. The review processes should:

- ensure that all aspects of the risk management process are reviewed at least once a year;
- ensure that risks themselves are subjected to review with appropriate frequency (with appropriate provision for management's own review of risks and for independent review/audit);
- make provision for alerting the appropriate level of management to new risks or to changes in already identified risks so that the change can be appropriately addressed.

7.3 A number of tools and techniques are available to help with achieving the review process

- Risk Self Assessment (RSA) is a technique which has already been referred to in the identification of risk (see 3.5). The RSA process also contributes to the review process. The results of RSA are reported into the process for maintaining the organisation-wide risk profile. (This process is also sometimes referred to as CRSA – "Control and Risk Self Assessment");
- "Stewardship Reporting" requires that designated managers at various levels of the organisation report upwards (usually at least annually at the financial year end, and often on a quarterly or half yearly interim basis) on the work they have done to keep risk and control procedures up to date and appropriate to circumstances within their particular area of responsibility. This process is compatible with RSA; managers may use RSA as a tool to inform the preparation of their Stewardship Report;
- The "Risk Management Assessment Framework", produced by the Treasury, provides a tool for evaluating the maturity of an organisation's risk management. This tool is especially useful in preparing for the annual "Statement on Internal Control" which is a public statement about the review of the system of internal control[1].

[1] See Government Accounting, Chapter 21 for more detail – www.government-accounting.gov.uk

In addition to these formal tools, individuals, work groups and teams should constantly by considering the risk issues which they face in the work they are doing.

7.4 Every central government organisation is required to make provision for Internal Audit. Internal Audit's work provides an important independent and objective assurance about the adequacy of risk management, control and governance[2]. Internal audit may also be used by management as an expert internal consultant to assist with the development of a strategic risk management process for the organisation. It will have a wide ranging view of the whole range of activities which the organisation undertakes, and will already have undertaken some form of assessment to inform its planning of systems and processes to be audited. However it is important to note Internal Audit is neither a substitute for management ownership of risk nor a substitute for an embedded review system carried out by the various staff who have executive responsibility for the achievement of organisational objectives (see the "Government Internal Audit Standards", HM Treasury, October 2001 and associated good practice guidance for more detail on internal audit issues).

7.5 Many organisations have specialist review and assurance teams which have been established for a particular purpose (for example, Accounts Inspection Teams, or Compliance Review Teams). Their work contributes to the assurances available about the risk and control systems in use in the organisation. "Stewardship" assurance mechanisms, whereby line managers give account of their stewardship of their areas of responsibility, are also important, especially in organisations with highly devolved control structures.

7.6 Except in rare circumstances, every government organisation will have an Audit Committee (established as a Committee of the Board, ideally with non-executive membership and Chaired by a non-executive) which will be charged with supporting the Accounting Officer in their responsibilities for issues of risk, control and governance and associated assurance (see the "Audit Committee Handbook, HM Treasury, October 2003 for more detail). The Audit Committee should be asked by the Accounting Officer /Board to:

- gain assurance that risk, and change in risk, is being monitored;
- receive the various assurances which are available about risk management and consequently delivering an overall opinion about risk management;
- comment on appropriateness of the risk management and assurance processes which are in place.

However it should be noted that the Audit Committee should not itself own or manage risks and is, as with internal audit, not a substitute for the proper role of management in managing risk.

[2] "Definition of internal Audit", Government Internal Audit Standards, HM Treasury, October 2001

7.7 Some organisations may establish a Risk Committee. The Board need to decide what role it wants to assign to the Risk Committee. If the Risk Committee is established as a committee of the Board and is (largely) non executive (i.e. – a "Risk *Assurance* Committee") it may undertake those functions outlined at 7.6 above which would otherwise be assigned to an Audit Committee; if, however, the Risk Committee is a forum for executive managers who have significant responsibility for the ownership and management of risk to meet together in order to share experience and co-ordinate their risk management actions (i.e. – a "Risk *Management* Committee" which discharges executive responsibility for ensuring that risk is effectively managed) the Audit Committee should retain the independent assurance role which is specified for it. The latter option does not preclude non-executive input to the considerations of the Risk Committee.

7.8 Annex B sets out the principles and key process elements for both deriving and delivering overall assurance on risk management and provides an overview for the assurance process.

8 COMMUNICATION AND LEARNING

8.1 Communication and learning is not a distinct stage in the management of risk; rather it is something which runs through the whole risk management process. There are a number of aspects of communication and learning which should be highlighted.

8.2 The identification of new risks or changes in risk is itself dependant on communication. "Horizon scanning" (see 3.7 and Annex C) in particular depends on maintaining a good network of communications with relevant contacts and sources of information to facilitate identification of changes which will affect the organisation's risk profile. This can range from information on national security which could affect a government organisations strategic planning, through commercial intelligence about the viability of partner organisations or key contractors, to information about plans which one government organisation has which may affect demands made on another government organisation.

8.3 Communication within the organisation about risk issues is important:

- It is important to ensure that everybody understands, in a way appropriate to their role, what the organisation's risk strategy is, what the risk priorities are, and how their particular responsibilities in the organisation fit into that framework. If this is not achieved, appropriate and consistent embedding of risk management will not be achieved and risk priorities may not be consistently addressed;
- There is a need to ensure that transferable lessons are learned and communicated to those who can benefit from them. For example, if one part of the organisation encounters a new risk and devises an effective control to deal with it, that lesson should be communicated to all others who may also encounter that risk;
- There is a need to ensure that each level of management, including the Board, actively seeks and receives appropriate and regular assurance about the management of risk within their span of control. They need to be provided with sufficient information to allow them to plan action in respect of risks where the residual risk is not acceptable, as well as assurance about risks which are deemed to be acceptably under control. As well as routine communication of such assurance there should be a mechanism for escalating important risk issues which suddenly develop or emerge.

8.4 Communication with partner organisations about risk issues is also important (see also Section 9 – The Extended Enterprise), especially if the organisation is dependent on the other organisation not just for a particular contract but for direct delivery of a service on behalf of the organisation. Misunderstanding of respective risk priorities can cause serious problems – in particular leading to inappropriate levels of control being applied to specific risks, and failure to gain assurance about whether or not a partner organisation has implemented adequate risk management for itself can lead to dependence on a third party which may fail to deliver in an acceptable way.

8.5 It is important to communicate with stakeholders about the way in which the organisation is managing risk to give them assurance that the organisation will deliver in the way which they expect, and to manage stakeholder expectation of what the organisation can actually deliver. This is especially important in relation to risks which affect the public and where the public depend on government to respond to the risk for them.

9 THE EXTENDED ENTERPRISE

9.1 No organisation is entirely self-contained – it will have a number of inter-dependencies with other organisations. These inter-dependencies are sometimes called the "extended enterprise" and will impact on the organisation's risk management, giving rise to certain additional risks which need to be managed. These considerations should include the impact of the organisation's actions on other organisations. This section highlights some potential extended enterprise relationships and the risk management implications which might arise.

9.2 Many organisations will have inter-dependencies with other Government organisations with which they do not have a direct control relationship – the delivery of their objectives will depend upon / impact upon the delivery of the other organisation's objectives. In these circumstances what one organisation does will have a direct impact on the risks which another organisation faces, and effective liaison between the two organisations is essential to facilitate an agreed risk management approach which will allow both to achieve their objectives.

9.3 Many government organisations will have a relationship with bodies which they either "parent" or which have a "parent" role over them. In particular many policy departments are dependent on Executive Agencies or Non-Departmental Public Bodies (NDPBs) for delivery of their policy, and many Executive Agencies and NDPBs are constrained in policy by their parent department. In these circumstances the risk priorities of a parent department will impact on the priorities of the organisations which they sponsor, and the sponsored organisations' experience of managing risk in delivery of the policy needs to be considered by the parent organisation in the further development of policy. Regular and open discussion of risk issues between parent organisations and sponsored organisations is critical to the overall effective delivery of public service.

9.4 Probably all government organisations will have dependencies on contractors or other third parties, although the extent of these dependencies will vary. These relationships may range from straightforward supply of goods which the organisation requires in order to function, through to delivery of major services to, or on behalf of, the organisation. In some cases a contract with a third party will have been created to deliberately transfer risk which the third party is in a better position to manage (see 7.1). This could include Public Private Partnerships or contracted out services such as delivery of the IT infrastructure for the organisation. A particular potential problem here is when the organisation has a high dependency on a contractor, but the organisation is only a minor client for the contractor (for example, a small NDPB purchasing bespoke software from a major IT consulting firm). It is important that organisations consider each of their significant relationships with contractors and third parties and ensure that appropriate communication and understanding about respective risk priorities is achieved.

9.5 Whatever the detailed nature of the risk relationships that the organisation has with others across the extended enterprise, each relationship will also give rise to a need for assurance to be provided that risk is being managed in that relationship both appropriately and as planned. Provision for obtaining such assurance is an integral part of the relationship.

10 Risk Environment and context

10.1 Beyond the boundary of the "extended enterprise", other factors contribute to the environment in which risk has to be managed. These factors (generally those in the "external" risk grouping in the table in Section 3) may either generate risks which cannot be directly controlled, or they may constrain the way in which the organisation is permitted to take or address risk. Often the only response which an organisation can make in relation to the risk environment is to prepare contingency plans. For example, most government organisations with central London headquarters cannot directly control the risks arising from international terrorism, but they can make contingency plans for how to ensure business continuity in the event of a major terrorist attack (see www.ukresilience.info/lead.htm for more information). It is important that an organisation should consider its wider risk environment and identify the way in which it impacts on its risk management strategy.

10.2 In particular, laws and regulations, can have an effect on the risk environment. It is important for an organisation to identify the ways in which laws and regulations make demands on it, either by requiring the organisation to do certain things or by constraining the actions which the organisation is permitted to take. For example, the way in which an organisation handles the risk of staff performing inadequately is constrained by employment legislation.

10.3 The economy, both domestically and internationally, is another important element of the risk environment. Whilst for most organisations the general economy is a given, it does affect the markets in which they have to function in obtaining or providing goods and services; in particular the economy can have an effect on the ability of an organisation to attract and retain staff with the skills which the organisation needs.

10.4 A particular aspect of the risk environment which is important for government organisations is Government itself. In principle, government organisations exist to deliver the policies which the Government and its Ministers have decided upon. There is a particular strand of risk management which is important in providing Ministers with risk based policy advice. Nevertheless, officials in government organisations may be constrained in the risks which they do or do not take by policy decisions.

10.5 Every organisation is also constrained by stakeholder expectation. Risk management actions, which appear good value and effective in the abstract, may not be acceptable to stakeholders. For government organisations this is especially important in respect of relationships with the public (see 7.5); actions that would be effective at dealing with a specific risk may have other effects that the public are unwilling to accept.

A EXAMPLE OF DOCUMENTING RISK ASSESSMENT

OBJECTIVE – To travel from A to B in time for an important meeting								
	Inherent assessment		CONTROLS IN PLACE	Residual assessment		ACTION PLANNED	TARGET DATE	OWNER
RISK	Impact	Likelihood		Impact	Likelihood			
Missing a train makes me late for the important meeting		High	Catch train one earlier than I actually need		Low	No further action planned		M.Y. Self
Severe weather prevents the train from running		Low	Cannot control		Low	Telephone conferencing facility to be installed as a contingency	August	A.N. Other
Engineering works make the train late	High	Medium	Check for engineering works and arrange flexibility with people I am meeting	Medium	Low	No further action planned		M.Y. Self

B OVERALL ASSURANCE ON RISK MANAGEMENT

PRINCIPLES OF ASSURANCE

1. Planning to gain assurance:

1.1 Assurance strategy – overall assurance will only be gained if a strategic plan for obtaining it is developed;

1.2 Assurance process – the processes for obtaining assurance should be embedded into existing processes.

2. Making explicit the scope of the assurance boundaries:

In order to arrive at an overall opinion the scope of the processes required for obtaining assurance need to encompass the whole of the organisation's risk management lifecycle. This does not mean that every risk and every control has to be reviewed in order to obtain assurance. However, the review, which takes place, will need to provide:

2.1 Assurance on the Risk Management Strategy - Ascertain the extent to which all line managers review the risks / controls within the ambit of their responsibility;

2.2 Assurance on management of risks/controls - encompass all the key risks and encompass enough of the other risks to support confidence in the overall opinion reached;

2.3 Assurance on the adequacy of the review/assurance process - quality assured to engender confidence in the review process.

3. Evidence:

The evidence supporting assurance should be sufficient in scope (2.2 above) and weight (4.2 below) to support the conclusion and be:

- relevant;
- reliable;
- understandable;
- free from material misstatement;
- neutral/free from bias;
- such that another person would reasonably come to the same conclusion.

4. Evaluation:

4.1 The objective is to:

- evaluate the adequacy of the risk management policy and strategy to achieve its objectives;
- evaluate the adequacy of the risk management processes designed to constrain residual risk to the risk appetite;
- identify limitations in the evidence provided or in the depth or scope of the reviews undertaken;
- identify gaps in control and/or over control, and provide the opportunity for continuous improvement; and
- support preparation of the SIC.

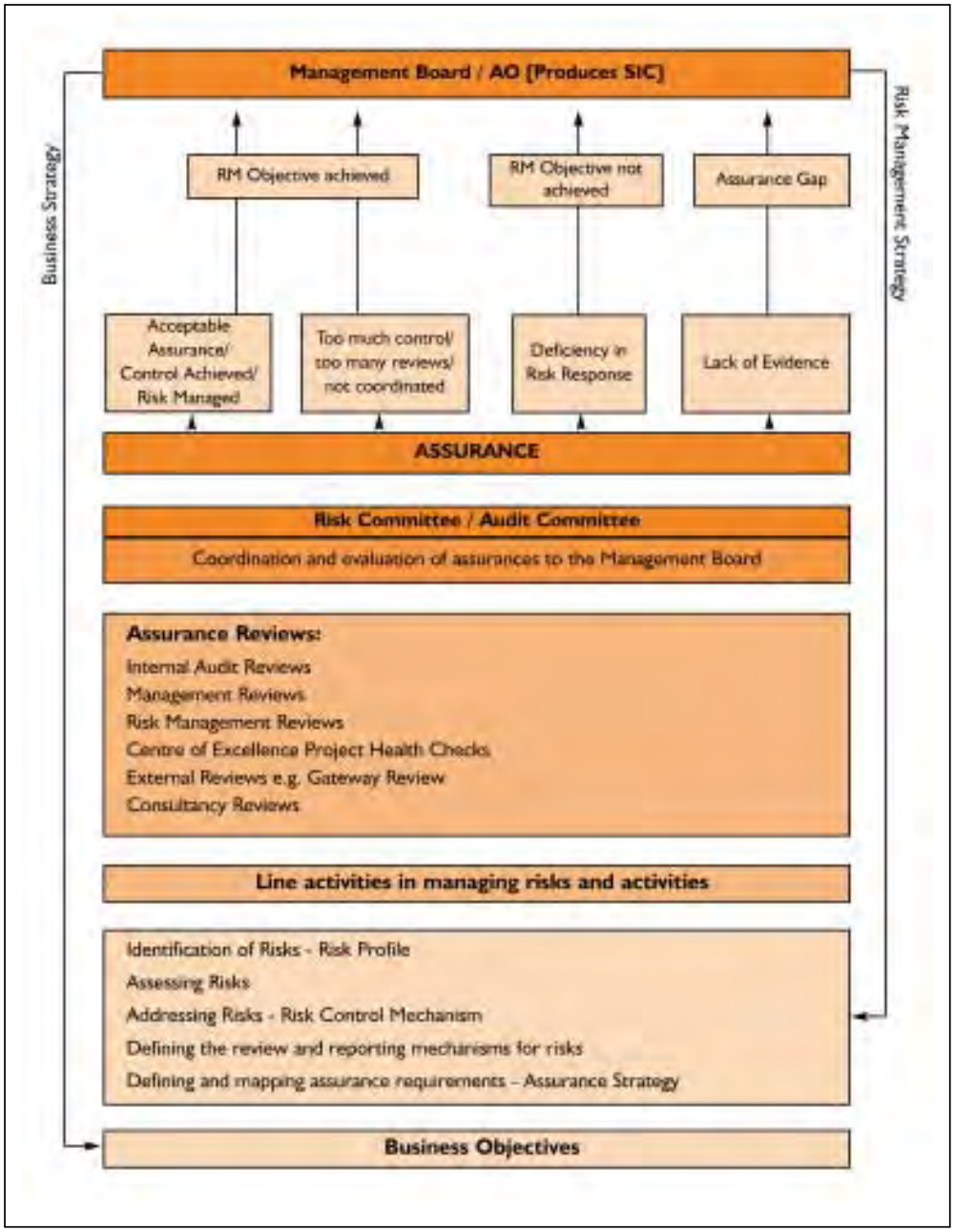
4.2 In evaluating evidence to arrive at an overall judgment or opinion all of the evidence criteria at 3 need to be considered. However it is important to recognise that:

- Not all evidence is of the same weight in deriving assurance. Evidence should be weighted:
  - According to its independence – the more independent the evidence, the more reliance can be placed on it. However circumstances may exist that could affect the reliability of the information obtained, e.g. for independent external evidence to be reliable the source of the evidence must be also knowledgeable;
  - According to its relevance – in determining the overall assurance there is a need to ensure that the evidence relates to those elements of the risk management lifecycle considered to be significant - evidence relevant to the more significant risks is consequently of greater relevance to the overall assurance;
  - Evidence may be flawed in terms of both quantity and quality where the evidence criteria are not met, leading to limitations in the assurance that can be provided. For example, merely obtaining more evidence will not compensate where the quality of evidence is low or where the source of evidence is not reliable.

5. Reviewing and Reporting:

5.1 Assurances are reported from many different sources within an organisation: from external sources, from suppliers and contractor, from third parties, from management and practitioner review internal to the organisation and from internal independent or neutral sources etc. The Assurance Strategy needs to define stages where assurances will be evaluated and opinions reported through the various layers of management to the Board.

5.2 Assurance opinions need to be reported clearly, and worded so as to clearly communicate the scope and criteria used in arriving at those conclusions.


Management Board / AO [Produces SIC]
Business Strategy
Risk Management Strategy
RM Objective achieved
RM Objective not achieved
Assurance Gap
Acceptable Assurance/ Control Achieved/ Risk Managed
Too much control/ too many reviews/ not coordinated
Deficiency in Risk Response
Lack of Evidence
ASSURANCE
Risk Committee / Audit Committee
Coordination and evaluation of assurances to the Management Board
Assurance Reviews:
Internal Audit Reviews
Management Reviews
Risk Management Reviews
Centre of Excellence Project Health Checks
External Reviews e.g. Gateway Review
Consultancy Reviews
Line activities in managing risks and activities
Identification of Risks - Risk Profile
Assessing Risks
Addressing Risks - Risk Control Mechanism
Defining the review and reporting mechanisms for risks
Defining and mapping assurance requirements – Assurance Strategy
Business Objectives

C

SUMMARY OF HORIZON SCANNING ISSUES

Provided by the Civil Contingencies Secretariat of Cabinet Office

- **Periodicity / Regularity:** horizon scanning may be continuous (in an organisation like the Civil Contingencies Secretariat (CCS) which continuously searches for potential future disruptive challenges) or periodic (e.g. weekly or annually);
- **Timescale:** Policy makers could well be interested in developments over the next twenty-five years whilst horizon scanning that supports operational decision making may be restricted to a six month timeframe;
- **Scope:** Some organisations may be fairly insular in their risk identification processes if they perceive that the major element of risk arises from within the organisation; others may need to consider a much wider scope if they consider that they may face risks from a wider environment. Depending on the nature of the organisation's business this element of risk identification may range from almost exclusively internal activity to activity that depends on international networks of technical information;
- **Opportunity/threat:** Some horizon scanning is concerned mainly with spotting potential problems, but it can equally be used to scan for opportunities ("positive risks"), and many problems may be translatable into opportunities if spotted early enough;
- **Rigour / technicality:** Horizon scanning varies in the extent to which it is structured and supported by technology. Some organisations use sophisticated assessment schemes and information search technologies; other organisations will rely almost entirely on informal networks of contacts and good judgment.

[see www.ukresilience.info/home.htm for more information]

D Glossary of Key Terms

Assurance	an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework.
Audit Committee	a Committee appointed to support the Accounting Officer (in NDPBs a Committee of the board to support the Board) in monitoring the corporate governance and control systems in the organisation.
Exposure	the consequences, as a combination of impact and likelihood, which may be experienced by the organisation if a specific risk is realised.
Horizon Scanning	systematic activity designed to identify, as early as possible, indicators of changes in risk.
Inherent Risk	the exposure arising from a specific risk before any action has been taken to manage it.
Residual Risk	the exposure arising from a specific risk after action has been taken to manage it and making the assumption that the action is effective.
Risk	uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combi-nation of likelihood and impact, including perceived importance.
Risk Appetite	the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.
Risk Assessment	the evaluation of risk with regard to the impact if the risk is realised and the likelihood of the risk being realised.
Risk Assurance Committee	a Committee established to undertake the role which the Audit Committee should otherwise undertake in respect of assurance on risk management.
Risk Management	all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Management Committee	a Committee established with executive authority to take action to manage the risks which face the organisation.

Risk Strategy	the overall organisational approach to risk management as defined by the Accounting Officer and/or Board. This should be documented and easily available throughout the organisation.
Risk Profile	the documented and prioritised overall assessment of the range of specific risks faced by the organisation.
Internal Control	any action, originating within the organisation, taken to manage risk. These actions may be taken to manage either the impact if the risk is realised, or the frequency of the realisation of the risk.


ISBN 1-84532-044-1-1
9 781845 320447

HM Government

The Orange Book

Management of Risk – Principles and Concepts

Term	Intention
shall	denotes a requirement: a mandatory element
should	denotes a recommendation: an advisory element
may	denotes approval
might	denotes a possibility
can	denotes both capability and possibility
is/are	denotes a description

References are shown in square brackets [] and listed in Annex 6.

The meaning of words is as defined in the Shorter Oxford English Dictionary, except where defined in Annex 5. It is assumed that legal and regulatory requirements shall always be met.

Produced by Mark Ripley, Government Finance Function

Alternative format versions of this report are available on request from GovFinance@hmtreasury.gov.uk

Contents

Introduction

In successful organisations, risk management enhances strategic planning and prioritisation, assists in achieving objectives and strengthens the ability to be agile to respond to the challenges faced. If we are serious about meeting objectives successfully, improving service delivery and achieving value for money, risk management must be an essential and integral part of planning and decision-making. While risk practices have improved over time across government, the volatility, complexity and ambiguity of our operating environment has increased, as have demands for greater transparency and accountability for managing the impact of risks. This updated guidance builds on the previous Orange Book to help improve risk management further and to embed this as a routine part of how we operate.

Public sector organisations cannot be risk averse and be successful. Risk is inherent in everything we do to deliver high-quality services. Effective and meaningful risk management in government remains as important as ever in taking a balanced view to managing opportunity and risk. It must be an integral part of informed decision-making; from policy or project inception through implementation to the everyday delivery of public services. At its most effective, risk management is as much about evaluating the uncertainties and implications within options as it is about managing impacts once choices are made. It is about being realistic in the assessment of the risks to projects and programmes and in the consideration of the effectiveness of the actions taken to manage these risks.

This isn't about adding new processes; it is about ensuring that effective risk management is integrated in the way we lead, direct, manage and operate. As an integrated part of our management systems, and through the normal flow of information, an organisation's risk management framework harnesses the activities that identify and manage the uncertainties faced and systematically anticipate and prepare successful responses. Its importance and value to success should not be underestimated.

As with all aspects of good governance, the effectiveness of risk management depends on the individuals responsible for operating the systems put in place. Our risk culture must embrace openness, support transparency, welcome constructive challenge and promote collaboration, consultation and co-operation. We must invite scrutiny and embrace expertise to inform decision-making. We must also invest in the necessary capabilities and seek to continually learn from experience.

This updated guidance has benefited from discussions with stakeholders and practitioners across the public sector and with colleagues from the private sector. We are grateful for their time and their valuable insights.

Scope

The document updates the version published in 2004. Like the original, it sets out the main principles underlying effective risk management in all government departments and arm's length public bodies[1] with responsibility derived from central government for public funds.

This document may be useful to all parts of the UK public sector, as the same principles generally apply, with adjustments for context.

Purpose

This document is intended for use by everyone involved in the design, operation and delivery of efficient, trusted public services. Its primary audience is likely to be:

- executive and non-executive members of the board;
- Audit and Risk Assurance Committee members;
- risk practitioners;
- senior leadership;
- policy leads; and
- programme and project Senior Responsible Officers (SROs).

The board of each public sector organisation should actively seek to recognise risks and direct the response to these risks. It is for each accounting officer, supported by the board, to decide how. The board and accounting officer should be supported by an Audit and Risk Assurance Committee, who should provide proactive support in advising on and scrutinising the management of key risks and the operation of efficient and effective internal controls.

Attempting to define a one-size-fits-all approach to managing risks, or to standardise risk management practices, would be misguided because public sector organisations are different sizes, are structured differently and have different needs.

This document does not set out the procedure by which an organisation should design and operate risk management. It sets out a principles-based approach that provides flexibility and judgement in the design, implementation and operation of risk management, informed by relevant standards[1] and good practice. Where relevant, the reader is directed to other standards and guidance, including related functional and professional standards and codes of practice (see Annex 6). References throughout the document are shown in square brackets [].

The Management of Risk framework is available through AXELOS[2], who manage guides that comprise the recommended best practice for government project delivery and provide advice on their application.

Comply or Explain

The document sets out main and supporting principles for risk management in government. In considering the effectiveness of risk management arrangements, assessing compliance with *Corporate Governance Code*[2] requirements, and overseeing the preparation of the governance

1 Executive Agencies, Non Departmental Public Bodies and Non Ministerial Departments.

2 AXELOS is a company part owned by the UK government. Their guides are available by subscription or individual purchase.

statement, the board shall consider adherence with the main principles, which are mandatory requirements. The supporting principles, which are advisory, should inform their judgements. Departures may be justified if good risk management can be achieved by other means.

The main principles are the core of the document. The way in which they are applied should be the central question for a board as it determines how it is to operate in accordance with the Corporate Governance Code. Each government organisation is required either to disclose compliance or to explain their reasons for departure clearly and carefully in the governance statement accompanying their annual resource accounts. The requirement for an explanation allows flexibility, but also ensures that the process is transparent, allowing stakeholders to hold organisations and their leadership to account.

Structure

The core document is structured around Sections (A-E), based on principles that are designed to provide the "what" and the "why", not the "how", for the design, operation and maintenance of an effective risk management framework.

The principles can be applied within and across departments, arm's length bodies and organisations with linked objectives, and to activity at any level of decision-making.

The principles should be used to inform an organisation's approach to risk management and its own more detailed policies, processes and procedures – the "how". Implementing and improving the risk management framework should support an incremental approach to enhancing risk management culture, processes and capabilities over time, building on what already exists to achieve improved outcomes.

The primary roles and responsibilities for the risk management framework are set out in each Section. The responsibilities and expectations of the board, the accounting officer and the Audit and Risk Assurance Committee are also summarised at Annex 1.

Some explanation of, and guiding principles on, the design and operation of the "three lines of defence" model are provided in Annex 2.

Annex 3 contains questions that may assist in assessing how the principles are applied in defining clear responsibilities, promoting the risk culture, developing capabilities and supporting the effectiveness of the risk management framework.

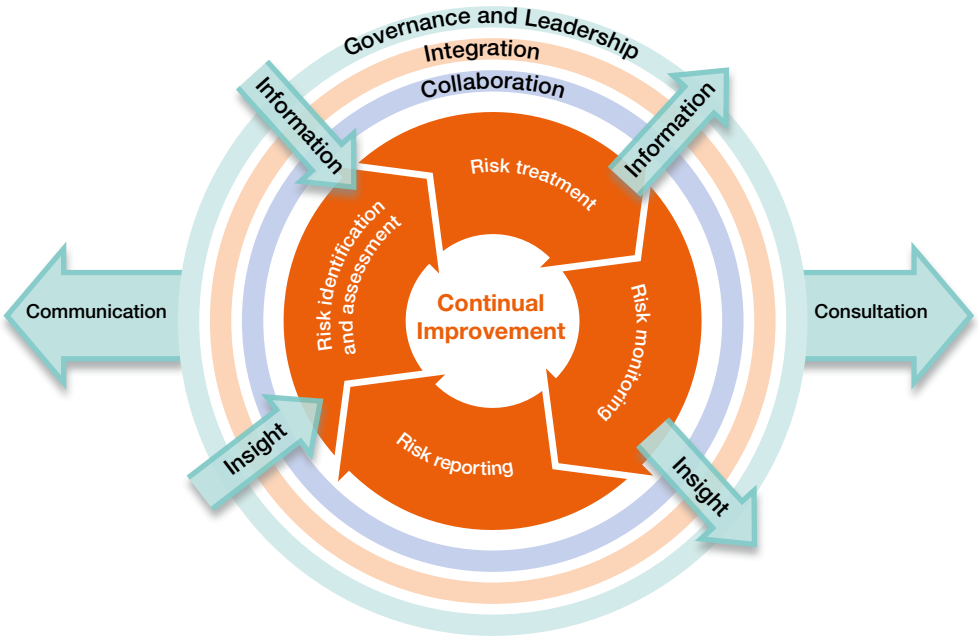
Some common categories or groupings of sources of risk are provided at Annex 4. These may help consider the range of potential risks that may arise; they are not intended to be comprehensive.

Definitions and supportive concepts are provided at Annex 5 of some terms used throughout this document to explain the scope and intended meaning behind the language used.

Annex 6 contains further details of other standards and guidance referenced throughout the document.

Risk Management Principles

Risk Management Framework



The risk management framework supports the consistent and robust identification and management of opportunities and risks within desired levels across an organisation, supporting openness, challenge, innovation and excellence in the achievement of objectives. For the risk management framework to be considered effective, the following principles shall be applied:

A. Risk management shall be an essential part of **governance and leadership**, and fundamental to how the organisation is directed, managed and controlled at all levels.

B. Risk management shall be an **integral** part of all organisational activities to support decision-making in achieving objectives.

C. Risk management shall be **collaborative and informed** by the best available information and expertise.

D. Risk management processes shall be **structured** to include:

   a. **risk identification and assessment** to determine and prioritise how the risks should be managed;

   b. the selection, design and implementation of **risk treatment** options that support achievement of intended outcomes and manage risks to an acceptable level;

   c. the design and operation of integrated, insightful and informative **risk monitoring**; and

   d. timely, accurate and useful **risk reporting** to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.

E. Risk management shall be **continually improved** through learning and experience.

Section A: Governance and Leadership

Main Principle

A **Risk management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels.**

Supporting Principles

A1 Each public sector organisation should establish governance arrangements appropriate to its business, scale and culture[3]. Human behaviour and culture significantly influence all aspects of risk management at each level and stage. To support the appropriate risk culture, the accounting officer should ensure that expected values and behaviours are communicated and embedded at all levels.

A2 The accounting officer, supported by the board, should periodically assess whether the leadership style, opportunities for debate and human resource policies support the desired risk culture, incentivise expected behaviours and sanction inappropriate behaviours. Where they are not satisfied, they should direct and manage corrective actions and seek assurances that the desired risk culture and behaviours are promoted.

CS Code/Brilliant CS values

Brilliant CS

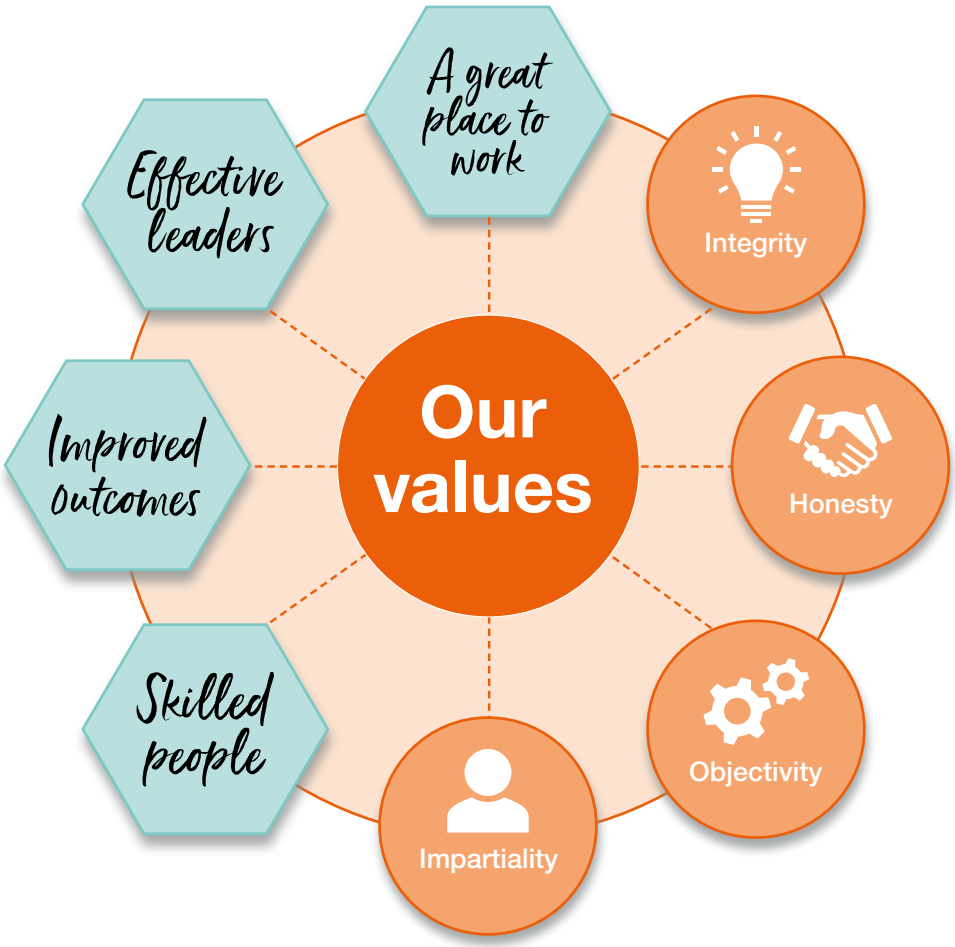
CS Code

'integrity' is putting the obligations of public service above your own personal interests

'honesty' is being truthful and open

'objectivity' is basing your advice and decisions on rigorous analysis of the evidence

'impartiality' is acting solely according to the merits of the case and serving equally well governments of different political persuasions



A3 The board should make a strategic choice about the style, shape and quality of risk management[4] and should lead the assessment and management of opportunity and risk. The board should determine and continuously assess the nature and extent of the principal risks[3] that the organisation is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.

3 A principal risk is a risk or combination of risks that can seriously affect the performance or reputation of the organisation.

A4 The board should ensure that roles and responsibilities for risk management are clear, to support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation. The accounting officer should ensure that roles and responsibilities are communicated, understood and embedded at all levels. The "three lines of defence model" provides a systematic approach that may be used to help clarify the specific roles and responsibilities that are necessary for the effective management of risks within an organisation (see Annex 2).

A5 The board should agree the frequency and scope of its discussions to review how management is responding to the principal risks and how this is integrated with other matters, including planning and performance management processes. Risk should be considered regularly as part of the normal flow of management information about the organisation's activities and in significant decisions on strategy, major new projects and other prioritisation and resource allocation commitments. Risk management should anticipate, detect, acknowledge and respond to changes and events in an appropriate and timely manner. Risks can crystallise quickly; the board and Audit and Risk Assurance Committee should ensure that there are clear processes for bringing significant issues to its attention more rapidly when required, with agreed triggers for doing so as a part of risk reporting (see Section D).

A6 Regular reports to the board should provide a balanced assessment of the principal risks and the effectiveness of risk management. The accounting officer, supported by the Audit and Risk Assurance Committee, should monitor the quality of the information they receive and ensure that it is sufficient to allow effective decision-making.

A7 The accounting officer, supported by the Audit and Risk Assurance Committee, should establish the organisation's overall approach to risk management. An effective risk management framework will differ between organisations depending on their purpose, objectives, context and complexity. The risk management framework should be periodically reviewed to ensure it remains appropriate (see Section E).

A8 The accounting officer should designate an individual to be responsible for leading the organisation's overall approach to risk management, who should be of sufficient seniority and should report to a level within the organisation that allows them to influence effective decision-making. They should be proactively involved with and influence governance and decision-making forums and should establish, and be supported through, effective communication and engagement with the accounting officer, senior management, the board and the chair of the Audit and Risk Assurance Committee. They should also exhibit a high level of objectivity in gathering, evaluating and communicating information and should not be unduly influenced by their own interests or by others in forming and expressing their judgements.

A9 The accounting officer should ensure the allocation of appropriate resources for risk management, which can include, but is not limited to, people, skills, experience and competence.

A10 The accounting officer, supported by senior management, must demonstrate leadership and articulate their continual commitment to, and the value of, risk management through developing and communicating a policy or statement to the organisation and other stakeholders, which should be periodically reviewed.

Section B: Integration

Main Principle

B Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives.

Supporting Principles

B1 The assessment and management of opportunity and risk should be an embedded part of, and not separate from:

- setting strategy and plans;
- evaluating options and delivering programmes, projects or policy initiatives;
- prioritising resources;
- supporting efficient and effective operations;
- managing performance;
- managing tangible and intangible assets;[5] and
- delivering improved outcomes.

The accounting officer, supported by senior management, should ensure that risks are transparent and considered as an integral part of appraising options, evaluating alternatives and making informed decisions.

B2 Effective appraisal supports the assessment of the costs, benefits and risks of alternative ways to meet objectives.[6] When conducting an appraisal, consideration should be given to the identification and analysis of risks in the design and implementation of options, including: analysis of varying scenarios, sensitivity in forecasts, the objective or subjective basis of assumptions, optimism or status quo bias, dependencies and the inter-relationships between risks. This analysis and evaluation should provide the foundation to understand the risks arising through chosen options and how these will be managed, including how these will be subject to effective and on-going monitoring (see Section D).

B3 Delivery confidence should be supported through the transparent identification of the principal risks faced and how those risks will be managed within business and financial plans.

B4 The board, and those setting strategy and policy, should use horizon scanning and scenario planning collectively and collaboratively to identify and consider the nature of emerging risks, threats and trends. The Government Office for Science ensures that government policies and decisions are informed by the best scientific evidence and strategic long-term thinking.[7] Some other common horizon scanning issues are informed by the Civil Contingencies Secretariat through the National Risk Assessment (NRA).[8]

B5 Government has an inherent role in protecting and assuring the public, which includes taking cost-effective action to reduce risk to a tolerable level and providing accurate and timely information about risks to the public.[9] Policy leads should take explicit steps to involve the public, understand what they are concerned about and why and communicate good information about risk that is targeted to the needs of the audiences involved. Government will:

- be open and transparent about its understanding of the nature of risks to the public and about the process it is following in handling them;
- seek wide involvement of those concerned in decision-making processes;
- act proportionately and consistently in dealing with risks to the public;
- base decisions for intervention on relevant evidence, including expert risk assessment; and
- place responsibility for managing risks to those best able to control them.

Section C: Collaboration and Best Information

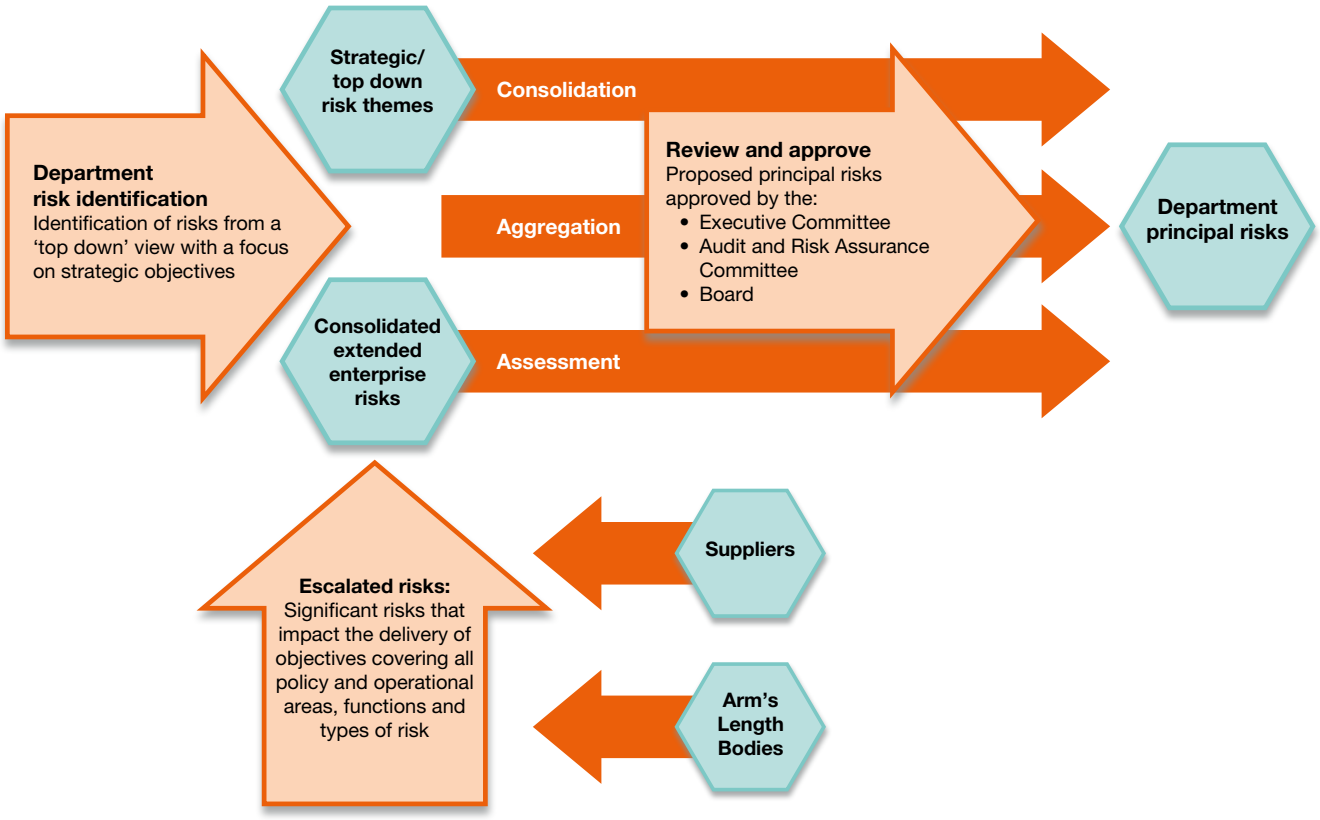
Main Principle

C Risk management shall be collaborative and informed by the best available information and expertise.

Supporting Principles

C1 The accounting officer, supported by the Audit and Risk Assurance Committee, should establish risk management activities that cover all types and source of risk (see Annex 4). There may be many different, but aligned, risk management processes that are applied at different levels within an organisation and across those involved in the end to end delivery of public services. The management of risks and the operation and oversight of internal control should be considered and aligned across this extended enterprise. This requires collaboration and cross-organisational working through a range of public sector, private sector and third-sector partnerships. The risk management framework should be designed to support a comprehensive view of the risk profile, aggregated where appropriate, in support of governance and decision-making requirements.

Risk escalation, consolidation and aggregation



C2 Nearly all government departments sponsor arm's length bodies for which they take ultimate responsibility, while allowing a degree of (or sometimes considerable) independence. Effective relationships and partnership working between departments and arm's length bodies, a mutual understanding of risk, and a proportionate approach to monitoring and reporting are critical. The principal accounting officer[4] should consider the organisation's overall risk profile, including the risk management within arm's length bodies, who should have their own robust and aligned arrangements in place. Informative and transparent management information should enable departments and arm's length bodies to promote transparency and understanding in achieving the effective management of risks, including the timely escalation of risks, as necessary, based on agreed criteria.

C3 Risk management processes (see Section D) should be conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of experts and stakeholders. Information and perspectives should be supplemented by further enquiry as necessary, should reflect changes over time and should be appropriately evidenced. Expert risk assessment methodologies may be highly specialised and may vary depending on the context.

C4 Those assessing and managing risks should consult with appropriate external and internal stakeholders to facilitate the factual, timely, relevant, accurate and understandable exchange of information and evidence, while considering the confidentiality and integrity of this information. Communication should be continual and iterative in supporting dialogue, providing and sharing information and promoting awareness and understanding of risks.

C5 Communication and consultation should also assist relevant stakeholders in understanding the risks faced, the basis on which decisions are made and the reasons why particular actions are required and taken. Communication and consultation should:

- bring together different functions and areas of professional expertise in the management of risks;
- ensure that different views are appropriately considered when defining risk criteria and when analysing risks (see Section D);
- provide sufficient information and evidence to facilitate risk oversight and decision making; and
- build a sense of inclusiveness and ownership among those affected by risk.

Complicated and ambiguous risk scenarios are inherent given the dynamic and/or behavioural complexity in public service delivery, often with no simple, definitive solutions. These risks require whole-system-thinking, aligned incentives, positive relationships and collaboration, alongside relevant technical knowledge, to support multi-disciplinary approaches to their effective management.

4 The Treasury appoints the permanent head of each central government department to be its accounting officer. Where there are several accounting officers in a department, the permanent head is the principal accounting officer.

C6 Functions[5] within and across organisations should play an integral part in identifying, assessing and managing the range of risks than can arise and threaten successful delivery against objectives. Function leads should provide expert judgement to advise the accounting officer to:

- set feasible and affordable strategies and plans;
- evaluate and develop realistic programmes, projects and policy initiatives;
- prioritise and direct resources and the development of capabilities;
- identify and assess risks that can arise and impact the successful achievement of objectives;
- determine the nature and extent of the risks that the organisation is willing to take to achieve its objectives;
- design and operate internal controls in line with good practice; and
- drive innovation and incremental improvements.

5 Functions are embedded in government departments and arm's length bodies, helping to deliver departmental objectives and better outcomes across government.

Section D: Risk Management Processes

Main Principle

D Risk management processes shall be structured to include:

a. **risk identification and assessment to determine and prioritise how the risks should be managed;**

b. **the selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level;**

c. **the design and operation of integrated, insightful and informative risk monitoring; and**

d. **timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.**

Risk Management Processes

Supporting Principles

D1 The accounting officer, supported by their nominated individual responsible for leading the organisation's overall approach to risk management, should ensure the adequate design and systematic implementation of policies, procedures and practices for risk identification and assessment, treatment, monitoring and reporting. Although risk management processes are often presented as sequential, in practice they are iterative.

Risk identification and assessment

D2 Risk identification activities should produce an integrated and holistic view of risks, often organised by taxonomies or categories of risk (see Annex 4). The aim is to understand the organisation's overall risk profile. The organisation can use a range of techniques for identifying specific *risks* that may potentially impact on one or more objectives. The following factors, and the relationship between these factors, should also be considered:

- tangible and intangible sources of risk;
- changes in the external and internal context;
- uncertainties and assumptions within options, strategies, plans, etc;
- indicators of emerging risks;
- limitations of knowledge and reliability of information; and
- any potential biases and beliefs of those involved.

Risks should be identified whether or not their sources are under the organisation's direct control. Even seemingly insignificant risks on their own have the potential, as they interact with other events and conditions, to cause great damage or create significant opportunity.

D3 While each risk identified may be important, some form of measurement is necessary to evaluate their significance to support decision-making. Without a standard for comparison, it is not possible to compare and aggregate risks across the organisation and its extended enterprise. This prioritisation is supported by risk assessment[10], which incorporates risk analysis and risk evaluation.

D4 The purpose of risk analysis is to support a detailed consideration of the nature and level of risk. The risk analysis process should use a common set of risk criteria to foster consistent interpretation and application in defining the level of risk, based on the assessment of the *likelihood* of the risk occurring and the *consequences* should the *event* happen (see Annex 5).

D5 Risk analysis can be undertaken with varying degrees of detail and complexity, depending on the purpose of the analysis, the availability and reliability of evidence and the resources available. Analysis techniques can be qualitative, quantitative or a combination of these, depending on the circumstances and intended use. Limitations and influences associated with the information and evidence bases used, and/or the analysis techniques executed, should be explicitly considered. These should be correctly sourced, appraised and referenced within risk reporting to decision-makers. All business critical analytical models in government should be managed within a framework that ensures appropriately specialist staff are responsible for developing and using the models as well as their quality assurance[11].

D6 Risk evaluation should involve comparing the results of the risk analysis with the nature and extent of risks that the organisation is willing to take - its risk appetite - to determine where and what additional action is required. Options may involve one or more of the following:

- avoiding the risk, if feasible, by deciding not to start or continue with the activity that gives rise to the risk;
- taking or increasing the risk in order to pursue an opportunity;
- retaining the risk by informed decision;
- changing the likelihood, where possible;
- changing the consequences, including planning contingency activities;
- sharing the risk (e.g. through commercial contracts[12]).

The outcome of risk evaluation should be recorded, communicated and validated at appropriate levels of the organisation. It should be regularly reviewed and revised based on the dynamic nature and level of the risks faced.

Risk treatment

D7 Selecting the most appropriate risk treatment option(s) involves balancing the potential benefits derived in enhancing the achievement of objectives against the costs, efforts or disadvantages of proposed actions. Justification for the design of risk treatments and the operation of *internal control* is broader than solely economic considerations and should take into account all of the organisation's obligations, commitments and stakeholder views.

D8 As part of the selection and development of risk treatments, the organisation should specify how the chosen option(s) will be implemented, so that arrangements are understood by those involved and effectiveness can be monitored. This should include:

- the rationale for selection of the option(s), including the expected benefits to be gained;
- the proposed actions;
- those accountable and responsible for approving and implementing the option(s);
- the resources required, including contingencies;
- the key performance measures and control indicators, including early warning indicators;
- the constraints;
- when action(s) are expected to be undertaken and completed; and
- the basis for routine reporting and monitoring.

D9 Where appropriate, contingency, containment, crisis, incident and continuity management arrangements should be developed and communicated to support resilience and recovery if risks crystallise.

Risk monitoring

D10 Monitoring should play a role before, during and after implementation of risk treatment. Ongoing and continuous monitoring should support understanding of whether and how the risk profile is changing and the extent to which internal controls are operating as intended to provide reasonable assurance over the management of risks to an acceptable level in the achievement of organisational objectives.

D11 The results of monitoring and review should be incorporated throughout the organisation's wider performance management, measurement and reporting activities. Recording and reporting aims to:

- transparently communicate risk management activities and outcomes across the organisation;
- provide information for decision-making;

- improve risk management activities; and
- assist interaction with stakeholders, including those with responsibility and accountability for risk management activities.

D12 The "three lines of defence" model sets out how these aspects should operate in an integrated way to manage risks, design and implement internal control and provide *assurance* through ongoing, regular, periodic and ad-hoc monitoring and review (see Annex 2). When an organisation has properly structured the "lines of defence", and they operate effectively, it should understand how each of the lines contributes to the overall assurance required and how those involved can best be integrated and mutually supportive. There should be no gaps in coverage and no unnecessary duplication of effort. Importantly, the accounting officer and the board should receive unbiased information about the organisation's principal risks and how management is responding to those risks.

Risk reporting

D13 The board, supported by the Audit and Risk Assurance Committee, should specify the nature, source, format and frequency of the information that it requires. It should ensure that the assumptions and models underlying this information are clear so that they can be understood and, if necessary, challenged. Factors to consider for reporting include, but are not limited to:

- differing stakeholders and their specific information needs and requirements;
- cost, frequency and timeliness of reporting;
- method of reporting; and
- relevance of information to organisational objectives and decision-making.

D14 The information should support the board to assess whether decisions are being made within its risk appetite to successfully achieve objectives, to review the adequacy and effectiveness of internal controls, and to decide whether any changes are required to re-assess strategy and objectives, revisit or change policies, reprioritise resources, improve controls, and/or alter their risk appetite.

D15 Clear, informative and useful reports or dashboards should promote key information for each principal risk to provide visibility over the risk, compare results against key performance/risk indicators, indicate whether these are within risk appetite, assess the effectiveness of key management actions and summarise the assurance information available. Reports should include qualitative and quantitative information, where appropriate, show trends and support early warning indicators. Understanding and decision-making should be supported through the presentation of information in summary form and the use of graphics and visualisation.

D16 Principal risks should be subject to “deep dive” reviews by the board and Audit and Risk Assurance Committee, with those responsible for the management of risks and with appropriate expertise present at an appropriate frequency depending on the nature of the risk and the performance reported.

Section E: Continual Improvement

Main Principle

E Risk management shall be continually improved through learning and experience

Supporting Principles

E1 The organisation should continually monitor and adapt the risk management framework to address external and internal changes. The organisation should also continually improve the suitability, adequacy and effectiveness of the risk management framework. This should be supported by the consideration of lessons based on experience and, at least annually, review of the risk management framework and the performance outcomes achieved. Annex 3 contains questions that may assist in assessing the efficient and effective operation of the risk management framework.

E2 All strategies, policies, programmes and projects should be subject to comprehensive but proportionate evaluation[13], where practicable to do so. Learning from experience helps to avoid repeating the same mistakes and helps spread improved practices to benefit current and future work, outputs and outcomes. At the commencement, those involved and key stakeholders should identify and apply relevant lessons from previous experience when planning interventions and the design and implementation of services and activities. Lessons should be continually captured, evaluated and action should be taken to manage delivery risk and facilitate continual improvement of the outputs and outcomes. Organisation leaders and owners of standards, processes, methods, guidance, tools and training, should update their knowledge sources and communicate learning as appropriate.

E3 Process/capability maturity models or continuum may be used to support a structured assessment of how well the behaviours, practices and processes of an organisation can reliably and sustainably produce required outcomes. These models may be used as a benchmark for comparison and to inform improvement opportunities and priorities.

E4 As relevant gaps or improvement opportunities are identified, the organisation should develop plans and tasks and assign them to those accountable for implementation.

Annex 1 – Roles and Responsibilities - Board, Accounting Officer and Audit and Risk Assurance Committee

Board

The board of each public sector organisation, informed and advised by their Audit and Risk Assurance Committee, should:

- lead the assessment and management of risk and take a strategic view of risks in the organisation.
- ensure that there are clear accountabilities for managing risks and that officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently.
- ensure that roles and responsibilities for risk management are clear to support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation.
- determine and continuously assess the nature and extent of the principal risks that the organisation is willing to take to achieve its objectives - its "risk appetite" - and ensure that planning and decision-making appropriately reflect this assessment.
- agree the frequency and scope of its discussions on risk to review how management is responding to the principal risks and how this is integrated with other matters considered by the board, including business planning and performance management processes.
- specify the nature, source, format and frequency of the information that it requires.
- ensure that there are clear processes for bringing significant issues to its attention more rapidly when required, with agreed triggers for doing so.
- use horizon scanning to identify emerging sources of uncertainty, threats and trends.
- assure itself of the effectiveness of the organisation's risk management framework.
- assess compliance with the Corporate Governance Code[2] and include explanations of any departures within the governance statement of the organisation's annual report and accounts.

Accounting Officer

The accounting officer of each public sector organisation, supported by the Audit and Risk Assurance Committee, should:

- periodically assess whether the organisational values, leadership style, opportunities for debate and learning, and human resource policies support the desired risk culture, incentivise expected behaviours and sanction inappropriate behaviours.
- ensure that expected values and behaviours are communicated and embedded at all levels to support the appropriate risk culture.
- designate an individual to be responsible for leading the organisation's overall approach to risk management, who should be of sufficient seniority and should report to a level within the organisation that allows them to influence effective decision-making.
- establish the organisation's overall approach to risk management
- establish risk management activities that cover all types of risk and processes that are applied at different organisational levels.
- ensure the design and systematic implementation of policies, procedures and practices for risk identification, assessment, treatment, monitoring and reporting.
- consider the organisation's overall risk profile, including risk management within arm's length bodies and the extended enterprise.
- demonstrate leadership and articulate their continual commitment to and the value of risk management through developing and communicating a policy or statement to the organisation and other stakeholders, which should be periodically reviewed.
- ensure the allocation of appropriate resources for risk management, which can include, but is not limited to people, skills, experience and competence.

- monitor the quality of the information received and ensure that it is of a sufficient quality to allow effective decision-making.
- ensure that risk is considered as an integral part of appraising option choices, evaluating alternatives and making informed decisions.
- be provided with expert judgements through functions to advise on:
  - the feasibility and affordability of strategies and plans;
  - the evaluation and development of realistic programmes, projects and policy initiatives;
  - prioritisation of resources and the development of capabilities;
  - the design and operation of internal control in line with good practice and the nature and extent of the risks that the organisation is willing to take to achieve its objectives; and
  - driving innovation and incremental improvements.
- clearly communicate their expectation that risk management activities are coordinated and that information is shared among across the 'lines of defence' where this supports the overall effectiveness of the effort and does not diminish any of the 'lines' key functions.

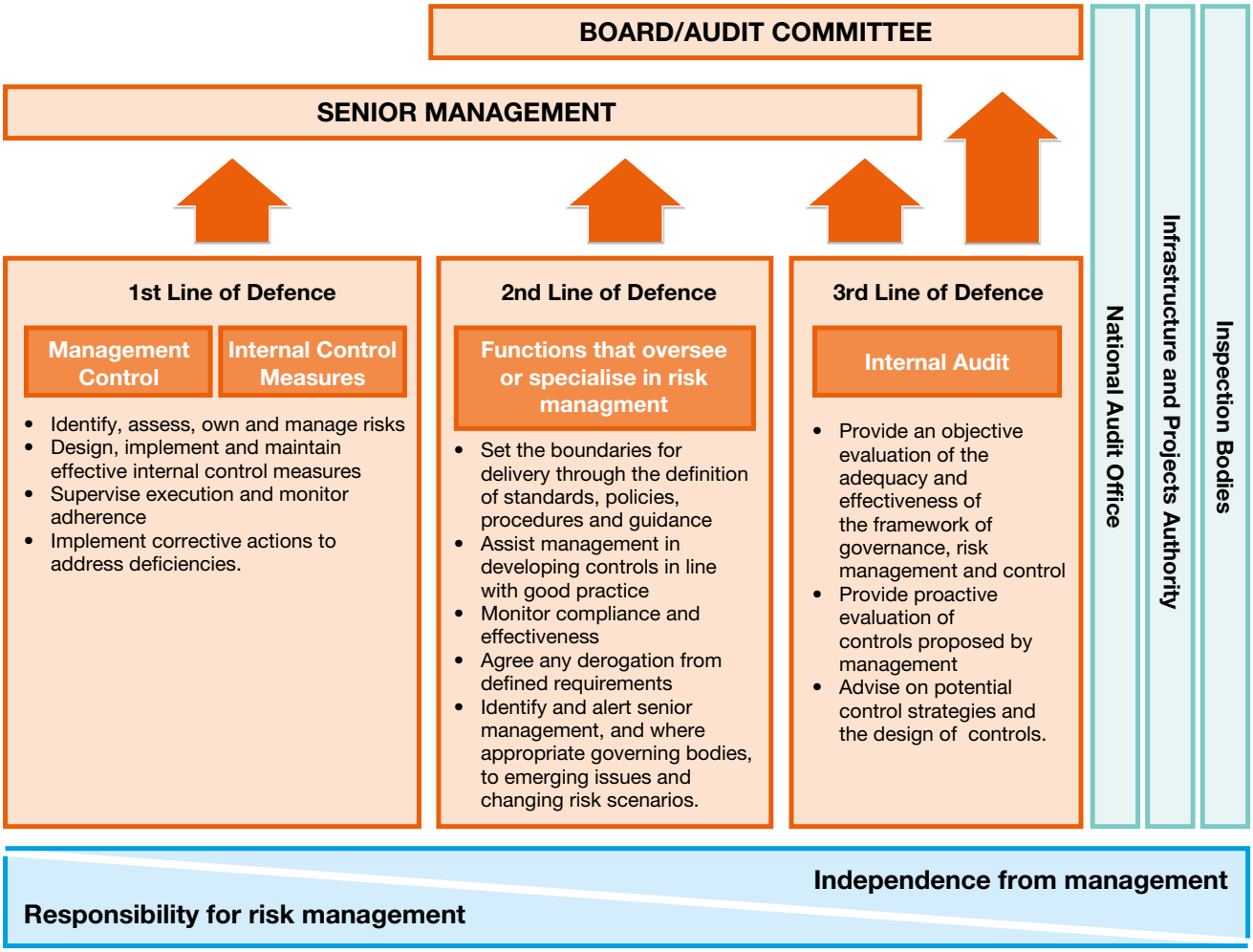
Audit and Risk Assurance Committee[14]

Leading the assessment and management of risk is a role for the board. The Audit and Risk Assurance Committee should support the board in this role. It is essential that the Audit and Risk Assurance Committee:

- understands the organisation's business strategy, operating environment and the associated risks, taking into account all key elements of the organisation as parts of an "extended enterprise";
- understands the role and activities of the board (or equivalent senior governance body) in relation to managing risk;
- discusses with the board its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so that management understands these parameters and expectations;
- understands the risk management framework and the assignment of responsibilities;
- critically challenges and reviews the risk management framework, without second guessing management, to evaluate how well the arrangements are actively working in the organisation; and
- critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks within the organisation's governance, operations, compliance and information systems.

Assurance should be obtained on risks across the departmental group. The group should focus on assurances over the management of cross organisational governance, risk and control arrangements to supplement departmental or entity level assurances. Similarly, assurance over the risk and control environment should also encompass services outsourced to external providers, including shared service arrangements, and risks that cross organisational boundaries, for example, in major projects.

Annex 2 – The Three Lines of Defence



Everyone in an organisation has some responsibility for risk management. The "three lines of defence" model provides a simple and effective way to help delegate and coordinate risk management roles and responsibilities within and across the organisation.

The model is not intended as a blueprint or organisational design, but may provide a flexible structure that can be implemented in support of the risk management framework. Functions within each of the "lines of defence" may vary from organisation to organisation and may operate differently.

Neither governance bodies nor senior management are considered to be among the "lines" in this model. They are the primary stakeholders served by the "lines of defence", as they collectively have responsibility and accountability for setting the organisation's objectives, defining strategies to achieve those objectives, and establishing roles, structures and processes to best manage the risks in achieving those objectives successfully.

First line of defence

Under the "first line of defence", management have primary ownership, responsibility and accountability for identifying, assessing and managing risks. Their activities create and/or manage the risks that can facilitate or prevent an organisation's objectives from being achieved.

The first line 'own' the risks, and are responsible for execution of the organisation's response to those risks through executing internal controls on a day-to-day basis and for implementing corrective actions to address deficiencies. Through a cascading responsibility structure, managers design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise effective execution. There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, variations in or inadequate processes and unexpected events, supported by routine performance and compliance information.

Second line of defence

The second line of defence consists of functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down the organisation. The second line should support management by bringing expertise, process excellence, and monitoring alongside the first line to help ensure that risk are effectively managed.

The second line should have a defined and proportionate approach to ensure requirements are applied effectively and appropriately. This would typically include compliance assessments or reviews carried out to determine that standards[6], expectations, policy and/or regulatory considerations are being met in line with expectations across the organisation.

Third line of defence

Internal audit form the organisation's "third line of defence". An independent internal audit function[15] will, through a risk-based approach to its work, provide an objective evaluation of how effectively the organisation assesses and manages its risks, including the design and operation of the "first and second lines of defence". It should encompass all elements of the risk management framework and should include in its potential scope all risk and control activities. Internal audit may also provide assurance over the management of cross-organisational risks and support the sharing of good practice between organisations, subject to considering the privacy and confidentiality of information.

External assurance

Sitting outside of the organisation's own risk management framework and the three lines of defence, are a range of other sources of assurance that support an organisation's understanding and assessment of its management of risks and its operation of controls, including:

6 In addition to professional standards, functional standards guide people working in and with the UK government. They exist to create a coherent and mutually understood way of doing business across organisational boundaries, and to provide a stable basis for assurance, risk management, and capability improvement.

- external auditors, chiefly the National Audit Office (NAO)[7], who have a statutory responsibility for certification audit of the financial statements;
- value for money studies undertaken by the NAO, which Parliament use to hold government to account for how it spends public money; and
- the Infrastructure and Projects Authority (IPA), who arrange and manage independent expert assurance reviews of major government projects that provide critical input to HM Treasury business case appraisal and financial approval points.

Other sources of independent external assurance may include independent inspection bodies, external system accreditation reviews/certification (e.g. ISO), and HM Treasury/Cabinet Office/ Parliamentary activities that support scrutiny and approval processes.

Coordination, cooperation and communication

The lines of defence have a common objective: to help the organisation achieve its objectives with effective management of risks. They often deal with the same risk and control issues. The accounting officer and the board should clearly communicate their expectation that information be shared and activities co-ordinated across each of the 'lines' where this does not diminish the effectiveness or objectivity of any of those involved.

Careful coordination is necessary to avoid unnecessary duplication of efforts, while assuring that all significant risks are addressed appropriately. Coordination may take a variety of forms depending on the nature of the organisation and the specific work done by each party. It is likely to be helpful to adopt a common 'language' or set of definitions across the 'lines of defence' to ease understanding, for example, in defining risk categories, risk criteria and what is an acceptance level of control or a significant control weakness.

Internal audit and external audit should work effectively together to the maximum benefit of the organisation and in line with international[16] and public sector standards.[17]

7 Some executive NDPBs may have private sector external auditors (either appointed by the relevant Secretary of State or by the Body's Executive) with a reporting line directly to the Secretary of State or to the body rather than through NAO to Parliament.

Annex 3 – Questions to Ask

These questions may assist in assessing how the risk management principles are applied to support the efficient and effective operation of the risk management framework. They should be read in conjunction with the principles set out in this document. The questions are not intended to be exhaustive and not all will be applicable in all circumstances. If the answers to the questions raise concerns, consideration should be given to whether action is needed to address possible areas for improvement.

Governance and Leadership

1. How is the desired risk culture defined, communicated, and promoted? How is this periodically assessed?

2. How do human resource policies and performance systems encourage and support desired risk behaviours and discourage inappropriate risk behaviours?

3. How has the nature and extent of the principal risks that the organisation is willing to take in achieving its objectives been determined and used to inform decision-making? Is this risk appetite tailored and proportionate to the organisation?

4. How are the board and other governance forums supported to consider the management of risks, and how is this integrated with discussion on other matters?

5. How effective are risk information and insights in supporting decision-making, in terms of the focus and quality of information, its source, its format and its frequency?

6. How are authority, responsibility and accountability for risk management and internal control defined, co-ordinated and documented throughout the organisation?

7. How is the designated individual responsible for leading the overall approach to risk management positioned and supported to allow them to exercise their objectivity and influence effective decision-making?

8. How are the necessary skills, knowledge and experience of the organisation's risk practitioners assessed and supported?

9. How has the necessary commitment to risk management been demonstrated?

Integration

10. How are risks considered when setting and changing strategy and priorities?

11. How are risks transparently assessed within the appraisal of options for policies, programmes and projects or other significant commitments?

12. How are emerging risks identified and considered?

13. How are risks to the public assessed and reflected within policy development and implementation?

14. How are National Risk Register risks, that are particularly pertinent to the organisation, recognised in risk assessments and discussions?

Collaboration and Best Information

15. How is an aggregated view of the risk profile informed across the organisation, arm's length bodies and the extended enterprise supporting the delivery of services?

16. How are the views of external stakeholders gathered and included within risk considerations?

17. How does communication and consultation assist stakeholders to understand the risks faced and the organisation's response?

18. How is function and professional expertise used to inform strategies, plans, programmes, projects and policies?

19. How do expert functions and professions inform the identification, assessment and management of risks and the design and implementation of controls?

20. How are functional standards communicated and their adherence monitored across the organisation?

Risk Management Processes

21. How are risk taxonomies or categories used to facilitate the identification of risks within the overall risk profile?

22. How are risk criteria set to support consistent interpretation and application in assessing the level of risk? How effective are these in supporting the understanding and consideration of the likelihood and consequences of risks?

23. How are limitations and influences associated with the information and evidence used with risk assessments highlighted?

24. How are interdependencies between risks or possible combinations of events ('domino' risks) identified and assessed?

25. How dynamic is the assessment of risks and the consideration of mitigating actions to reflect new or changing risks or operational eficiencies?

26. How are exposures to each principal risk assessed against the nature and extent of risks that the organisation is willing to take in achieving its objectives – its risk appetite – to inform options for the selection and development of internal controls?

27. How are decisions made in balancing the potential benefits of the design and implementation of new or additional controls with the costs, efforts and any disadvantages of different control options?

28. How are contingency arrangements for high impact risks designed and tested to support continuity, incident and crisis management and resilience?

29. How is the nature, source, format and frequency of the information required to support monitoring of risk management and internal control defined and communicated?

30. How are new and changing principal risks highlighted and escalated clearly, easily and more rapidly when required?

31. How comprehensive, informative and coordinated are assurance activities in helping achieve objectives and in supporting the effective management of risks?

32. How do disclosures on risk management and internal control contribute to the annual report being fair, balanced and understandable?

Continual Improvement

33. How are policies, programmes and projects evaluated to inform learning from experience? How are lessons systematically learned from past events?

34. How is risk management maturity periodically assessed to identify areas for improvement? Is the view consistent across differing parts or levels of the organisation?

35. How are improvement opportunities identified, prioritised, implemented and monitored?

Annex 4 – Example Risk Categories

Strategy risks – Risks arising from identifying and pursuing a strategy, which is poorly defined, is based on flawed or inaccurate data or fails to support the delivery of commitments, plans or objectives due to a changing macro-environment (e.g. political, economic, social, technological, environment and legislative change).

Governance risks – Risks arising from unclear plans, priorities, authorities and accountabilities, and/or ineffective or disproportionate oversight of decision-making and/or performance.

Operations risks – Risks arising from inadequate, poorly designed or ineffective/inefficient internal processes resulting in fraud, error, impaired customer service (quality and/or quantity of service), non-compliance and/or poor value for money.

Legal risks – Risks arising from a defective transaction, a claim being made (including a defence to a claim or a counterclaim) or some other legal event occurring that results in a liability or other loss, or a failure to take appropriate measures to meet legal or regulatory requirements or to protect assets (for example, intellectual property).

Property risks – Risks arising from property deficiencies or poorly designed or ineffective/inefficient safety management resulting in non-compliance and/or harm and suffering to employees, contractors, service users or the public.

Financial risks – Risks arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting.

Commercial risks – Risks arising from weaknesses in the management of commercial partnerships, supply chains and contractual requirements, resulting in poor performance, inefficiency, poor value for money, fraud, and /or failure to meet business requirements/objectives.

People risks – Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, the unavailability of sufficient capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance.

Technology risks – Risks arising from technology not delivering the expected services due to inadequate or deficient system/process development and performance or inadequate resilience.

Information risks – Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.

Security risks – Risks arising from a failure to prevent unauthorised and/or inappropriate access to the estate and information, including cyber security and non-compliance with General Data Protection Regulation requirements.

Project/Programme risks – Risks that change programmes and projects are not aligned with strategic priorities and do not successfully and safely deliver requirements and intended benefits to time, cost and quality.

Reputational risks – Risks arising from adverse events, including ethical violations, a lack of sustainability, systemic or repeated failures or poor quality or a lack of innovation, leading to damages to reputation and or destruction of trust and relations.

Failure to manage risks in any of these categories may lead to financial, reputational, legal, regulatory, safety, security, environmental, employee, customer and operational consequences.

Annex 5 – Definitions and Supportive Concepts

Governance[2] is the system by which organisations are directed and controlled. It defines accountabilities, relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives[8] are set, and provides the means of attaining those objectives and monitoring performance. This includes establishing, supporting and overseeing the risk management framework.

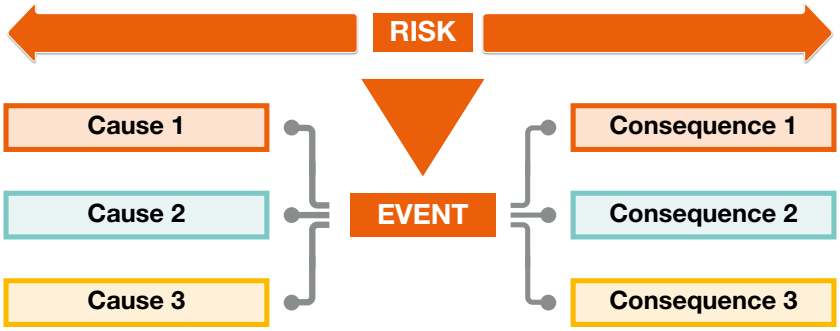
Risk Management is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.

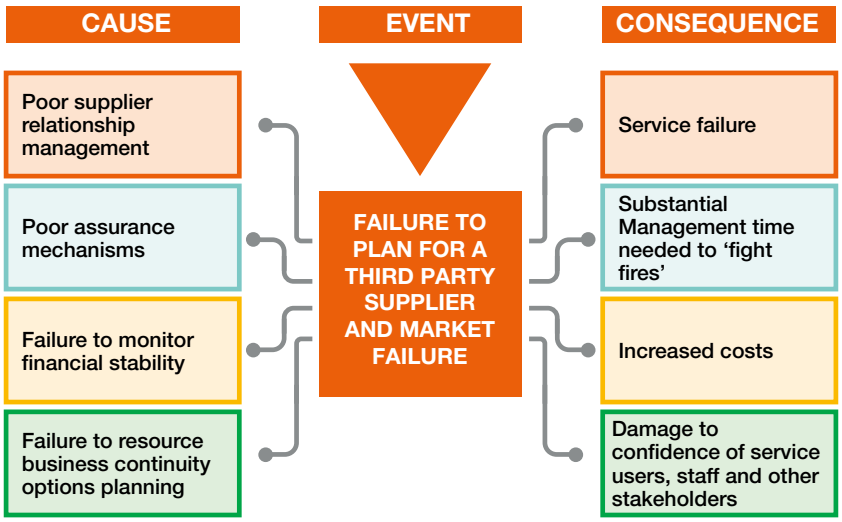
Risk is the effect of uncertainty on objectives. Risk is usually expressed in terms of causes, potential events, and their consequences:

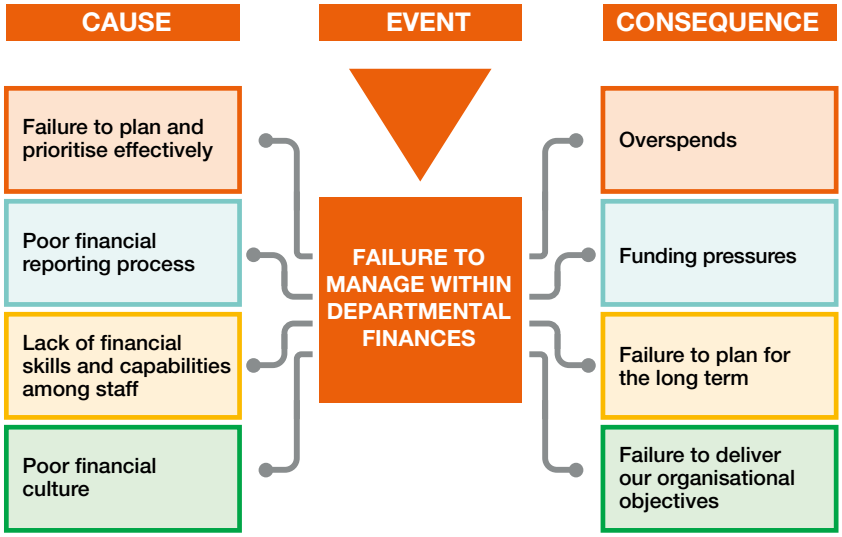
- A *cause* is an element which alone or in combination has the potential to give rise to risk;
- An *event* is an occurrence or change of a set of circumstances and can be something that is expected which does not happen or something that is not expected which does happen. Events can have multiple causes and consequences and can affect multiple objectives;
- the *consequences* should the event happen – consequences are the outcome of an event affecting objectives, which can be certain or uncertain, can have positive or negative direct or indirect effects on objectives, can be expressed qualitatively or quantitatively, and can escalate through cascading and cumulative effects.

8 Objectives can have different aspects and categories – covering efficient and effective operations, financial and non-financial reporting, and compliance with laws and regulations - and can be applied at different levels.

Stating risks: causes, events and consequences







In stating risks, care should be taken to avoid stating consequences that may arise as being the risks themselves, i.e. identifying the symptoms without their cause(s). Equally, care should be taken to avoid defining risks with statements that are simply the converse of the objectives, i.e. failure to achieve the intended output/outcome.

Organisations typically assess consequences using a combination of criteria, which commonly include financial, reputational, legal, regulatory, safety, security, environmental, employee, customer and operational effects. The criteria used should be dynamic and should be periodically reviewed and amended, as necessary. Scales should allow meaningful differentiation for ranking and prioritisation purposes based on assigning values to each risk using the defined criteria.

When assigning a consequence rating to a risk, the rating for the highest, most credible worst-case scenario should be assigned.

The risk analysis process defines the level of risk, based on the assessment of the ***likelihood*** of the risk occurring and the consequences should the event happen. Likelihood is the assessment of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively, and described using general terms or mathematically (such as a probability or a frequency over a given time period).

Risk analysis should also consider:

- sensitivity and confidence levels, based on the information available;
- complexity and connectivity;
- time-related factors and volatility; and
- the effectiveness of existing internal control.

Internal Control is the dynamic and iterative framework of processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risk. Internal controls permeate and are inherent in the way the organisation operates and are affected by cultural and behavioural factors.

Where additional action is required to bring the levels of risk within the nature and extent that the organisation is willing to take to achieve its objectives, the organisation should select, develop and implement options for addressing risk through preventive, directive, detective, and/or corrective controls that manage risks to an acceptable level. These might be manual or automated. This involves an iterative process of:

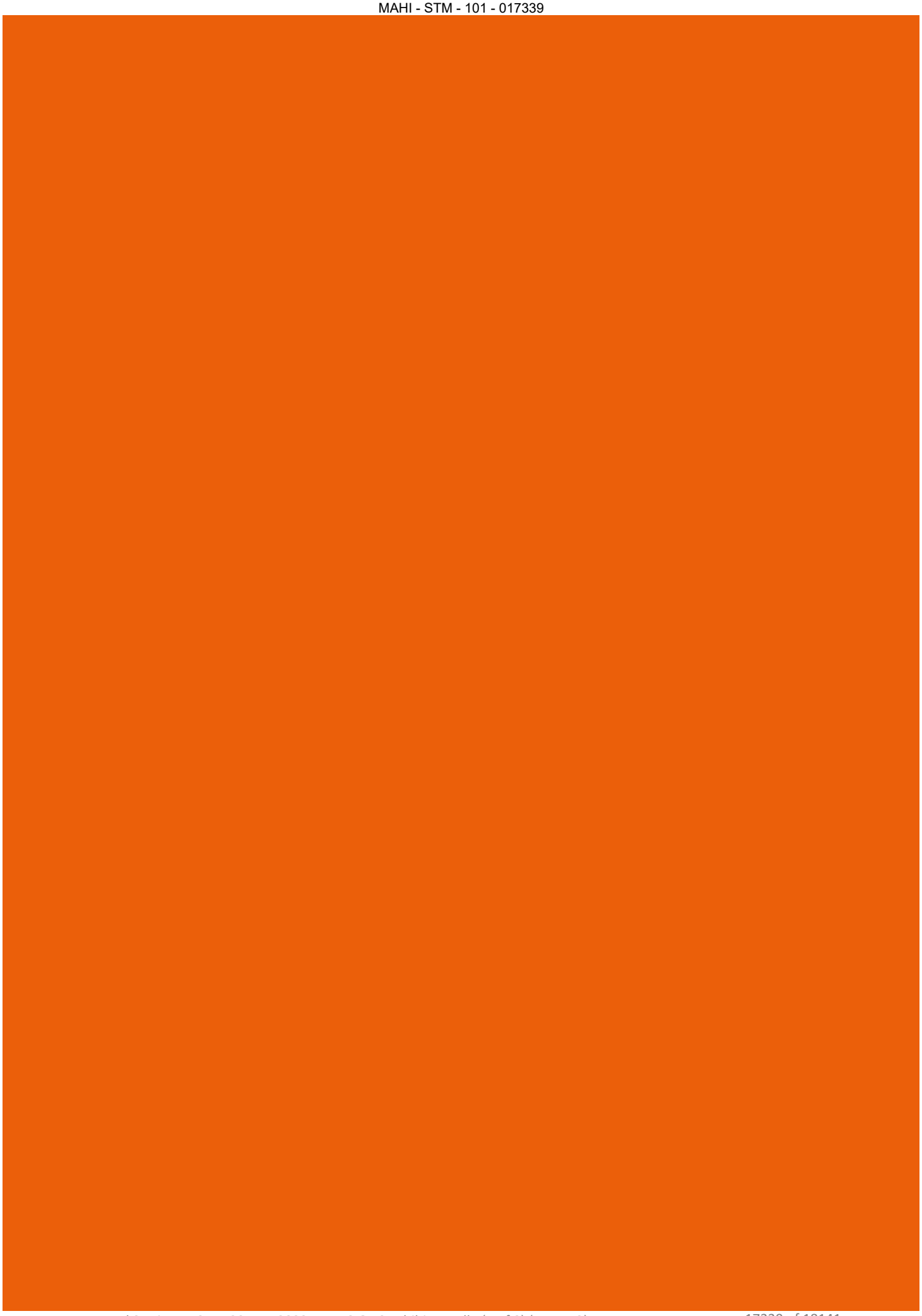
- planning and implementing internal control;
- assessing the effectiveness of internal control;
- deciding whether the nature and extent of the remaining risk after the implementation of internal controls is acceptable; and
- if not acceptable, reassessing options and taking further action where appropriate.

Internal control, even if carefully designed and implemented, might not produce the intended or expected outcomes. Internal control can also introduce new risks that need to be managed.

Assurance is a general term for the confidence that can be derived from objective information over the successful conduct of activities, the efficient and effective design and operation of internal control, compliance with internal and external requirements, and the production of insightful and credible information to support decision-making. Confidence diminishes when there are uncertainties around the integrity of information or of underlying processes.

Annex 6 – References

ID	Description
1	BS ISO 31000:2018(E) - Risk management – Guidelines
2	Corporate governance code for central government departments https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments
3	Managing Public Money – Section 4 Governance and Management https://www.gov.uk/government/publications/managing-public-money
4	Managing Public Money – Annex 4.3 Risk
5	Budget 2018: 2.18 The Balance Sheet Review – https://www.gov.uk/government/publications/budget-2018-documents/budget-2018 and Getting smart about intellectual property and intangible assets https://www.gov.uk/government/publications/getting-smart-about-intellectual-property-and-intangible-assets
6	Central Government Guidance on Appraisal and Evaluation - The Green Book https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf
7	The Future Toolkit provides guidance on horizon scanning and outlines how scenarios can be used to further investigate emerging risks https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/674209/futures-toolkit-edition-1.pdf
8	The National Risk Assessment (NRA) - a strategic medium-term planning tool that captures examples of civil emergencies that could plausibly affect the UK within its territorial boundaries and should be used to inform integrated emergency management decisions
9	The Principles of Managing Risks to the Public https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191518/Managing_risks_to_the_public_appraisal_guidance.pdf
10	ISO 31010:2009 is a supporting standard for BS ISO 31000 and provides guidance on selection and application of systematic techniques for risk assessment
11	Guidance on producing quality analysis for government – The Aqua Book https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/416478/aqua_book_final_web.pdf
12	The Outsourcing Playbook - Central Government Guidance on Outsourcing Decisions and Contracting https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/780361/20190220_OutsourcingPlaybook_6.5212.pdf
13	Guidance for evaluation – The Magenta Book https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/220542/magenta_book_combined.pdf
14	HM Treasury Audit and Risk Assurance Committee Handbook, March 2016 https://www.gov.uk/government/publications/audit-committee-handbook
15	Public Sector Internal Audit Standards https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf
16	International Standards on Auditing - ISA 315 and 610



NORTH & WEST BELFAST HEALTH & SOCIAL SERVICES TRUST

North and West Belfast Health and Social Services Trust

RISK MANAGEMENT STRATEGY

Human Resources
&
Corporate Affairs

2003

INDEX

1.0 Introduction

In May 2001 the Department of Finance and Personnel issued a Dear Accounting Officer letter "Corporate Governance: statement on Internal Control".

The Trust Board in November 2001, after consideration of the issues agreed to move to implement 'Controls Assurance' as its key control system in its Corporate Governance Framework. The Department have since issued a draft circular formally adopting the Controls Assurance model. Controls Assurance is being introduced incrementally and is designed to help HPSS organisations achieve continuous and sustained improvement in their performance through effective risk management and internal control.

Under the Controls Assurance Risk Management System (Core Standard), HPSS Trusts are required to have a Board approved strategy and policy for managing risk that identifies accountability arrangements, resources available and contains guidance on what may be regarded as acceptable risk within the Trust.

The purpose of this document is to define the Trust's strategy for risk management in the future, and on endorsement by the Trust Board, will become the Trusts policy for Risk Management. The Strategy cover:

- Strategic Intent
- Policy Objectives
- Accountability and Reporting Structures
- Risk Management Process
- Key Risk Indicators
- Monitoring, Reviewing and Auditing

2.0 Strategic Intent

The Trust Board recognises that risk management is a key component of good management practice and to be most effective should become embedded as part of the Trust's Culture. The Board is, therefore, committed to ensuring that risk management is established as an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate project. It is imperative that responsibility for implementation is accepted at all levels of the organisation.

The Trust Board acknowledges that the provision of appropriate training and education is central to the achievement of this aim.

3.0 Scope of Strategy

This document applies to all employees of the Trust and in particular managers at all levels to ensure that risk management is a fundamental part of the total management approach to Quality, Corporate and Professional Governance and the Trusts Controls Assurance programme.

4.0 Objectives of Strategy

The Department of Health has provided the foundation for risk management in the nationally defined 21 Controls Assurance and Risk Management standards. However, these were intended only as a starting point and means of comparison, and were not expected to cover all the risks, which the Trust will have to manage.

It is proposed, therefore, to introduce a holistic approach to risk management across the organisation, which embraces financial, organisational and professional risks, and for all parts of the organisation to be involved.

The key objectives of this strategy are to provide the framework for achieving:

- Improved compliance with the Controls Assurance Standards
- The Department of Health's milestones for Controls Assurance performance improvement as detailed at Appendix A
- The integration of risk management with the Trusts Business Planning process and its strategic aims and objectives.
- The convergence of organisational controls assurance, financial controls assurance and professional governance systems.

The Trust aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, clients, staff and assets. A primary concern is the provision of, risk free environments together with working policies and practices, which take into account, assessed risks.

In order to achieve this objective, the Trust will adopt a pro-active approach with a programme of risk management which aims to provide protection against preventable injury and/or loss to patients, clients, staff and the general public.

5.0 Accountability and Reporting Structures

5.1 Responsibility of the Trust Board

The Trust Board is responsible for reviewing the effectiveness of internal controls – financial, organisational and professional. The Board is required to produce statements of assurance that it is doing its "reasonable best" to manage the Trust's affairs efficiently and effectively through the implementation of internal controls to manage risk.

5.2 Responsibility of the Risk Management Steering Committee

Term of reference for the Risk Management Steering Committee are detailed at Appendix B.

5.3 Responsibility of the Chief Executive

The Chief Executive as accountable officer has overall responsibility for Risk Management and Controls Assurance within the Trust.

5.4 Responsibility of the Director of Human Resources & Corporate Affairs

The Director of Human Resources and Corporate Affairs has responsibility for ensuring the implementation of the Risk Management strategy and Controls Assurance programme in the Trust.

5.5 Responsibility of the Medical Director (Community)

The Medical Director as chair of the Professional Risk Management committee has overall responsibility for Professional Governance and Professional Risk. The following Directors have delegated responsibility as detailed below:

- Director of Operations has delegated responsibility for Social Care Governance and Social Care Risk.
- Director of Medical Services (Hospital) has delegated responsibility for Professional Governance and Professional risk at the hospital.
- Director of Nursing has delegated responsibility for establishing risk management as an integral and vital process in the Trusts Quality Strategy, and ensuring that all equality related risks are assessed and managed.

5.6 Responsibility of All Managers

All levels of management must understand and implement the Trust Risk Management Strategy.

5.6.1 All Managers are responsible for ensuring that specific Directorate/Departmental Risk Management Strategies are prepared in accordance with the Trust Risk Management Strategy/Policy.

5.6.2 All Managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated area (s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities.

5.6.3 All Managers are responsible for preparing specific Directorate/Departmental policies and guidelines to ensure all necessary multidisciplinary risk assessments are carried out within their Directorate/Department in liaison with appropriate relevant advisors where necessary eg Health and Safety, Infection Control, Hotel Services, Estates, Environmental etc.

5.6.4 All Managers are responsible for ensuring appropriate Directorate/Departmental structures and systems are in place to learn from reported incidents, accidents, complaints and claims.

5.6.5 All Managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area (s) and scope of responsibility.

In situations where high significant risks have been identified and where local control measures are deemed to be potentially inadequate, Directors/Managers are responsible for submitting the risk area to the Trusts Risk Register for the attention of Risk Management Steering Committee/Operational Management Group as appropriate.

5.6.6 All Managers must ensure that all staff must be given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trusts operations including sub-contractors, members of the public, visitors etc.

5.6.7 All Managers and/or their designated representatives will implement the strategys by:-

- Ensuring that they have adequate knowledge and/or access to all legislation relevant to their area and as advised by appropriate experts ensure that compliance to such legislation is maintained.

- Ensuring that adequate resources are made available to provide safe systems of work. This will include making provision for risk assessments, appropriate control measures raising outstanding concerns, ensuring safe working procedures/practices and continued monitoring and revision of same.

- Ensuring that there is a core of appropriate mandatory training for all employees to attend eg Induction, Health and Safety, Fire, Manual handling, Dealing with violence and aggression, Food Hygiene, Resuscitation Training, etc and that appropriate mandatory updates/refreshers are maintained.

- Identifying and releasing suitable staff to be trained as risk assessors, incident/accident investigators, first aiders, manual handling/health and safety co-ordinators etc.

- Promoting greater risk management and health and safety awareness amongst all staff, and by ensuring that only properly trained and competent staff are responsible for assessing risks and determining adequate control measures within the working environment.

- Monitoring professional/clinical performance, health and safety standards including risk assessments, infection control measures, use of personal protective clothing/equipment etc and ensuring that these are reviewed and updated regularly.

- Ensuring the identification of all employees who require Health Surveillance according to risk assessments; ensuring that where Health Surveillance is required no individual carries out these specific duties until they have attended the Occupational Health department and have been passed fit.

- Ensuring that the arrangements for the first aiders and first aid equipment required within the Directorate/ Department are complied with. Ensuring the location of first aid facilities are known to employees and that proper care is taken of casualties and that employees know where to obtain appropriate assistance in the event of serious injury.

- Making adequate provision to ensure that fire, bomb alerts, civil disturbance and other emergencies are appropriately dealt with.

- Ensuring the systems for preparation, maintaining and review of specific robust Directorate/Departmental Business Continuity plans are in place.

5.7 Responsibility of all employees

All employees should be aware of their personal responsibility in the management of risk and should specifically:

- Report all incidents/accidents and near misses using the recognised channels. The Trust recognises that the development of a culture, which accepts that the reporting of adverse events or near misses is largely on a fair blame basis (see 5.8)

- Provide safe professional/clinical practice in diagnosis treatment and care.

- Be aware that they have a duty under Health and Safety legislation to take reasonable care for their own safety and safety of others who may be affected by the Trust's business.

- Comply with all Trust policies, procedures, regulations and instructions to protect the health, safety and welfare of anyone affected by the Trust's business.

- Be familiar with the Trust Risk Management Policy and Directorate/Departmental policies, professional/clinical and health and safety procedures and comply with these.

- Either intentionally, nor recklessly interfere with or misuse any equipment provided for the protection of safety and health.

- Be aware of all emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular Directorate/Departmental location/work environment.

5.8 A Fair Blame Culture

The Trust supports a 'fair blame' culture, exceptional cases will arise where there is clear evidence of wilful or gross carelessness or neglect contravening the Trust's policies and procedures and/or professional codes of conduct, or where there is repeated evidence of poor performance despite training intervention and support.

5.8.1 Whistle Blowing

All employees should be familiar with the Trust's guidance to staff on raising concerns and requirements of the Public Interest Disclosure Act 1998 (refer Department of Health Circular HSC 1999/198). The Trusts Whistle Blowing policy is currently with staff side for approval.

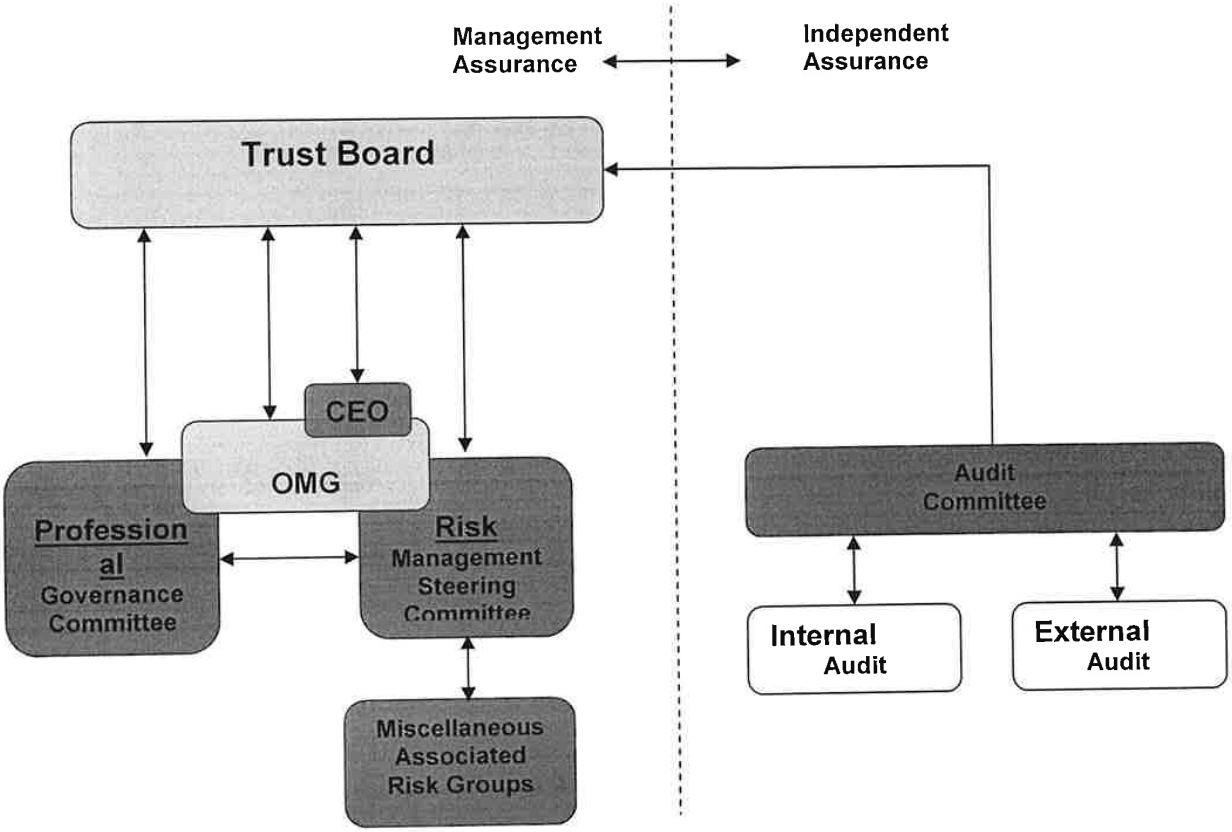
5.9 Convergence Between clinical/professional Governance and Controls Assurance

The Department of Health and Social Services and Public Safety expect there will be a convergence between clinical/professional governance and Controls Assurance.

Currently the 'system of internal control' in the HPSS comprises three distinct sub-systems: financial, organisational and clinical/professional controls. Risk Management is a management practice with generic principles, which can be applied to all three internal control sub-systems. The Trust will, through its risk management structures, work to actively identify the relationships that exist between clinical/professional governance and controls assurance.

5.10 Risk Management Structure

The overall structure for risk management is detailed in the table.



Controls Assurance is identified as a key system in the Trust's Risk Management Approach and corporate governance arrangements.

Through the implementation of Controls Assurance, Director Leads have been identified for each of the Controls Assurance standards. These Directors responsibilities are to ensure appropriate baseline assessments are completed for each standard and to co-ordinate the implementation of actions required to improve the Trust's compliance over the next five years. The Director Leads for the respective Standards are as follows:

Lead Director	Standards
Mr Eamonn Molloy **Director of Human Resources & Corporate Affairs**	• Buildings, Land, Plant and Non-medical Equipment • Catering & Food Hygiene • Emergency Planning • Environmental Management • Governance • Health and Safety Management • Human Resources • Purchasing & Supply • Risk Management • Security • Transport Management • Waste Management
Dr Robin McKee **Director of Medical Services (Community)**	• Decontamination of Re-Usable Medical Devices • Infection Control • Medical Devices and Equipment Management • Medicines Management (Safe and Secure Handling of Medicines)
Mr Paul Ryan **Director of Planning/Contracts & Information**	• Information & Communications Technology • Records Management
Mr Peter Harvey **Director of Finance**	• Financial Management
Ms Bernie McNally **Director of Social Work/Children & Mental Health Services**	• Fire Safety

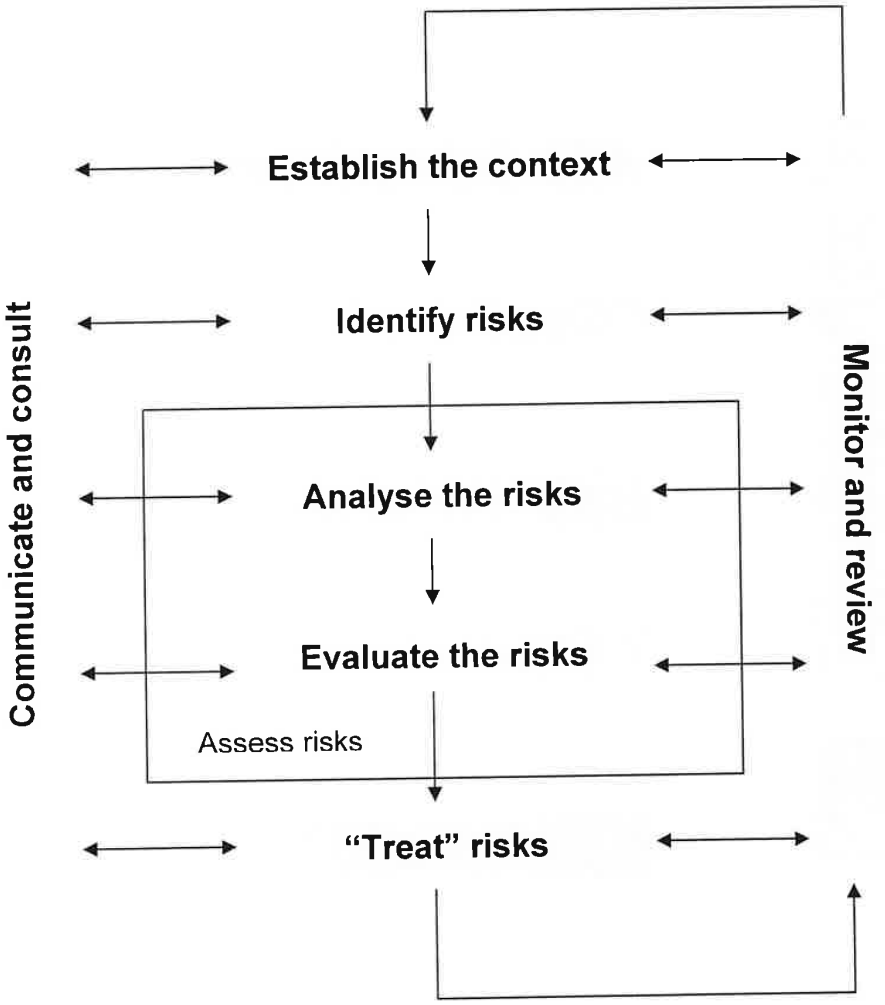
6.0 Risk Management Process

Risk Management is a multifaceted process, appropriate aspects of which are often best carried out by a multidisciplinary team. It is an iterative process that can contribute to organisational improvement. The shift in culture and systems now required, is to explicitly and quantifiably assess risk and to systematically record:

- The process and outcome of assessment.
- The process and outcome of decision-making.
- The evidence base or reasons for decision.

The systematic approach to risk management will be based on the following model:

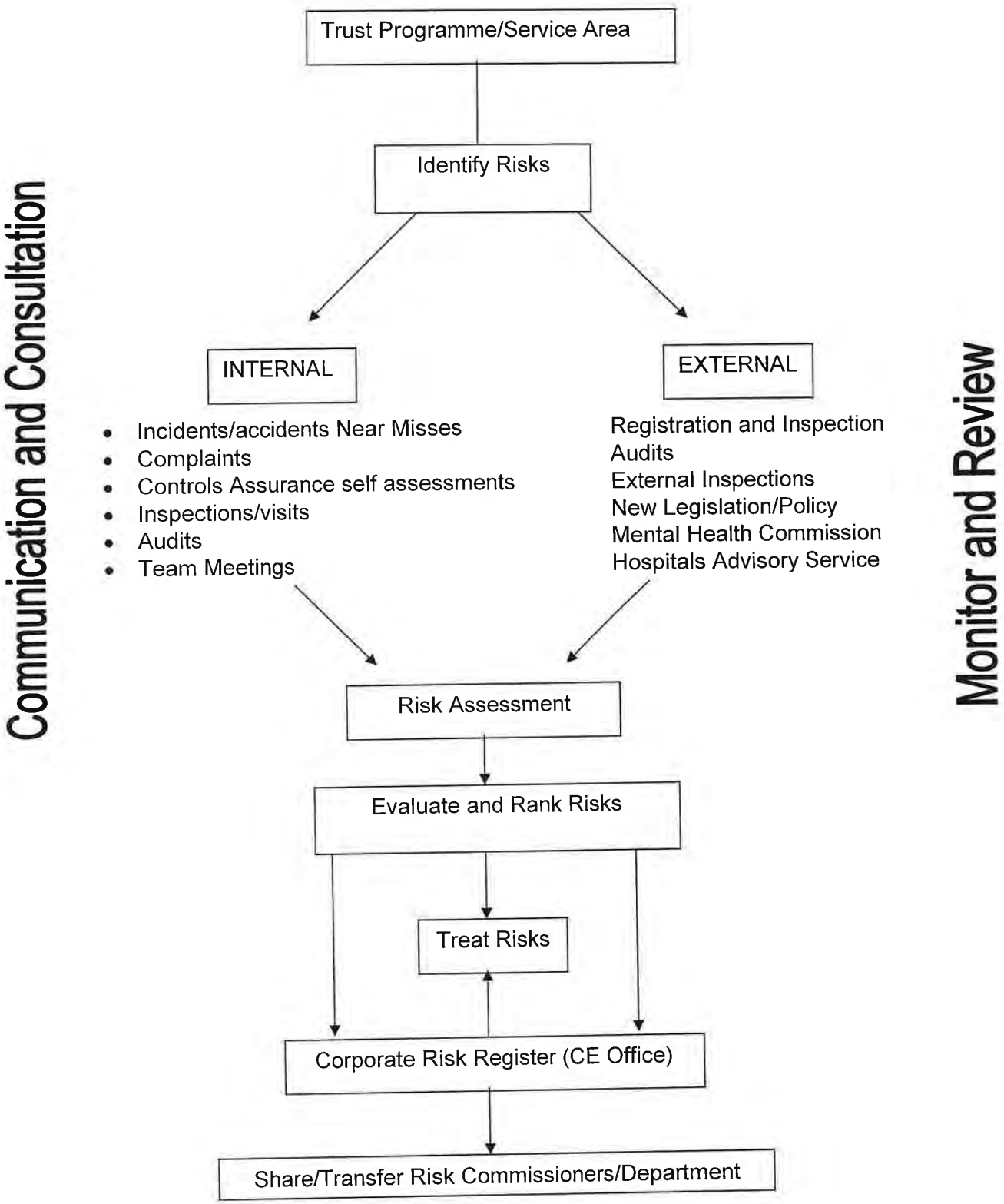
Risk Management Process
(AS/NZS 4360:1999 – Risk Management)



Establish the Context	-	Define the activity.
	-	What are the goals and objectives?
Risk Identification	-	What can happen?
	-	How can it happen?
Risk Assessment	-	How could risks occur?
	-	What would be the effect if they did?
	-	How could they be reduced?
Evaluation and ranking	-	Evaluate options for reducing risks.
	-	Quantify costs of actions to reduce risks.
	-	Identify actions, which reduce total, cost of risk and give best value for money.
	-	Compare costs against benefits.
Risk Treatment	-	AVOID: not proceeding with activity likely to generate the risk.
	-	REDUCE: reducing or controlling the likelihood and consequences of the occurrence.
	-	TRANSFER: Arranging for another party to bear or share some part of the risk through contracts, partnerships joint ventures etc.
	-	ACCEPT: some risks may be minimal and retention acceptable.
Monitor and Review	-	Monitor risk impact.
	-	Review effectiveness of action.
	-	Has the risk priority changed?
Communicate and Consult	-	Who needs to know?
Internal/External	-	Who is affected?

Risk Management Process
North and West Belfast HSS Trust

Adopting the Australia/New Zealand Standard theory to practice within the Trust the process will be as follows:



6.1 Risk Quantification and Acceptability

The Australia Standard defines risk as: *"The chance of something happening that will have an impact on objectives. It is measured in terms of consequence and likelihood"*

Therefore:

RISK = Consequences (Severity) x Likelihood (Frequency)

It is proposed to adopt a systematic and common approach to quantifying risk through defining qualitative measures of consequences (severity) and likelihood (frequency) as detailed in the tables below:

Frequency – (An assessment of likelihood of risk occurring)

Score	Descriptor	Description
5	Almost Certain	Likely to re-occur on many occasions, a persistent issue
4	Likely	Will probably re-occur but is not a persistent issue
3	Possible	May re-occur occasionally
2	Unlikely	Do not expect it to happen again but it is possible
1	Rare	Do not believe that this will ever happen again

Severity (Consequence rating of risk)

Score	*Descriptor*	Potential Impact on Individual(s)	Potential Impact on Trust	Number of Persons Affected at one time	Potential Financial Loss/ Complaint/ Litigation
1	*Insignificant*	• No injury or adverse outcome	• No risk to Trust	None – one	• Remote litigation risk • Complaint unlikely • Damage/ theft/ loss of equipment/ property < £100
2	*Minor*	• First aid • Minor injury • Minor illness	• Minimal risk to Trust • Staff absence < 3 days	Two	• Litigation unlikely • Complaint possible • Damage/ theft/ loss of equipment/ property > £100 < £1,000
3	*Moderate*	• Injury/ illness requiring 3 days or more absence • Temporary incapacity • Prolonged/ additional treatment and/or care	• Riddor reportable • MDA reportable • Needs careful PR • Staff absence < 4 weeks	3 – 10	• Litigation possible • Complaint expected • Damage/ theft/ loss of equipment/ property > £1,000 < £10,000
4	*Major*	• Major/ serious injury • Major clinical/ professional intervention required • Permanent incapacity	• Service reductions • Service closures • Staff absence > 4 weeks • Local adverse publicity	10 – 20	• Litigation expected • Damage/ theft/ loss of equipment/ property > £10,000 < £50,000
5	*Catastrophic*	• Death	• Regional/ national adverse publicity • Subject to external investigations	> 30	• Serious litigation expected • Damage/ theft/ loss of equipment/ property £50,000 +

This facilitates the construction of a Risk Matrix for evaluating the risk for criticality – low, moderate, significant and high and subsequently its priority and route for action.

Risk Matrix

Frequency	Severity				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain					
4 Likely					
3 Possible					
2 Unlikely					
1 Rare					

The Turnbull report on Internal Control requires that Board's be informed of the significant risks that face the organisation. Significant risks being defined as:

"Risks that are significant to the fulfilment of the (organisations) objectives"
Using the risk matrix the following guidelines will be used:

High Risk	Red	Entry on corporate Risk Register and report to Board with proposed treatment plans
Significant Risk	Orange	Report to Risk Management Steering Committee. Reviewed at Directorate level. risks which can not be treated should be entered on corporate risk register and reported to Board with proposed treatment plans.
Moderate Risk	Yellow	Reviewed at Directorate level. Risks which can not be treated should be notified to Risk Management Steering committee with proposed treatment plans.
Low Risk	Green	Acceptable risk but Action taken at Directorate level to treat as appropriate

6.2 Trust Risk Register

With the imminent implementation of Controls Assurance, the Trust will produce a Corporate Risk Register for 2002/03, which will form the basis of the Trusts Risk Management plan and programme.

The Risk Register will be a living document that will in future include risks identified through Controls Assurance self-assessments, Board, Directorate and individual risk assessments and adverse/incident event reporting.

The Risk register will be utilised to inform the Trusts Strategic, business and capital planning functions, resource bids, and capital and revenue allocations.

6.3 Stakeholder Involvement

It is good practice to involve stakeholders, as appropriate, in all areas of the Trusts activities, and this includes consulting on relevant significant and high risks.

The Trust has a wide range of communication and consultation mechanisms in existence with relevant stakeholders, both internal and external. Future Trust policy and consultation documents should include a risk analysis giving relevant stakeholders opportunity to comment on the risk elements at consultation stage.

General public awareness raising of the Trusts Risk Management strategy and policy will be achieved through its presentation at public Board meetings and explicit references in the Trusts annual report.

7.0 Risk Management Training and Education

The Trust Board recognise that the provision of appropriate training and education is central to the implementation, maintenance and development of its Risk Management Strategy.

An ongoing training and education programme will be developed to ensure that Board Members, senior, middle and first line managers, professional and other staff obtain training and education to the required levels and standards appropriate to their role within the Trust.

A specialist core team, consisting of Controls Assurance standard leads and other relevant managers will be established to provide advice and support to others within the Trust in the management of risk.

General awareness raising for staff will be undertaken through staff briefings, induction programmes and the inclusion of relevant documents/policies on the Trust Intranet. Regular developments and updates will be communicated via the Trust News Letter, All Points.

8.0 Key Performance Indicators

Initially, it is proposed to measure improvements in risk management performance, through monitoring and compliance with the Risk Management (Core Standard) and the other twenty Controls Assurance Standards.

Further key performance indicators will require to be developed over time following implementation and review of this strategy.

9.0 Monitoring Review and Audit

The Trust Board will receive an annual report covering:

- Compliance Assessment with the Risk Management and Organisational Controls Assurance Standards.
- An updated Corporate Risk Management Action Plan.
- A review of the Risk Management Strategy.

Arrangements will be made as part of the Annual Internal Audit plan agreed by the Audit committee, for periodic audits to be carried out to provide assurances to the Board that the Risk Management System in place conforms to the requirements of the Risk Management System (Core Standards).

10.0 Approval and Review Mechanisms

- This strategy has been developed in the light of currently available information, guidance and legislation that may be subject to review and change.
- The strategy will be reviewed annually by the Risk Management Steering Committee and any recommendations for change submitted to the Trust Board.
- The strategy was approved by Trust Board on ___/___/___
  And becomes effective on ___/___/___

Chief Executive
(Chair of Risk Management
Steering Committee)

Dated_____

Signed_____

Chairperson

Dated_____

Signed_____

APPENDIX A: MILESTONES

(April 2003)

Board fully briefed on the purpose and function of Controls Assurance and its links with other initiatives

Appropriate structural arrangements in place

Organisation-wide baseline self-assessment against relevant Controls Assurance standards

Board-endorsed prioritised action plan with assigned responsibilities resulting from the baseline assessment

Board-endorsed risk management policy and strategy, including definition of 'acceptable risk'

System in place for continuously informing the board on compliance with Controls Assurance standards

Ongoing self-assessment against Controls Assurance and other relevant standards

Board monitoring of standards compliance in relation to progress against action plan

Demonstrable improvement in standards compliance against baseline self-assessment

Basic Controls Assurance statement in annual report

Some staff involvement

Minimal risk register

(April 2004)

Level 1 attainment

Substantive compliance with Controls Assurance Standards

Demonstrable application of the fundamentals of good risk management and internal control across the organisation

Some use of structured assessment techniques, eg control self-assessment (CSA) workshops

Reasonable involvement of staff

Buy-in obtained from different levels of management

Risk awareness training

Comprehensive organisation-wide risk register based on 'common currency'

System for continuously informing the board of 'significant risks' and for providing simple and straightforward early warning mechanisms

Positive acceptance of internal audit

Robust prioritisation methodology based on risk ranking and cost-benefit analysis

Board involvement in setting priorities of risk management and internal control

Establishment of key performance and risk indicators

Some use of benchmarking

Comprehensive Controls Assurance statement in annual report

(April 2005)

Level 2 attainment

Comprehensive system for producing performance information to assist the board with its evaluation of the effectiveness of internal control and risk management

Risk management internal control is part of the vocabulary throughout the organisation

Demonstrable ongoing improvement in key performance and risk indicators

Good use of benchmarking

Internal audit work closely with in-house technical specialists (eg estates, health and safety, infection control etc)

Internal audit is a source of advice on aspects of risk and control

Good use of structured assessment techniques, eg control-self assessments (CSA) workshops, including board involvement

Involvement of staff in deciding on objectives

Awareness of key objectives throughout the organisation

Convergence between Professional Governance and Controls Assurance

Tangible evidence of teamwork approach in operation throughout the organisation

Consultation throughout the organisation

Risk management and aspects of internal control is part of performance appraisal and personal development plan for staff, including board members

APPENDIX B: RISK MANGEMENT STEERING COMMITTEE TERM OF REFERENCE

1.0 AIM

1.1 To develop and review the Risk Management Strategy and strategic framework in support of the Trust's annual Controls Assurance Statement. To ensure that appropriate measures are taken to reduce risk and to improve the effectiveness of treatment, care and support given to patients, and clients. To identify, assess, evaluate, reduce and where possible, eliminate as economically as possible areas of risk which may give rise to injuries to patients, clients, staff and visitors; losses; damage to property or any other incident which may adversely effect the Trust's operation or reputation.

1.2 To provide a forum of Senior Managers who can provide a detailed overview of the Trust's service provision, policies and procedures. Within this overview, the Committee will provide recommendations according to the risk prioritisation, to the appropriate management groups and Trust Board in order to modify systems and services which will lead to the reduction of anticipated risk to the Trust.

1.3 The Risk Management Steering Committee recognises the need to converge professional and operational risk functions and will develop appropriate structures, responsibilities and reporting mechanisms as the programme develops.

2.0 Scope of Responsibility

2.1 Informing and consulting the Board on all significant risks and associated risk treatment plans on a continuous basis; promoting the issue of risk management.

2.2 Ensuring that all employees, including managers and the Board, are provided, where appropriate, with adequate risk management information, instruction, training and education.

2.3 Ensuring that all relevant stakeholders are kept informed on the management of significant risks faced by the Trust.

2.4 To assist all directorates in defining and promoting risk management strategies/actions via individual business plans, thus ensuring Controls Assurance in the form of risk management is an integral part of each directorate.

2.5 Overseeing the work of other risk management groups, professions and operations, Health and Safety Committee; Infection Control etc.

2.6 Overseeing the implementation and effectiveness of risk treatment plans from whatever source.

2.7 To review and if necessary prioritise recommendations/action plans based on Controls Assurance baseline assessments.

2.8 Developing and implementing an action plan within the Trust Governance Report in the light of risks identified across the Trust and recorded within the Trust Risk Register.

3.0 Objectives

3.1 To reduce risks to patients, clients, employees and others, to manage and control risks where acceptable and to transfer/share risk where unacceptable or unavoidable.

3.2 To identify, control and eliminate, or reduce to an acceptable level, all risks which may adversely effect:

- The quality of treatment and care
- The reputation of the trust
- The ability of the trust to provide services
- The health, safety and welfare of patients, clients, staff and visitors
- The ability of the Trust to meet its contractual obligations
- The financial standing of the Trust

3.3 To maximise the resources available for patient/client services, treatment and care.

3.4 To endeavour to ensure the Trust is not exposed to a risk, which has not been identified and evaluated.

3.5 To understand the risks the Trust faces, their causes and control and cost of risk to the Trust.

3.6 To ensure that the Trust responds in an appropriate and timely fashion to identified risks/adverse events.

3.7 To minimise the costs diverted to risk/claim funding.

4.0 Membership

4.1 The Risk Management Steering Committee will consist of the following:

- Chief Executive (Chair)
- Director Human Resources/Corporate Affairs (Lead Director)
- Director Medical Services (Community)
- Director Medical Services (Hospital)
- Director of Finance
- Director of Operations
- Director Nursing and Quality
- Director Planning Contracts Information
- Director Hospital and Learning Disability

In attendance

- ❖ Assistant Director Corporate Affairs (Risk Management)
- ❖ Professional Governance Co-ordinator (Clinical and Social Care)
- ❖ Assistant Director Estates (Health & Safety)
- ❖ Headquarters Administration Services Manager (Board Governance/complaints)

- ❖ These representatives will also act as central sources of information support and advice in relation to programme and service specific management of risk throughout the Trust.

4.2 The Chairman of the Risk Management Steering Committee is the Chief Executive.

4.3 The Trust through the Risk Management Steering Committee recognises that in many decisions other Senior Managers will require to be involved in strategic management decisions. The Committee will invite other personnel to join them dependent on the agenda.

4.4 Members are encouraged to prioritise their time for attendance; representatives may be asked to attend meetings on an exception basis.

4.5 Flexibility of membership is incorporated within the Committee's terms of reference and should reflect contemporaneous issues at both regional and local levels.

5.0 Accountability

5.1 Accountable to the Trust Board through the Trust executive.

6.0 Frequency of meetings

6.1 Meetings are held every two months.

7.0 Agenda items

7.1 Agenda items should be submitted 10 days in advance of the meeting to the Trust Lead in Controls Assurance and Risk Management who will subsequently ratify the next agenda with the Chairman.

8.0 Reporting

8.1 Quarterly reports summarising the activities of the Committee and the progress made against the plans identified within the Annual Trust Risk Management Action Plan will be prepared and submitted to the Trust Board by the Trust Lead in Controls Assurance and Risk Management and Chairman on behalf of the committee.

9.0 Lead Director – Controls Assurance and Risk Management

9.1 Director of Human Resources and Corporate Affairs

10.0 Communication

10.1 In order to ensure effective communication, the Trust Lead in Controls Assurance and Risk Management will act as the central point of contact for the committee.

11.0 Review

11.1 The Trust Board will review these terms of reference annually after initial endorsement.

Signed.....
Chief Executive,
Chair, Risk Management Committee

Dated.....

Signed.....
Trust Lead Director,
Controls Assurance and
Risk Management

Dated.....

Risk management in the NHS

NHS Management Executive

FOREWORD

Risk management is an important activity for all parts of the NHS. With all the changes in recent years, including the loss of crown immunity, it is no longer an optional extra.

I believe risk management has two major contributions to make. It can play a valuable role in ensuring that we provide a high quality, safe service to our patients. It can also help towards the provision of a more cost effective service by eliminating, or reducing, unnecessary costs.

A comprehensive risk management programme needs to address all parts of the service, from clinical services to the management of waste. This manual provides a structured approach to a complex subject. It is aimed at the general manager who needs a clear overview of risk management, rather than being a technical guide.

I recommend this manual to all chief executives and their staff.

Sir Duncan Nichol
Chief Executive
NHS Management Executive

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Produced
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December

Price: £10.

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HSC	Controls Assurance Standard	Risk Management

RISK MANAGEMENT

Statement of Standard

An independently assured risk management system is in place that conforms to the principles contained in AS/NZS 4360:2004, and which meets HSC and other requirements in respect of managing risks, hazards, incidents, complaints and claims.

Overview

This Standard is principally concerned with ensuring that all the Department's arm's length bodies (ALBs) – ie HSC bodies, the Northern Ireland Fire and Rescue Service (NIFRS), the Regulation and Quality Improvement Authority (RQIA), the Northern Ireland Social Care Council (NISCC) and the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) – have the basic building blocks in place for managing risk through development and implementation of a comprehensive risk management system.

This Standard, together with the Governance and Financial Management Standards, provides the basis for statutory reporting for the Governance Statement as set out by the Department of Finance in Managing Public Money NI A3.1 : Governance Statement

https://www.finance-ni.gov.uk/publications/managing-public-money-ni-chapter-3-and-associated-annex

Subsequent to this, new requirements were introduced for 2008/09 by Circular HSS(F) 19/09 in mitigating information risks. From 2009/10, each ALB is required to provide a mid-year assurance statement from the accounting officer attesting to the robustness of the organisation's system of internal control. The adoption of an Assurance Framework, to assist boards in the control of risks to strategic objectives, has also been made mandatory from April 2009.

Risk management should be recognised within an organisation as an integral part of good practice and should be part of the organisation's culture. It should be integrated into its philosophy, practices and business plans, and not be viewed or practised as a separate programme. When this is achieved, risk management becomes the business of everyone in the organisation.

Business continuity management is complementary to risk management. Having an appropriate business continuity management plan will contribute a response to specific risks and also to the overall risk awareness of the organisation. However the primary driver for business continuity management planning is on maintaining the organisations' ability to deliver its critical functions for a defined period. Like risk management, business continuity management should be seen as a core element of normal good management practice.

Whilst this standard does address key issues, it does not purport to be exhaustive. The boards of HSC bodies, NIFRS, RQIA, NISCC, and NIPEC should satisfy themselves that all relevant internal control and risk management requirements incumbent upon them, including those associated with the duty of quality, are properly identified and suitably addressed. When addressing risks to the organisation, in particular those which the organisation deems high/extreme to the achievement of key objectives, the risk and actions identified across other organisational controls assurance standards need to be considered.

The design of a risk management system will be influenced by and tailored to the existing structure of the individual body, the services provided and the processes and specific practices followed. A specific risk management approach applicable to all organisations is, therefore, unlikely to be serviceable. However, common principles can be identified and used to form the basis for the Standard. These in large part originate from the Australia/New Zealand Standard on risk management, which defines a set of generic principles for establishing a risk management system in any organisation. The Standard has been licensed for the HSC and the full Standard has been made available to all relevant bodies, which are encouraged to make use of the information and guidance contained in AS/NZS 4360:2004. Only 10% or less of the standard's definitions and references should be extracted and used within internal policy and procedure documents.

KEY REFERENCES

Statutes

Statutory Instruments: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003/431 (NI 9)

Statutory Rules: Social Security (Claims and Payments) Regulations (Northern Ireland) 1977 No.351

Statutory Rules: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 No.455

Guidance and Codes

HPSS Complaints Procedures Directions (Northern Ireland) Order 1996

The Miscellaneous Complaints Procedures Directions (Northern Ireland) 1996

HPSS (Special Agencies) Complaints Procedures Directions (Northern Ireland) 1996

Standards Australia Risk Management AS/NZS 4360:2004

NHS Good Practice Guide for Convenors, October 1999

Complaints in Health and Social Care – Standards and Guidelines for Resolution and Learning

Financial Reporting Council:

Health Estates (various) Firecode (Northern Ireland)

Department of Health, Social Services and Public Safety (2004): Guidance Note – Implementing the Equality Good Practice Reviews

ALARM /UCL - Clinical incident investigation protocol

NHS Resilience and Business Continuity Management Guidance –

DHSSPS Hospital Lockdown Guidance for Health and Social Care Trusts –

Circulars

Circular HSS (PDD) 1/1994 - Management of Food Services and Food Hygiene in the HPSS

Circular HSS (THR) 1/1999 – Management of Food Services and Food Hygiene in the HPSS

Circular HSC (SQSD) 5/10 – Handling Clinical and Social Care Negligence and Personal Injury Claims

Circular HSS (F) 19/2000 – Clinical Negligence Central Fund: Accounting Arrangements

Managing Public Money NI A3.1 : Governance Statement
https://www.finance-ni.gov.uk/publications/managing-public-money-ni-chapter-3-and-associated-annex

Circular HSS (PPM) 4/2005 – AS/NZS 4360: 2004 – Risk Management

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services
htm

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management

The Northern Ireland Adverse Incident Centre (NIAIC) operates as a function of the DoH with the objective of taking all reasonable action within its remit to safeguard the health of HSC service-users and staff through the provision of a regional centre for the voluntary reporting and investigation of adverse incidents involving medical devices, non-medical equipment, plant and building elements and for providing relevant safety guidance in relation to these items.

Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers
Department of Health, Social Services and Public Safety (2003): Code of Conduct for HPSS Managers

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance

Managing Public Money NI A3.1 : Governance Statement
https://www.finance-ni.gov.uk/publications/managing-public-money-ni-chapter-3-and-associated-annex

Circular HSS(SQSD) 18/2007 – Conducting Patient Safety Reviews/Lookback Exercise

Circular HSS(SQSD) 18/2007 – Guidance Document – A Practical Guide to Conducting Patient Safety Reviews or Lookback Exercises

Circular HSS(SQSD) 34/2007 – Guidance Document

Circular HSC(SQSD) 22/2009 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular HSC (SQSD) 08/2010 – Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls assurance standards – update

Other Publications

Lord Woolf's Report (1996) 'Access to Justice'. The Stationery Office, London

National Audit Office 2000, *Supporting Innovation: Managing risk in government departments.* The Stationery Office, London, HC 86f4 Session 1999-2000

Best Practice – Best Care (2001): A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS.

HM Treasury (2001) *Management of Risk: A Strategic Overview*

Health & Safety Executive (2003): 'Interventions to control stress at work in hospital staff'. The Health & Safety Executive, London

HM Treasury (2004): *Managing risks with delivery partners*

Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS

Safety First: a framework for sustainable improvement in the HPSS

An Assurance Framework: a Practical Guide for Boards of DoH Arm's Length Bodies

INDEX OF RISK MANAGEMENT CRITERIA

Criterion 1 (*Board accountability*)

Board level responsibility for risk management, including business continuity, is clearly defined and there are clear lines of individual accountability for managing risk throughout the organisation, leading to the board.

Criterion 2 (*Organisation-wide risk management processes*)

The organisation's senior management has defined and documented its strategy for managing risks, including objectives for, and its commitment to, risk management. The risk management strategy is relevant to the organisation's strategic context and its goals, objectives and the nature of its business. Management ensures that the strategy is understood, implemented and maintained at all levels of the organisation.

Criterion 3 (*Organisation-wide accountability*)

A committee structure is in place, which supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the board.

Criterion 4 (*Adverse incidents*)

An agreed process for reporting, managing, analysing and learning from adverse incidents is in place, in accordance with HSC guidance.

Criterion 5 (*Complaints and claims*)

An agreed process for reporting, managing, analysing and learning from complaints and claims is in place, in accordance with HSC guidance.

Criterion 6 (*Risk management process*)

A risk management process, based on the requirements of AS/NZS 4360:2004 and covering all risks, is embedded throughout the organisation at all levels, including the board, with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the board in order to learn and make improvements to the system.

Criterion 7 ***(Business Continuity Management)***
Business continuity management plans aligned to the International Standard on Business Continuity Management Systems (ISO 22301) are in place and can be activated in order to protect and maintain essential services to a pre-defined level through a business disruption.

Criterion 8 (*Capability*)

All employees, including members of the board, clinical and social care professionals, managers, bank, locum and agency staff, together with (where relevant) contractors and volunteers are provided with appropriate risk management and business continuity management training.

Criterion 9 (*Independent assurance*)

The board receives independent assurance(s) that a risk management system is in place that meets the requirements of this standard.

HSC	Controls Assurance Standard	Risk Management

CRITERION 1

Board level responsibility for risk management, including business continuity, is clearly defined and there are clear lines of individual accountability for managing risk throughout the organisation, leading to the board.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers. DHSSPS(2003): Code of Conduct for HPSS Managers

Guidance

Implementation of risk management programmes at all levels, especially at the corporate level, is a challenge for all managers. Its success will depend largely on the support of the Chief Executive and senior management team. Critical to this process is the involvement of clinical and social care professionals – nursing, medical, social services, pharmacy and allied health professionals.

The ultimate goal of any risk management programme is to make the effective management of risk an integral part of everyday practice. This can only be achieved if there is a comprehensive and cohesive risk management system in place, underpinned by clear accountability arrangements throughout the management organisational structure.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The Chief Executive has overall responsibility for risk management.
- An Executive Director, who may be the Chief Executive, has been designated accountable for the implementation of risk management and controls assurance
- A risk management strategy has been approved by and is owned by the board.
- Clear lines of accountability for risk management have been established throughout the organisation.
- One or more persons are charged with the responsibility for advising on and co-ordinating risk management activities. The designated Executive Director should be consulted on the strategic direction of all such activities.

Examples of Verification

- Risk management strategy has been approved by the board;
- Job descriptions for executive directors and senior managers;
- Job descriptions for specialist risk management advisors or governance managers;
- Risk management organisational chart;
- Assurance Framework in place and in operation;
- Terms of reference for the exclusively non-executive audit committee;
- Minutes of the audit committee;
- Terms of reference of the board sub-committee(s) responsible for overseeing risk management;
- Minutes of the board sub-committee(s) responsible for overseeing risk management;
- Minutes of the board;
- Copy correspondence or minutes of meetings of the executive directors with responsibility for risk management;
- Audits/checks of compliance with risk management objectives, financial, organisational and clinical and social care.

CRITERION 2

The organisation's senior management has defined and documented its strategy for managing risks, including objectives for, and its commitment to, risk management. The risk management strategy is relevant to the organisation's strategic context and its goals, objectives and the nature of its business. Management ensures that the strategy is understood, implemented and maintained at all levels of the organisation.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Managing Public Money NI A3.1 : Governance Statement
- Assurance Framework in place.

Guidance

Management of risk should be integrated into the philosophy of an organisation. A risk management strategy should be developed, which provides the organisation with strategic direction.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a board-approved strategy for risk management which promotes integrated governance and which is reviewed annually.
- The risk management strategy includes a list of key objectives for managing risk and is relevant to the organisation's strategic aims and objectives and the nature of its services.
- The strategy takes a holistic approach to the management of risk across the organisation and sets out the organisation's attitude to risk.
- The strategy clearly describes the process for reviewing the organisation's performance with regard to the management of risk.
- The strategy contains guidance on acceptable risk and for the management of situations in which control failure leads to material realisation of risk.
- The strategy includes reference to other risk management policies/procedures.
- Individual directorates/departments maintain local strategies that reflect their individual risk profile.
- The strategy specifies how new activities should be assessed for risk and incorporated into risk management structures.
- The strategy makes reference to and considers appropriately shared risks and those owned elsewhere (eg by independent contractors)

Examples of Verification

- Risk management strategy;
- Minutes of the board;
- Assurance Framework in place and in operation;
- List of internal and external stakeholders;
- Evidence of the risk management strategy being linked to the strategic/corporate plan;
- Specialist risk management policies and procedures;
- Risk management organisational chart;
- Evidence of strategy distribution to staff and its availability to other stakeholders;
- Local risk management strategies

CRITERION 3

A committee structure is in place, which supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the board.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers. DHSSPS(2003): Code of Conduct for HPSS Managers
- Managing Public Money NI A3.1 : Governance Statement
- Audit Committee Handbook, April 2013 – HM Treasury

Guidance

The full benefit of risk management will only be achieved if there is a comprehensive and cohesive system in place, underpinned by an organisation-wide risk management structure.

To ensure that all significant risks are properly considered and communicated to the board, boards of HSC bodies should ensure that they have a sub-committee for overseeing risk management within their organisations.

Departmental guidance concerning the composition, modus operandi etc of this sub-committee is currently under review. Pending revised guidance, the following sub-criteria will continue to help in deciding whether the key requirements of the main criterion are being met:

- There is a board sub-committee(s) responsible for overseeing all aspects of risk management.
- The role and responsibilities of the committee(s) responsible for overseeing risk management activities are clearly defined to ensure that an integrated governance approach is being taken and that any necessary separations of clinical and social care, financial and organisational risks are kept under review.
- The Executive Director designated with responsibility for specific aspects of risk management must be a member of the committee.
- There is at least one Non-Executive Director as a member of the committee.
- The Committee's responsibility includes organisation-wide co-ordination and prioritisation of risk management issues.
- The committee(s) responsible for risk management issues oversee the work of any specialist risk management groups, and these specialist groups report directly to it.

- The role of the Audit Committee in reviewing and providing verification on the systems in place for risk management is clearly defined.

Examples of Verification

- Risk management strategy;
- Terms of reference for committees;
- Risk management organisational chart;
- Minutes of meetings;
- Annual risk management reports;
- Schemes of delegation;
- Annual report;
- Committee objectives;
- Agendas and supporting documentation
- RQIA assessment (for HSC bodies)

CRITERION 4

An agreed process for reporting, managing, analysing and learning from adverse incidents is in place, in accordance with HSC and NIFRS guidance.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004.

- Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation.
- Health Estates, Northern Ireland Adverse Incident Centre (NIAIC), Reporting Adverse Incidents and Disseminating Medical Devices/Equipment Alerts DB(NI) 2008 (01).
- DHSSPS, 2001 – Guidance for reporting accidents with, and defects in, medicinal products
- Managing Public Money NI A3.1 : Governance Statement
- Safety First: a framework for sustainable improvement in the HPSS
- Circular HSS(SQSD) 18/2007 – Guidance Document on Conducting Patient Safety Reviews/Lookback Exercise
- Circular HSS(SQSD) 34/2007 – Guidance Document on HSC Regional Template and Guidance for Incident Review Reports
- Circular HSC(SQSD) 22/2009 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS
- Circular HSC (SQSD) 08/2010 – Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Guidance

Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses and hazards, which help to facilitate wider organisational learning.

Incidents and their consequences, if not properly managed, may result in loss of public confidence in the organisation, loss of assets and unnecessary proliferation of loss.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a board-approved policy/procedure for recording, reporting, analysing and managing incidents and that these are treated in accordance with DoH guidance.

- The policy/procedure is based upon a standard definition of incidents
- The policy/procedure promotes a positive and non-punitive approach towards incident reporting.
- The policy/procedure states that all incidents must be reported promptly and an incident form completed and submitted to the risk manager (or equivalent).
- The policy/procedure contains clear guidance to be followed on incident investigation and root cause analysis.
- The policy/procedure states that management actions and preventative measures taken must be recorded.
- For adverse incidents that could have an impact or 'adverse effect' upon staff, users or the public, the policy/procedure requires a mechanism to be in place to inform the board. Furthermore the senior manager at board level who has overall responsibility for the reporting and management of adverse incidents within the organisation should consider the incident against the provisions of Circular HSC (SQSD) 08/2010 and take action accordingly.
- All incidents are reported on a standard form(s), which may be paper-based or electronic, and which captures a 'minimum dataset' of information in accordance, where relevant, with HSC guidance.
- All reported incidents are graded according to severity of outcome and potential future risk to users and/or the organisation.
- Based on the grading, reported incidents are subject to an appropriate level of local investigation and causal analysis and, where relevant, an improvement strategy is prepared, implemented and monitored.
- All reported incidents and causal factors are classified and categorised in accordance with a standardised classification scheme.
- Aggregate reviews of local incident data/information are carried out on an ongoing basis and the significant results are communicated to local stakeholders.

Examples of Verification

- Incident reporting policy/procedure;
- Incident report form and guidelines for completion;
- Incident investigation reports;
- Trend analysis reports;
- Minutes of the committees responsible for overseeing risk management;
- Copies of relevant reports to the DoH and to other external bodies and stakeholders;
- Induction training programmes;
- Completed incident report forms;
- Relevant correspondence;
- Action plans and follow up reports;
- Major incident policy;
- RQIA assessment (for HSC bodies).

CRITERION 5

An agreed process for reporting, managing, analysing and learning from complaints and claims is in place, in accordance with guidance.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004.
- Complaints in Health and Social Care – Standards and Guidelines for Resolution and Learning.
- Circular HSC(SQSD) 23/2009 – Guidance on Complaints Handling in Regulated Establishments and Agencies.
- Circular HSC(SQSD) 34/2007 – HSC Regional Template and Guidance for Incident Investigation/Review Reports
- Circular HSC (SQSD) 08/2010 – Phase 2 –Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services
- Circular HSC (SQSD) – Handling Clinical and Social Care Negligence and Personal Injury Claims
- Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation.
- DHSSPS (2004): Guidance Note – Implementing the Equality Good Practice Reviews
- Safety First: a framework for sustainable improvement in the HPSS

Guidance

Competent handling of complaints can assist in improving the quality of care and minimising claims by listening to the voice of service users and using this as an opportunity for the organisation to learn from complainants. Complaints and claims when examined in conjunction with reported incidents, accidents and near misses allow trends to be identified at both a local and regional level. This leads to prevention of recurrence or of more serious incidents and complaints occurring.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a documented complaints procedure, which meets HSC requirements and is approved by the board.
- There is a designated complaints manager responsible for co-ordinating the local complaints arrangements and managing the process
- There is a designated senior person within the organisation with responsibility for the local complaints procedure.

- The arrangements for making complaints are publicised to service users.
- Front line staff receive training and guidance on the complaints procedure to enable them to deal with complaints on the spot.
- The organisation has an effective system for the recording of complaints.
- The organisation monitors how it, or those providing care on its behalf, deals with, and responds to, complaints.
- The organisation learns from complaints and improves services as a result.
- Independent review panelsare in place in full accordance with the HPSS Complaints Procedure (1996).
- All reported complaints are graded according to severity as well as potential future risk to users and/or to the organisation.
- One or more persons are charged with the responsibility for the management and co-ordination of claims.
- There is a documented claims management procedure, which meets HSC requirements and is approved by the Board.
- All reported claims are graded according to severity as well as potential future risk to users and/or to the organisation.
- Information on complaints is reported to and considered by a relevant sub-committee of the Board.

Examples of Verification

- Complaints policy/procedure;
- Compliance with the standards for complaints handling;
- Claims handling policy/procedure;
- Evidence of dissemination of learning within the organisation and use of the Equality Good Practice Review on the handling of complaints
- Job descriptions;
- Annual/Board reports;
- Reports of the committee responsible for overseeing risk management;
- Complaints committee reports
- Training needs analysis;
- Training programmes;
- Training evaluation forms;
- Induction programme;
- Complaints leaflets and posters;
- Complaints files;
- Customer feedback;
- Independent review reports (including those from RQIA);
- Evidence of claims management training;
- Evidence of claim settlement negotiations.

CRITERION 6

A risk management process, based on the requirements of AS/NZS 4360:2004 and covering all risks, is embedded throughout the organisation at all levels, including the board, with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the board in order to learn and make improvements to the system.

Organisations should be aware that the AS/NZS 4360:2004 has been superseded by a new International Standard on Risk management. The Department has a license that allows organisations to reproduce and extract 10% or less of the AS/NZS 4360:2004 definitions and references. This license will expire in 2018. It should be noted that over the forthcoming years the Department in discussion with organisations will determine the appropriate way forward in relation to risk management.

Source

- Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services.
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Managing Public Money NI A3.1 : Governance Statement
- Assurance Framework in place and in operation;
- Standards Australia Risk Management AS/NZS 4360: 2004.

Guidance

The organisation must be aware of its risk profile across its entire range of activities. Specific risk assessments will have been undertaken but in order to prioritise action an organisation-wide review is necessary to ensure that all exposures are duly considered.

“Key risks”, sometimes termed “principal risks”, are those which have significant potential to impair or affect the operational or financial ability of the organisation to deliver services and meet objectives, and may be strategic or operational in nature.

A comprehensive assessment of risks should be carried out, creating a continuum of risk assessments across the length and breadth of the organisation, encompassing all risks.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- Risks are systematically identified, recorded, assessed and analysed on a continuous basis.

- A comprehensive risk register is maintained on an ongoing basis for all units (eg directorates, departments, functions or sites) for significant projects and for the organisation as a whole. The corporate/organisation-wide risk register is 'owned' and regularly reviewed by the board.
- The risk register should identify risks in a consistent and structured way, show dependencies, and ensure linkage between principal and other key risks.
- There should be a reasonable mechanism for managing relationship risk, ie service partners/key suppliers taking into account the behaviour and risk priorities of those partners.
- Common terminology for risk activities, taking into account DoH guidelines, is applied throughout the organisation.
- For all risks identified as requiring treatment, actions are determined, appropriately recorded and implemented in order of priority using, where relevant, appropriate decision-making tools (e.g. risk ranking or cost-benefit analysis)
- The board is informed of and, where necessary, consulted on all principal/significant risks and associated risk treatment plans on a continuous basis. Any risk exposure should be recorded and exposure justified. Adequate contingency plans should be in place.
- All relevant stakeholders are kept informed and, where appropriate, consulted on the management of risks faced by the organisation.
- All relevant staff are kept informed of the management of significant risks faced by the organisation.
- Key indicators capable of showing improvements in management of risk and/or providing early warning of risk are used at all levels of the organisation, including the board, and the efficacy and usefulness of the indicators are reviewed regularly.
- An annual report is produced for the board to demonstrate the risk management system's continuing suitability and effectiveness in satisfying the organisation's risk management policy and strategy.

Examples of Verification

- Risk management strategy;
- Risk identification tools;
- Hazard reporting policy and forms;
- Risk assessment tools and forms;
- Completed risk assessments;
- Risk treatment options;
- Evidence of risk treatment;
- Business plans;
- Annual report;
- Risk registers;
- Minutes of committees;
- Job descriptions;
- Training programmes;

- Action plans;
- Evidence of communication with stakeholders;
- Evidence of communication with staff;
- Assurance Framework in place and in operation;
- Monitoring and review procedure;
- Performance indicators;
- Evidence of monitoring and review;
- Board minutes;
- Patient surveys;
- Incident, complaints and claims analysis.

Criterion 7

Business continuity management plans aligned to the International Standard on Business Continuity Management Systems (ISO 22301) , are in place and can be activated in order to protect and maintain essential services to a pre-defined level through a business disruption.

Source

- International Standard on Business Continuity Management Systems (ISO 22301)
- DHSSPS Policy Circular: Hospital Lockdown Guidance for Health and Social Care Trusts (March 2011)

Guidance

Good corporate governance practice requires all HSC organisations to have arrangements in place to enable them to continue to deliver their essential or priority services during periods of business disruption. This disruption may be internal to the organisation, for example the loss of a key building because of fire, flooding, the loss of IT services or because of a staffing crisis. Or it may be external, for example the loss of power supplies, prolonged disruptions due to strikes, or lack of fuel supplies.

The **International Standard on Business Continuity Management Systems (ISO 22301)** , defines BCM as 'a holistic management process that identifies potential threats to an organisation and the impacts to operations that those threats, if realised, might cause, and which provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities.'

BCM is, therefore, a process that helps manage risks to the smooth running of an organisation or delivery of a service, ensuring continuity of critical functions to a pre-defined level in the event of a disruption, and effective recovery afterwards. It forms a vital part of good corporate governance and risk management processes, as well as being part of good emergency planning and preparedness.

The business continuity management process is linked to risk management and should form part of organisations' corporate business planning cycles. It should include annual review and update to keep BCM plans current. Business continuity management measures must therefore be part of every organisation's core business, not just an adjunct to it, and should be seen as part of normal good management practice.

Some elements of BCM will also overlap with emergency preparedness arrangements which aim to prevent emergencies occurring (where possible), and when they do occur, to reduce, control or mitigate the effects of the emergency in the management of its impact. But the focus of emergency planning is on dealing with the emergency and the consequences of that emergency, not with maintaining the core business of the organisation.

Business continuity management enables an organisation to anticipate, prepare for, prevent, respond to and recover from disruptions, to a pre-defined level, whatever their source and whatever aspect of the business they affect.

In developing and reviewing their business continuity management plans HSC organisations should ensure that they can demonstrate a systematic, planned and reviewed approach to BCM. The BCMS should detail how organisations will meet the general requirements articulated in ISO 22301 in relation to the following:

- **Context of the organisation** – understanding the organisation and its context, understanding the needs and expectation of interested parties and the scope of the BCM system. This will include determining internal and external issues that are relevant to the organisation's purpose and that affects its ability to achieve the expected outcomes of its BCMS, including understanding the needs and expectations of interested parties, supply chains, etc.
- **Leadership** – describing how top management and other relevant management roles demonstrate leadership with respect to business continuity management systems and management's ongoing commitment to the process, including providing the necessary resources for the BCMS and communicating the importance of effective business continuity management. Such leadership should be established as a core competence within the business continuity policy (which identifies all organisation roles, and ensuring that the responsibilities and that the authority for the relevant roles are assigned).
- **Planning** – establishing the strategic objectives and guiding principles for the BCMS, including identifying all actions in place to address risks and opportunities, in conjunction with business continuity management objectives and plans to achieve these objectives.
- **Support** – identifying the key elements that need to be in place to support BCMS, e.g. all resources, competent staff, training and awareness-raising, how resources have been determined and provided for the establishment, implementation, maintenance and continual improvement of the business continuity management system.
- **Operation** – operational planning and control to achieve business continuity, including Business Impact Analysis, risk assessment, identifying a business continuity management strategy, establishing

and implementing business continuity procedures and evidence of regular exercising and testing to validate plans.

- **Performance evaluation** – once the BCMS is implemented it will require permanent monitoring and regular review to improve its operation. This requires regular monitoring, measurement, analysis and evaluation; the conduct of internal audits; and the gathering of information to support management reviews at planned intervals.
- **Improvement** – striving for continual improvement, including taking any corrective action needed to address non-conformity which was identified through performance evaluation.

Examples of Verification

- Corporate Business Continuity Management Plans (aligned to ISO 22301)
- Notes of performance monitoring meetings
- Internal and external audit reports on the BCM plan
- Hospital lockdown plan/policy where appropriate

Links with other Standards

- Governance
- Financial Management
- Human Resources
- Emergency Planning

CRITERION 8

All employees, including members of the board, professionals, managers, bank, locum and agency staff, together with, where relevant, contractors and volunteers are provided with appropriate risk management and business continuity training.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Managing Public Money NI A3.1 : Governance Statement
- Report on Induction Process for Medical Staff in HSC

Guidance

This contributes to the organisation's risk management culture, which needs to be embedded at all levels throughout the organisation.

An appropriate training programme is an important means of achieving competence and helps to ensure compliance with safe working practices. All job descriptions for employees within the organisation should contain reference to their risk management responsibilities.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The organisation has assessed and delivered the level of risk management training that is needed throughout.
- Training records are kept, monitored and reviewed and inadequate attendance rectified.
- Induction for all new starters includes risk management training.
- The organisation can demonstrate that risk management training is effective through monitoring and review.
- Employees with responsibility for co-ordinating and advising on aspects of risk management have adequate training and development to fulfil their role.

Examples of Verification

- Training needs assessment;
- Training prospectus;
- Local training needs assessment;
- Training records (risk management training in the *wider* sense such as training on fire safety, health & safety, first aid/CPR, management of

needle stick injuries, management of aggression, records management, etc.);
- Reports on attendance levels;
- Induction programme;
- Local induction procedures;
- Training objectives;
- Evidence of review of training objectives;
- Training course evaluations.

CRITERION 9

The board receives independent assurance(s) that a risk management system is in place that meets the requirements of this standard.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004;
- Assurance Framework in place and in operation;
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Managing Public Money NI A3.1 : Governance Statement

Guidance

Reviews by independent bodies will assist organisations in demonstrating performance, and also in highlighting areas that need to be addressed. This will give the organisation assurance that controls are working satisfactorily and that local and national targets are being met. RQIA has access to controls assurance information and the Authority's reports on assessment of access to, and quality of services commissioned and provided by HSC and other organisations should be given due consideration and actioned as appropriate.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The role of the Audit Committee in reviewing and providing assurance on the risk management systems in place is clearly defined.
- The role of the internal audit function in reviewing and providing verification on the systems in place for risk management is clearly defined.
- The internal audit function, aided as necessary by relevant technical specialists, carries out periodic reviews to provide assurances to the organisation that a suitable risk management system is in place and working properly taking into consideration reviews by other review bodies**.**
- The organisation has a system in place to ensure that reviews carried out by external agencies are effectively co-ordinated and any recommendations implemented within the context of available resources.
- Reports are presented to the Audit Committee and copied to the overarching committee(s) responsible for risk and any other relevant committee/group.

Examples of Verification

- Assurance Framework in place and in operation;
- Internal Audit reports;
- Internal audit statement to Chief Executive;
- Audit Committee minutes;
- Minutes of the committee(s) responsible for overseeing risk management;
- Minutes of the committee(s) responsible for overseeing Clinical and Social Care Governance;
- Reports from RQIA and other review bodies;
- Reports from external audit (NIAO);
- Reports from multi-professional audit.

Belfast Health and Social Care Trust

RISK MANAGEMENT STRATEGY

2008 – 2011

CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2007/08

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's strategic themes. It will inform the management planning process and assist us in achieving corporate and service group objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has five long term corporate objectives. These are:

- To provide safe, high quality and effective care
- To modernize and reform our services
- To improve health and wellbeing through engagement with our users, communities and partners
- To show leadership and excellence through organisational and workforce development
- To make the best use of our resources to improve performance and productivity.

The Trust will manage risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Board Assurance Framework;

- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;

- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;

- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;

- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage leaning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The growing interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and other initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities. These include Agenda for Change, Working Time Regulations, the Consultant Contract and the Hospital at Night Imitative. Appropriate risk assessment and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) has huge potential to support staff development, knowledge and competency in relation to risk and ensure that the individual's role in risk management is linked to their job profile. The KSF and its associated development review process will apply across the whole Trust for all staff (except medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

3.1 raise staff awareness of the principles and practice of risk management;

3.2 establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;

3.3 achieve improved patient outcomes and experience through the implementation of effective governance arrangements;

3.4 protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;

3.5 establish priorities for the control of risks, based on a suitable assessment process;

3.6 minimise financial liability through effective Controls Assurance;

3.7 minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;

3.8 involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

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4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Director's Office) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, service group management and staff. These managers must investigate adverse incidents and complaints, according to agreed procedures and provide reports and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each service group and corporate department produce risk registers and action plans, to address identified risks. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are required to co-operate with the introduction of

[2] Belfast HSC Trust "Board Assurance Framework 2007 - 08" Section 6 & 7

this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within service groups. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this strategy to ensure that all groups/committee/bodies that support the Trust in the management of

[3] Loc. Cit Appendix B

organisational risk are identified and their lines of accountability are clearly defined.

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DHSSPSNI guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in service groups and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- A matrix to identify the risk evaluation score that uses consequence and likelihood scales.
- Consequence descriptors that cover different areas of risk.
- Likelihood descriptors for frequency and probability
- Management authority for each level of risk (extreme, high, medium and low).

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DHSSPS April 2006

- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed work programme required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and a comprehensive dynamic organisational risk register, which is developed in conjunction with accurate departmental and service group risk registers. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Service Group/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Service groups are required to develop and maintain a register of all identified risks specific to their own activities and circumstances. It is envisaged that service groups will use the Datix Risk Register module to facilitate the maintenance of the registers. Service groups are expected to review their risk registers three times a year.

The corporate risk register is populated by extreme risk issues identified from a number of internal sources including the service group risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process. The term “extreme” represents an activity, event or situation that has the potential to cause harm to the organisation.

The corporate risk register provides an assurance to the Board of Directors as to the identification and management of the

organisation's principal risks. It will be reviewed and reported every four months to the Trust Assurance Committee.

7.1.2 Assurance Framework

The purpose of the Assurance Framework is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The assurance framework differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required

7.1.3 Incident reporting

The Trust relies upon the accurate reporting of incidents by all its staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public.

In the short term this may mean an increase in the number of incidents identified within the Trust. Any media interest will be managed in a positive way, by reassuring the public that increased reporting is essential to the prevention of serious incidents and the increase in incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents is important. The Trust expects the number of reported incidents to rise as methods and systems of reporting are improved. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems include proactive management and analysis of

complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues across service groups will be established. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon the on-going establishment of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure will be the cornerstone of this communication. Each Service Group will need to have a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Office will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways.

The Trust has a large number of external partners including the DHSSPSNI, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is implemented. The RQIA and Internal

Auditors will have a role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and will be reflected in the Knowledge and Skills Framework for other staff.

A range of training and education relating to risk management will be available within the Trust aimed at the specific needs of staff members. This will start at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust will monitor the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of “working groups” will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.

The Risk Management, Governance and Health & Safety Controls Assurance standards are monitored on an annual basis, the annual compliance scores will be reported to the Assurance Committee, a sub committee of the Trust Board. Gaps in control will be linked to the Assurance Framework and Corporate Risk Register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The legacy Trusts of the Belfast HSC Trust have made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work, harmonise systems and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

APPENDIX 1
Risk Evaluation System

1 The risk evaluation system will allow managers to arrive at a risk evaluation score and subsequent risk level. Guidance appropriate to the risk level identified is provided for management. Risks can then be prioritised and action taken accordingly.

2 Risks that appear in the red section of the risk matrix are considered to be 'UNACCEPTABLE' as there is an extreme risk of harm to an individual(s) or the organisation. The event, whether actual or "near miss" must be immediately referred to the relevant Director. The Director will assist with the implementation of the action plan to control the risk, consulting with appropriate technical experts as necessary (clinical/non clinical risk managers, radiation safety advisers etc). Unacceptable risks will be reviewed and validated, in the first instance, by the Risk Register Review Group.

The corporate risk register will comprise red risks from service and corporate risk registers including control assurance risk registers. The Assurance Group will review the corporate risk register and agree which risks should be incorporated into the principal risk register.

3 Red coded risks, that cannot immediately be reduced, must also be referred to the Senior Manager Corporate Governance, Medical Director's Office for further assessment if necessary.

4 If an incident has occurred, and this has been assessed as a serious adverse incident then it must be reported in accordance with the Trust Adverse Incident Policy, the HSCB Procedure for the reporting and follow up of Serious Adverse Incidents (SAIs), April 2010 without delay.

5 Amber coded risks have a high potential to cause harm to an individual(S) or the organisation. The Service Group/Corporate Department should manage amber coded risks as far as practicable. The risk issue, actual or near miss should be reported to the Service Manager and an action plan implemented to control the risk. If it is not possible to reduce the risk with immediate effect the matter should be referred to the Service Group senior team. Managers would be expected to consult with technical experts within the Trust, eg health and safety, infection prevention and control and radiation safety to determine suitable control mechanisms.

6 Yellow coded risks have a medium potential to cause harm to an individual(s) or the organisation. Management action must be specified at departmental level and control mechanisms regularly reviewed

7 Green coded risks have a low potential to cause harm to an individual or the organisation. Green coded risks should be managed at the local department level. It is quite likely that the level of risk has been reduced as far as reasonably practical. An element of risk may still remain but this is deemed as 'ACCEPTABLE' by the organisation. It is appropriate and acceptable to reduce red, amber and yellow coded risks to this 'green level'.

Risk Evaluation System

Instructions for use

1 Identify the risk
2 Using Table 1 identify the consequence should the risk occur, select number from scale 1 to 5.
3 Using Table 2 identify the likelihood and immediacy of the risk occurring (scale 1 to 5).

Table 1: Consequence Descriptors and Scores

	1	2	3	4	5
Descriptors	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
A **Objectives/ Projects**	Insignificant cost Increase/schedule slippage. Barely Noticeable reduction in scope or quality	Less than 5% over budget/ Schedule slippage. Minor reduction in scope/ quality/	5-10% over budget/ Schedule slippage. Reduction in scope or quality.	10-20% over budget/schedule slippage. Doesn't meet secondary objectives.	More than 25% over budget/schedule slippage. Does not meet primary objectives
B **Injury**	Minor injury not requiring first aid or any intervention. No time off work.	Minor injury or illness first aid/intervention required. Requiring first aid or increased patient monitoring. Increased hospital stay 1-3 days. Requiring time off work <4days	RIDDOR reportable. Requiring time off work 4-14days. Semi permanent physical/emotional injury/trauma/harm. Treatment given. (Recovery expected within 1 year). Increased hospital stay 4-15 days.	Permanent physical/emotional injuries/trauma/harm (recovery expected within 1 year). Increased hospital stay >15 days. Requiring time off work >14 days	Incident that led to one or more deaths.
C **Numbers Affected**	None	Very few 1 - 2	Small numbers 3 - 10	11-49	50+
D **Patient/Client Experience**	Unsatisfactory patient/client experience not directly related to care	Unsatisfactory patient/client experience – readily resolvable	Mismanagement of patient/client care	Serious mismanagement of patient/client care	Totally unsatisfactory patient outcome or experience
E **Complaints/ Claims**	Locally resolved complaint	Justified complaint peripheral to care	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess limit. Multiple justified complaints.	Multiple claims or single major claim.
F **Service/ Business Interruption**	Loss or interruption between I and 8 hours	Loss/interruption between 8 and 24 hours	Loss/interruption between 1 and 7 days	Loss/interruption more than 1 week	Permanent loss of service or facility
G **Staffing and Competence**	Short term low staffing, level temporarily reduces service quality (less than 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objectives/service due to lack of staff. Minor error due to poor training. Ongoing unsafe	Uncertain delivery of key objective/service due to lack of staff. Serious error due to poor training.	Non delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to insufficient training.
H **Financial**	Small Loss	Loss of more than 0.1% of budget	Loss of more than 0.2% of budget	Loss of more than 0.5% of budget	Loss of more than 1% of budget
I **Inspection/ Audit**	Minor recommendations Minor non compliance with standards. Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non compliance with standards.	Reduced rating. Challenging recommendations. Non compliance with core standards	Criminal prosecution/ prohibition notice. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
J **Adverse publicity/ reputation**	Rumours	Local media – short term interest. Minor effect on staff morale.	Local media – Long term. Significant effect on staff morale.	Regional media less than 3 days. Independent review.	Regional media more than 3 days. MLA concern. DHSSPS executive investigation following incident or complaint.

Table 2 – Likelihood score

Frequency and Probability scales are provided to be used as appropriate, but only one score can be selected.

	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to Occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	< 10% Will only occur In exceptional circumstances	10-24% Unlikely to occur	25-49% Reasonable chance of occurring	50-74% Likely to occur	75% + More likely to occur than not

4 Multiply the consequence by the likelihood score = risk rating (scale of 1 to 25)

5 The risk matrix shows the likelihood of risk – extreme, high, medium or low.

Table 3 Risk Rating Matrix (adapted from AS/NZ 4360, 2004)

LIKELIHOOD	**Consequence**				
	Insignificant 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
5 - Almost certain (will undoubtedly recur, a persistent issue)					
4 - Likely (will probably recur, not a persistent issue)					
3 - Possible (may recur occasionally)					
2 - Unlikely (do not expect it to happen again)					
1 - Rare (can't believe it will ever happen again)					

Risk Rating

Low	Medium	High	Extreme

6 Identify the level at which the risk will be managed – see Table 4 for details of management action required.

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Service Manager	N/A
Yellow	Ward/Dept Manager	Service Manager/Co Director	Service Area
Amber	Service Manager	Co Director/ Director	Service Group
Red	Director	Assurance Group	Corporate

7 Use the priority table to determine when risk needs to be actioned and reviewed.

Guide to Priority Levels

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 1month
Amber – High	Action within 1 month	Review within 3 months
Yellow – Medium	Action within 3 months	Review within 6 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 4

- **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Service Group/Corporate Department Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. Where the risk is not immediately reducible the risk will be added to the Service Group/Corporate Risk Register via the Assurance Group.**
- **These risks will be reviewed and validated by the Risk Register Review group prior to going to Assurance Group. The Assurance Group will agree those risks which will be recorded on the principal risk document.**

- **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Service Group Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. It is recommended that HIGH RISKS are recorded on the Service Group risk register.**

- **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level.**

- **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable.**

APPENDIX 2

Area	Action	Responsibility	Timescale	Status
Assurance Framework	Review annually in line with new DHSSPS guidance and take account of changes to expert/advisory committees, identify any gaps in compliance and action accordingly	Directors	June 2010	
	Develop Datix Assurance Framework and integrate with risk registers and harmonise risk rating matrix through all modules	Co Director Risk & Governance /R & G Senior Managers	April 2010	Decision taken by Assurance Group Sept 09 to implement this in 2010/11
Risk Registers	Develop Datix risk registers for service groups and controls assurance leads to include the integration of incidents, claims and complaints with risk register module. Roll-out of Datix risk register module to service group governance leads and provide training.	Co Director Risk & Governance/ Senior Manager Corp Governance IT Lead	Sept 2010 Sept 2010	Work on-going. Modules moving to Belfast Server in line with ITC Strategy
Management of adverse incident reporting policy	Revise policy in line with new DHSSPS SAI and RAIL systems and Assurance Framework guidance. Develop and deliver training programme to be included in Learning and Development Brochure and TAS	Senior Manager Pt/Client Safety/ Senior Manager Corp Risk/ Senior Manager Corp Governance	April 2010 Sept 09 Ongoing	Programme developed and managed through TAS

Area	Action	Responsibility	Timescale	Status
Incident reporting systems	Web based reporting to continue to be rolled-out across the Trust in partnership with ICT.	As above	March 2011	
	The Datix system to be developed to track and trend incidents, complaints and claims within and across service groups. These will be reported on and inform the Corporate risk register.	As above	May 2010	
	To facilitate this electronic process all incidents, claims and complaints will be graded in line with the Risk Management Strategy.			Litigation team currently reviewing risk rating systems for Clinical Negligence
Committee Structures	The assurance committees' infrastructure will be continually reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation annually.	Assurance Group Committee Chairs	Ongoing	To be tabled at Assurance Committee Oct 09 & Feb 10
Communication	The process for communication in relation to risk and governance to be further reviewed to include the improved use of the Trust Intranet, linkage with Stds, Guidelines, SABs etc	Medical Director's Service Group Governance & Quality Corporate Nursing	March 2010	Datix Alert module purchased. MDG intranet site in development.

Area	Action	Responsibility	Timescale	Status
Education and Training	The range of training programmes and tools for staff education in the Trust will be further developed in line	Medical Director's Office /HR / Service Groups / Corporate Nursing	June 2010 Ongoing	
Education and Training cont/d	the Learning and Development Strategy including development of Statutory/Mandatory Training Matrix.	Medical Director's Office /HR / Service Groups / Corporate Nursing	June 2010 Ongoing	
Patient/Client and Service Users	A process to be established to ensure that patients, clients and service users contribute to the on-going development of the risk management infrastructure within the Trust. Involvement of staff, patients, clients, service users and partner organisations in continuous improvement initiatives and learning lessons will be developed on an ongoing basis.	Directors Medical Director's Office Corporate Nursing	June 2010 On going Sept 2010	
Evaluation, Monitoring and Audit of Assurance Framework/Policies/ Standards/Guidelines etc	An annual review of the implementation of the Risk Management Strategy and Action Plan will be undertaken and presented to the Assurance Committee. Audit the dissemination of Trust Policy, Standards and Guidelines. Agree Internal Audit risk management programme for 2010/11 and report progress to Audit Committee throughout 2010/11.	Co Director Risk & Governance Co Director Risk & Governance Medical Director/ Deputy CE & Finance Director	April 2010 Sept 2010 May 2010	.

Area	Action	Responsibility	Timescale	Status
Structures	Develop and agree risk and governance structures for Medical Director's Office and Service Groups.	Directors	Sept 07	Completed
Assurance Framework	Develop and agree a Trust Assurance Framework	Directors	Sept 07	Completed
Risk Registers	Evaluate the Datix computerised risk management system to ascertain its capability to integrate incidents, claims and complaints with risk register module. Agree new Trust site licence Roll-out of Datix risk register module to service group governance leads	Co Director Risk & Governance/ Senior Manager Corp Governance IT Lead	March 08 May 08 June 08	Project Board and Team agreed
Management of adverse incident reporting policy	Develop a single Belfast Trust adverse incident reporting policy incorporating the management of Serious Adverse Incidents and the management of the investigation of incidents, complaints and claims	Senior Manager Pt/Client Safety/ Senior Manager Corp Risk/ Senior Manager Corp Governance	Feb 08	In draft format for Trust Policy Committee Feb 25 08
Incident reporting systems	Incident reporting to be managed centrally using Datix and incident coding to be standardised across the organisation and in accordance with DHSSPS guidance. Web based reporting to continue to be rolled-out across the Trust.	Senior Manager Pt/Client Safety/ Senior Manager Corp Risk/ Senior Manager Corp Governance	May 08 Ongoing	Work on standard codes underway. Reps on DHSSPS project team.

Area	Action	Responsibility	Timescale	Status
Incident reporting systems cont/d	The Datix system to be developed to track and trend incidents, complaints and claims within and across service groups. These will be reported on and inform the Corporate risk register. To facilitate this electronic process all incidents, claims and complaints will be graded according to risk. Ongoing support will be given from the Medical Director's Risk and Governance teams to enable service groups to develop local risk management systems in line with the Risk Management Strategy	Senior Manager Pt/Client Safety/ Senior Manager Corp Risk/ Senior Manager Corp Governance	Ongoing	
Committee Structures	The assurance committees' infrastructure will be reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation.	Assurance Group Committee Chairs	March 08	ToR and work plans requested for Assurance Group Feb 08
Communication	The process for communication in relation to risk and governance will be reviewed to include the improved use of the Trust Intranet, SABs etc	Medical Director's Service Group Governance & Quality Corporate Nursing	Sept 08	
Education and Training	A review of all training relating to risk management will be undertaken to ensure a standardised approach to training and education for staff. The range of training programmes and tools for staff education in the Trust will be further developed in line with the Learning and Development Strategy.	Medical Director's Office HR Service Groups Corporate Nursing	Sept 08 Ongoing	H & S managers meeting with HR and BMC re e learning package Feb 08

Area	Action	Responsibility	Timescale	Status
Patient/Client and Service Users	A process to be established to ensure that patients, clients and service users contribute to the on-going development of the risk management infrastructure within the Trust Involvement of staff, patients, clients, service users and partner organisations in continuous improvement initiatives and learning lessons will be developed on an ongoing basis.	Directors Medical Director's Office Corporate Nursing	Sept 08 On going	
Evaluation, Monitoring and Audit of Policies	An annual review of the implementation of the Risk Management Strategy and Action Plan will be undertaken. A system to prioritise actions necessary to improve compliance with the Controls Assurance Standards will be implemented.	Co Director Risk & Governance Co Director Risk & Governance Standard owners	March 09 March 08	Risk evaluation using risk matrix appendix 1 to be shared with lead assessors.

2.018

Belfast Health and Social Care Trust

RISK MANAGEMENT STRATEGY

2012 – 2015

22-06-12

CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2007/08

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's strategic themes. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has five long term corporate objectives. These are:

- To provide safe, high quality and effective care;
- To modernise and reform our services;
- To improve health and wellbeing through engagement with our users, communities and partners;
- To show leadership and excellence through organisational and workforce development;
- To make the best use of our resources to improve performance and productivity.

The Trust will manage risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Board Assurance Framework;
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;

- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;

- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;

- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The growing interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and other initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities. Appropriate risk assessment and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) has huge potential to support staff development, knowledge and competency in relation to risk and ensure that the individual's role in risk management is linked to their job profile. The KSF and its associated development review process will apply across the whole Trust for all staff (except

medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;
- establish priorities for the control of risks, based on a suitable assessment process;
- minimise financial liability through effective Controls Assurance;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must investigate adverse incidents and complaints, according to agreed procedures and provide reports and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are required to co-operate with the introduction of

[2] Belfast HSC Trust "Board Assurance Framework 2007 - 08" Section 6 & 7

this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this strategy to ensure that all groups/committee/bodies that support the Trust in the management of

[3] Loc. Cit Appendix 3

organisational risk are identified and their lines of accountability are clearly defined.

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DHSSPSNI guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- A matrix to identify the risk evaluation score that uses consequence and likelihood scales.
- Consequence descriptors that cover different areas of risk.
- Likelihood descriptors for frequency and probability
- Management authority for each level of risk (extreme, high, medium and low).

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DHSSPS April 2006

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed work programme required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and a comprehensive dynamic organisational risk register, which is developed in conjunction with accurate departmental and directorate risk registers. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances. It is envisaged that Directorates will use the Datix Risk Register module to facilitate the maintenance of the registers. Directorates are expected to review their risk registers at least three times a year.

The corporate risk register is populated by extreme risk issues identified from a number of internal sources including the

Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process. The term "extreme" represents an activity, event or situation that has the potential to cause harm to individual(s) or the organisation.

The corporate risk register is used to support ongoing review and update of the Principal Risk Document. The Principal Risk Document provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. It will be reviewed and reported to Assurance Committee every four months

7.1.2 Principal Risk Document

The purpose of the Principal Risk Document is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The Principal Risk Document differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required

The ongoing development and review of the Assurance Framework including the Principal Risk Document provides robust processes within the organisation to escalate concerns and risks adequately and supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.3 Incident reporting

The Trust relies upon the accurate reporting of incidents by all its staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident

reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents is important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues across directorates will be established. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon the on-going establishment of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure will be the cornerstone of this communication. Each Directorate will need to have a local infrastructure to support the communication and

feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Office will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways.

The Trust has a large number of external partners including the DHSSPSNI, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is implemented. The RQIA and Internal Auditors will have a role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and will be reflected in the Knowledge and Skills Framework for other staff.

A range of training and education relating to risk management will be available within the Trust aimed at the specific needs of staff members. This will start at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust will monitor the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of "working groups" will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.

The Risk Management, Governance and Health & Safety Controls Assurance standards are monitored on an annual basis, the annual compliance scores will be reported to the Assurance Committee, a sub committee of the Trust Board. Gaps in control will be linked to the Assurance Framework and Corporate Risk Register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

APPENDIX 1

Risk Evaluation System

Instructions for use

1 Identify the risk
2 Using Table 1 identify the consequence should the risk occur, select number from scale 1 to 5.
3 Using Table 2 identify the likelihood and immediacy of the risk occurring (scale 1 to 5).

Table 1: Consequence Descriptors and Scores

	1	2	3	4	5
Descriptors	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
A **Objectives/ Projects**	Insignificant cost Increase/schedule slippage. Barely Noticeable reduction in scope or quality	Less than 5% over budget/ Schedule slippage. Minor reduction in scope/ quality/	5-10% over budget/ Schedule slippage. Reduction in scope or quality.	10-20% over budget/schedule slippage. Doesn't meet secondary objectives.	More than 25% over budget/schedule slippage. Does not meet primary objectives
B **Injury**	Minor injury not requiring first aid or any intervention. No time off work.	Minor injury or illness first aid/intervention required. Requiring first aid or increased patient monitoring. Increased hospital stay 1-3 days. Requiring time off work <4days	RIDDOR reportable. Requiring time off work 4-14days. Semi permanent physical/emotional injury/trauma/harm. Treatment given. (Recovery expected within 1 year). Increased hospital stay 4-15 days.	Permanent physical/emotional injuries/trauma/harm Increased hospital stay >15 days. Requiring time off work >14 days	Incident that led to one or more deaths.
C **Numbers Affected**	None	Very few 1 - 2	Small numbers 3 - 10	11-49	50+
D **Patient/Client Experience**	Unsatisfactory patient/dient experience not directly related to care	Unsatisfactory patient/dient experience – readily resolvable	Mismanagement of patient/dient care	Serious mismanagement of patient/dient care	Totally unsatisfactory patient outcome or experience
E **Complaints/ Claims**	Locally resolved complaint	Justified complaint peripheral to care	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess limit. Multiple justified complaints.	Multiple claims or single major claim.
F **Service/ Business Interruption**	Loss or interruption between I and 8 hours	Loss/interruption between 8 and 24 hours	Loss/interruption between 1 and 7 days	Loss/interruption more than 1 week	Permanent loss of service or facility
G **Staffing and Competence**	Short term low staffing, level temporarily reduces service quality (less than 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objectives/service due to lack of staff. Minor error due to poor training. Ongoing unsafe	Uncertain delivery of key objective/service due to lack of staff. Serious error due to poor training.	Non delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to insufficient training.
H **Financial**	Small Loss	Loss of more than 0.1% of budget	Loss of more than 0.2% of budget	Loss of more than 0.5% of budget	Loss of more than 1% of budget
I **Inspection/ Audit**	Minor recommendations Minor non compliance with standards. Recommendations given.	Reduced rating. Challenging recommendations. Non compliance with standards.	Reduced rating. Challenging recommendations. Non compliance with core standards	Criminal prosecution/ prohibition notice. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
J **Adverse publicity/ reputation**	Rumours	Local media – short term interest. Minor effect on staff morale.	Local media – Long term. Significant effect on staff morale.	Regional media less than 3 days. Independent review.	Regional media more than 3 days. MLA concern. DHSSPS executive investigation following incident or complaint.

Table 2 – Likelihood score

Frequency and Probability scales are provided to be used as appropriate, but only one score can be selected.

	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to Occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	< 10% Will only occur In exceptional circumstances	10-24% Unlikely to occur	25-49% Reasonable chance of occurring	50-74% Likely to occur	75% + More likely to occur than not

4 Multiply the consequence by the Likelihood score = risk rating (scale of 1 to 25)

5 The risk matrix shows the level of risk – extreme, high, medium or low.

Table 3 Risk Rating Matrix (adapted from AS/NZ 4360, 2004)

LIKELIHOOD	Consequence				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 - Almost certain					
4 - Likely					
3 - Possible					
2 - Unlikely					
1 - Rare					

Risk Rating

Low	Medium	High	Extreme

6 Identify the level at which the risk will be managed – see Table 4 for details of management action required.

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	N/A
Yellow	Local Manager	Service Manager/Co Director	Service Area
Amber	Service Manager	Director	Directorate
Red	Director	Assurance Group	Corporate

7 Use the priority table to determine when risk needs to be actioned and reviewed.

Guide to Priority Levels

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 4

➢ Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. Where the risk is not immediately reducible the risk will be added to the Directorate/Corporate Risk Register via the Assurance Group.
➢ Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. It is recommended that HIGH RISKS are recorded on the Directorate risk register.
➢ Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level.
➢ Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable.

RISK MANAGEMENT STRATEGY WORK PROGRAMME 2012/2013 **APPENDIX 2**

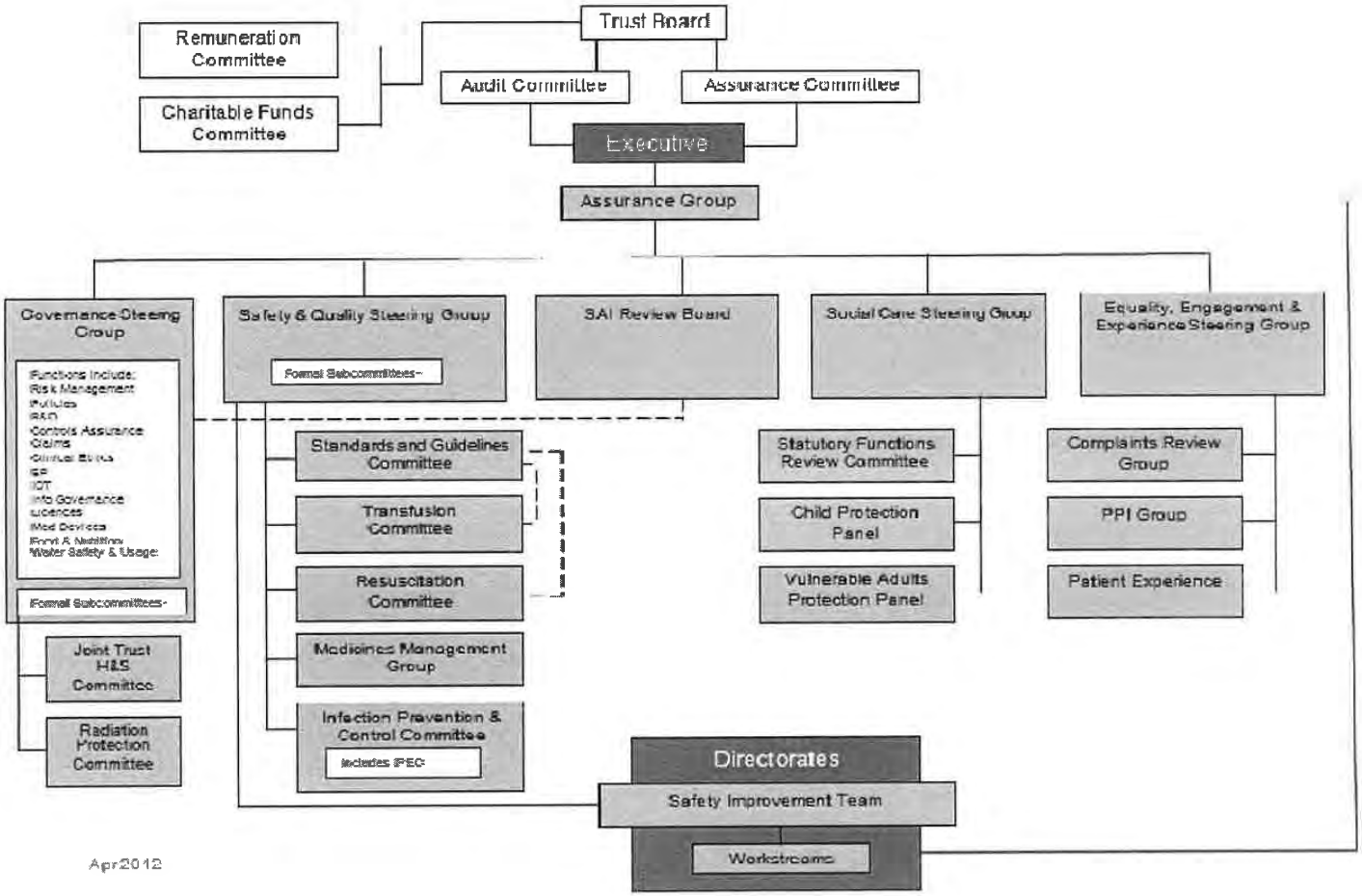
Area	Action	Responsibility	Timescale	Status
Assurance Framework	Maintain a comprehensive assurance framework reflective of all aspects of Trust business. Review the Principal Risk Document format	Directors Co Director Risk & Governance / Senior Manager Corporate Governance	Ongoing Jun 2012	
Risk Registers	Further develop web-based risk registers using Datix for directorates and controls assurance leads to include the integration of incidents, claims and complaints risk register modules. Roll-out of Datix risk register module to key Directorate staff and support its use with training. Complete a three-year implementation plan using the BRAAT (Belfast Risk Audit & Assessment Tool) promoting best practice in the management of safety and risk, and influence the provision of a safer working environment and compliance with relevant audit standards.	Co Director Risk & Governance/ Senior Manager Corp Governance Senior Manager Corporate Governance/Datix Manager Directorates Co Director Risk & Governance R&G Senior Managers	Mar 2013 Ongoing Oct 2013	Roll out commenced
Management of adverse incident reporting policy	Contribute to proposed revision of HSCB SAI procedure Revise policy in line with proposed new DHSSPS SAI procedure.	Co Director Risk & Governance R&G Senior Managers	Jun 2012 Sep 2012	Revision of policy commenced in preparation to

Area	Action	Responsibility	Timescale	Status
	Deliver training programme included in Learning and Development brochure and TAS.	Co Director Risk & Governance R&G Senior Managers	Ongoing	revised HSCB procedure
Incident reporting systems	Web-based reporting to continue to be rolled out across the Trust, in partnership with ITC. Continued support will be given from the Medical Director's Risk and Governance teams to enable directorates to further develop local risk management systems in line with the Risk Management Strategy.	Senior Manager Corp Governance R&G Senior Managers	Mar 2012 Ongoing	
Committee Structures	The assurance committees' infrastructure will be continually reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation annually.	Assurance Group Committee Chairs	Ongoing	Formal sub-committee updates submitted to Assurance Group Jun 2012
Communication	The process for communication in relation to risk and governance including dissemination of external standards to be further reviewed to include the improved use of the Trust Intranet, SABs etc Contribute to HSCB Safety Alert reform	Medical Director's Directorate Governance & Quality Corporate Nursing Co Director and Senior Managers R&G Directorates	Ongoing Jun 2012	
Education and Training	The range of training programmes and tools for staff education in the Trust will be further developed in line with the Learning and Development Strategy.	Medical Director's Office HR	Ongoing	A number of eLearning packages

Area	Action	Responsibility	Timescale	Status
		Directorates Corporate Nursing		commenced
Patient/Client and Service Users	A process to be established to ensure that patients, clients and service users contribute to the ongoing development of the risk management infrastructure within the Trust. Involvement of staff, patients, clients, service users and partner organisations in continuous improvement initiatives and learning lessons will be developed on an ongoing basis.	Directors Medical Director's Office Corporate Nursing	Mar 2013 Ongoing	Amber PCC reps on complaints review. New PPI/Experience Steering Group introduced Patient rep on audit panels. Patient advocate to be introduced to complaint management process 2013.
Evaluation, Monitoring and Audit of Policies	An annual review of the implementation of the Risk Management Strategy and Action Plan will be undertaken.	Co Director Risk & Governance	Jun 2012	

Appendix 3

ASSURANCE COMMITTEE SUB-COMMITTEE STRUCTURE



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Belfast Health and Social Care Trust

RISK MANAGEMENT STRATEGY

2013 – 2016

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CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2013-2014

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's strategic themes. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has five long term corporate objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.
- Continuous Improvement - We will seek to be a leading edge Trust through innovation at all levels in the organisation
- Partnerships - We will work collaboratively with all stakeholders and partners to improve health, social care and well being and tackle inequalities and social exclusion
- Our People - We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce
- Resources - We will work to optimise the resources available to us to achieve shared goals

The Trust will manage risks by:

- Undertaking a quarterly assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Principal Risk Document;
- Ensuring there are appropriate systems to monitor and review risks which are delegated below Corporate level;
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;
- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;
- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;
- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The growing interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and other initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities. Appropriate risk assessment

and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) supports staff development, knowledge and competency in relation to risk and ensures that the individual's role in risk management is linked to their job profile and incorporated within their KSF Post Outline under the Core Dimension for Health, Safety and Security. The KSF and its associated development review process apply across the whole Trust for all staff (except medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;
- establish priorities for the control of risks, based on a suitable assessment process;
- minimise financial liability through effective Controls Assurance;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures and provide reports which identify learning and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are

[2] Belfast HSC Trust "Board Assurance Framework –2013 -2014" Section 6 & 7

required to co-operate with this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this revised strategy to ensure that all groups/committee/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

[3] Loc. Cit Appendix 3

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

> *"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".*[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DHSSPSNI guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk;
- Likelihood descriptors for frequency and probability;
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales;
- Management authority for each level of risk (extreme, high, medium and low).

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DHSSPS April 2006

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed work programme required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic risk registers at all levels of the organisation. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least four times a year.

Risk Tolerance

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

Risk Appetite

Risk appetite is the extent of exposure to risk that is judged tolerable. The concept may be looked at in different ways depending on whether the risk being considered is a threat or an opportunity.

Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1) for detail.

7.1.2 Principal Risk Document

The purpose of the Principal Risk Document is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The Principal Risk Document differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required.

The ongoing development and review of the Assurance Framework including the Principal Risk Document provides robust processes within the organisation to escalate concerns and risks adequately and supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.3 Corporate Risk Register

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
- Existing standards and guidance ignore or contribute to the risk;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Principal Risk Document. The Principal Risk Document provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. Both the Principal Risk Register and Corporate Risk Register will be reviewed and reported to Assurance Committee four times a year.

7.1.4 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems also include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues associated with reported incidents across directorates will be maintained. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon maintaining of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication. Each Directorate has established and will maintain a local infrastructure to support the communication and feedback

process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Directorate will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways. The Trust has developed a whistle blowing policy in recognition of the fact that individual members of staff in the Belfast Health and Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have. The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

The Trust has a large number of external partners including the DHSSPSNI, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and is reflected in the Knowledge and Skills Framework for other staff under the Core Dimension for Health, Safety and Security.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of "working groups" will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.
The Risk Management, Governance and Finance Controls Assurance standards are monitored on an annual basis, the annual compliance scores will be reported to the Assurance Committee, a subcommittee of the Trust Board. Gaps in control will be linked, to an appropriate risk register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

Appendix 1

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that on Datixweb, step 3 above is automatically completed once the consequence and likelihood scores are entered.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Medium-term harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term / permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

➢ **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.**
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

RISK MANAGEMENT STRATEGY WORK PROGRAMME 2013/2014

APPENDIX 2

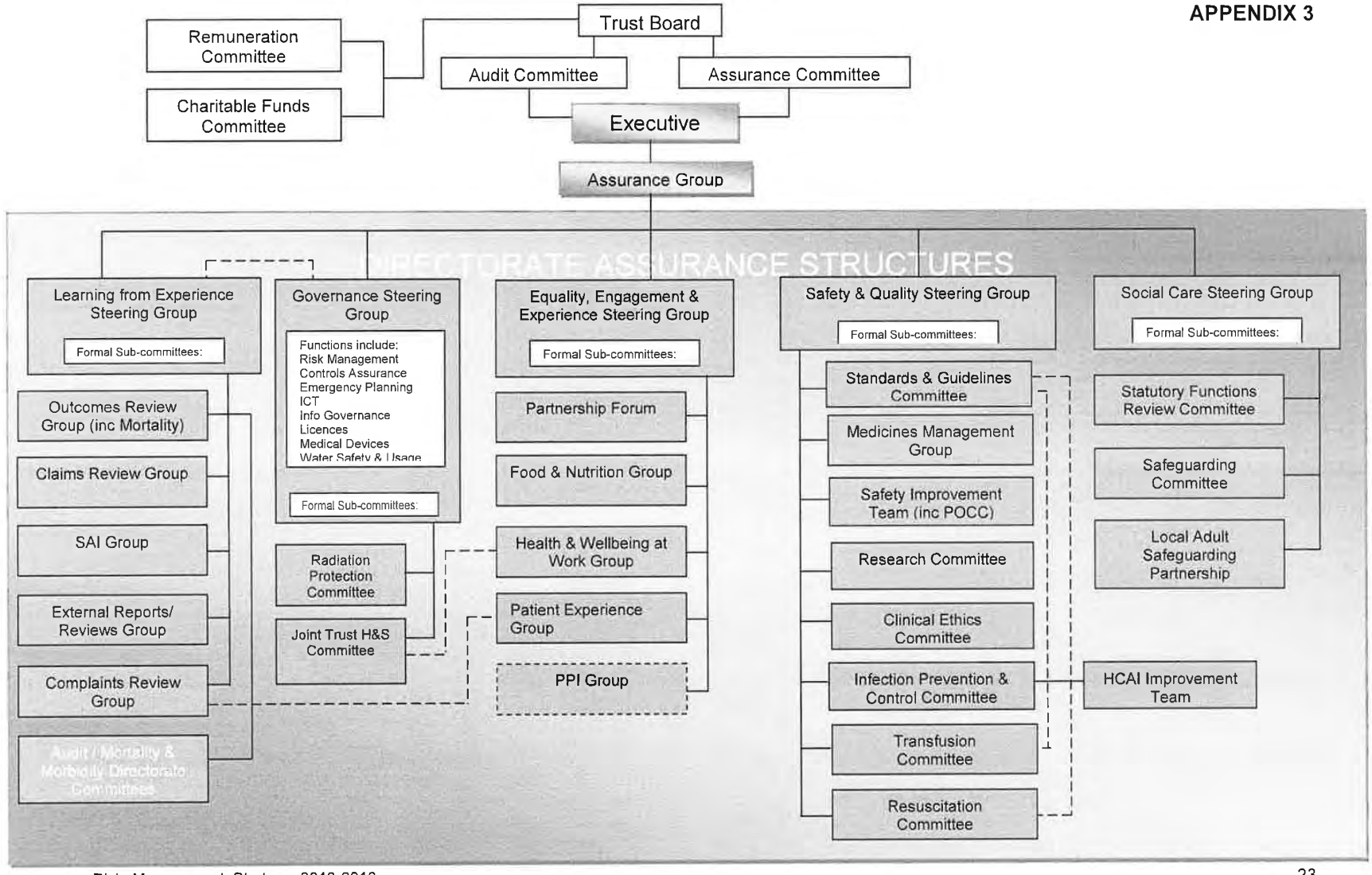
Area	Action	Responsibility	Timescale	Status
Assurance Framework	Maintain a comprehensive assurance framework reflective of all aspects of Trust business. Ensure the Assurance Framework structure optimises learning from patient experience and events.	Directors	June 2013	Complete
Risk Registers	Roll-out of Datix risk register module to key Directorate staff and support its use with training.	Co Director Risk & Governance/ Senior Manager Corp Governance	Dec 2013	Risk register roll out progressing with last Directorate now engaged. New date for completion Dec 2013
	Complete a three-year implementation plan using the BRAAT (Belfast Risk Audit & Assessment Tool) promoting best practice in the management of safety and risk, and influence the provision of a safer working environment and compliance with relevant audit standards.	Directorates Co Director Risk & Governance R&G Senior Managers	Jan 2014	Roll out commenced with training and support available including regular reports providing progress updates for Directorates.
	Implement use of regional risk matrix for all analysis and evaluation of risks and incidents.	Directorates Co Director Risk & Governance R&G Senior Managers	Oct 2013	Included in Strategy documentation June 2013
	Develop risk register guidance for population, monitoring and review of risk registers	Directorates Co Director Risk & Governance R&G Senior Managers	Sept 2013	For consultation in June 2013

Area	Action	Responsibility	Timescale	Status
Patient/Client and Service Users	Implement actions from the Trust post Francis action plan	Medical Director	Apr 2014	Draft action plan to be approved by Assurance Committee June 2013
Management of adverse incident reporting policy	Contribute to proposed revision of HSCB SAI procedure Revise policy in line with proposed new DHSSPS SAI procedure. Deliver training programme included in Learning and Development brochure and TAS and revise e learning package.	Co Director Risk & Governance R&G Senior Managers Co Director Risk & Governance R&G Senior Managers	Sep 2013 Nov 2013 Dec 2013	Delayed by HSCB to Sept 2013 Revision of has policy commenced in preparation to revised HSCB procedure. Monthly Incident training established and available for all staff. E learning currently being updated.
Incident reporting systems	Web-based reporting to continue to be rolled out across the Trust aiming to achieve 90% reporting via the web.	Senior Manager Corp Governance	Apr 2014	79% of incidents reported via the web at end April 2013
Committee Structures	The assurance committees' infrastructure will be continually reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation annually.	Assurance Group Committee Chairs	June 2013	Complete
Communication	Explore an electronic solution for dissemination and monitoring of external standards. Establish a Risk and Governance site on Belfast Hub to support good communication.	Medical Director's Directorate Governance & Quality Corporate Nursing Co Director Risk & Governance R&G Senior Managers	Feb 2014 May 2013	 Complete

Area	Action	Responsibility	Timescale	Status
Education and Training	Develop in house training (including e learning) to further support management of risks.	Co Director Risk & Governance/ Senior Manager Corp Governance	Jan 2014	
Evaluation, Monitoring and Audit of Policies	An annual review of the implementation of the Risk Management Strategy and Action Plan will be undertaken.	Co Director Risk & Governance	Jun 2013	Complete

Assurance Sub-Committee Structure

APPENDIX 3



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Belfast Health and Social Care Trust

caring supporting improving together

RISK MANAGEMENT STRATEGY

2016 – 2019

CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2016-2017

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's strategic objectives and Corporate Management Plan. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has five long term corporate objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.
- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver improvements in service, quality and experience to the people who use our services
- Partnerships - Service Commitment: -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion
- Our People - Service Commitment: we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce
- Resources - Service Commitment: we will work to optimise the resources available to us to achieve shared goals.

The Trust will manage risks by:

- Undertaking a quarterly assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Principal Risk Document;
- Ensuring there are appropriate systems to monitor and review risks which are delegated below Corporate level;
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;
- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;
- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;
- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The growing interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and Organisational Development initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities.

Appropriate risk assessment and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) supports staff development, knowledge and competency in relation to risk and ensures that the individual's role in risk management is linked to their job profile and incorporated within their KSF Post Outline under the Core Dimension for Health, Safety and Security. The KSF and its associated development review process apply across the whole Trust for all staff (except medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;
- establish priorities for the control of risks, based on a suitable assessment process;
- to be a problem sensing organisation that learns form past harm and identifies risks;
- minimise financial liability through effective Controls Assurance;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures and provide reports which identify learning and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are required to co-operate with this strategy, to take any reasonable action

[2] Belfast HSC Trust "Board Assurance Framework –2016 -2017"

to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this revised strategy to ensure that all groups/committee/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

[3] Belfast HSC Trust "Board Assurance Framework –2016 -2017"

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

> *"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".*[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DHSSPSNI guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk;
- Likelihood descriptors for frequency and probability;
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales;
- Management authority for each level of risk (extreme, high, medium and low).

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DHSSPS April 2006

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed action plan required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic risk registers at all levels of the organisation. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least four times a year.

Risk Tolerance

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

Risk Appetite

Risk appetite is the extent of exposure to risk that is judged tolerable. The concept may be looked at in different ways depending on whether the risk being considered is a threat or an opportunity.

Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1) for detail.

7.1.2 Principal Risk Document

The purpose of the Principal Risk Document is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The Principal Risk Document differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required.

The ongoing development and review of the Assurance Framework including the Principal Risk Document provides robust processes within the organisation to escalate concerns and risks adequately and supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.3 Corporate Risk Register

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Principal Risk Document. The Principal Risk Document provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. Both the Principal Risk Register and Corporate Risk Register will be reviewed and reported to Assurance Committee four times a year.

7.1.4 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported

within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems also include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues associated with reported incidents across directorates will be maintained. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon maintaining of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication. Each Directorate has established and will maintain a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Directorate will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways. The Trust has a Whistle Blowing Policy in recognition of the fact that individual members of staff in the Belfast Health and Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have. The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

The Trust has a large number of external partners including the DHSSPSNI, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and is reflected in the Knowledge and Skills Framework for other staff under the Core Dimension for Health, Safety and Security.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of "working groups" will be necessary to

address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.
The Risk Management, Governance and Finance Controls Assurance standards are monitored on an annual basis, the annual compliance scores will be reported to the Assurance Committee, a subcommittee of the Trust Board. Gaps in control will be linked, to an appropriate risk register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

9 Related Risk Management Policies and Procedures

- Adverse Incident Reporting and Management Policy
- Being Open Policy
- Claims Management Policy & Procedural Arrangements
- General Health and Safety Policy
- Guidance on RIDDOR reporting
- Guidance on Writing a Witness Statement
- Guidance on General Health & Safety Risk Assessment Process
- Management of Complaints & Compliments Policy
- Management of Medical Devices Procedures and Guidelines
- Procedure for Grading an Incident
- Procedure for Investigating an Incident
- Procedure on Memorandum of Understanding
- Procedure for Reporting and Managing Incidents
- Procedure for Reporting and Managing Serious Adverse Incidents
- Risk Register Production and Management Guidance
- Whistle Blowing Policy
- Sharing Learning Policy

Appendix 1

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

➢ **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.**
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Appendix 2

RISK MANAGEMENT STRATEGY ACTION PLAN 2016/2017

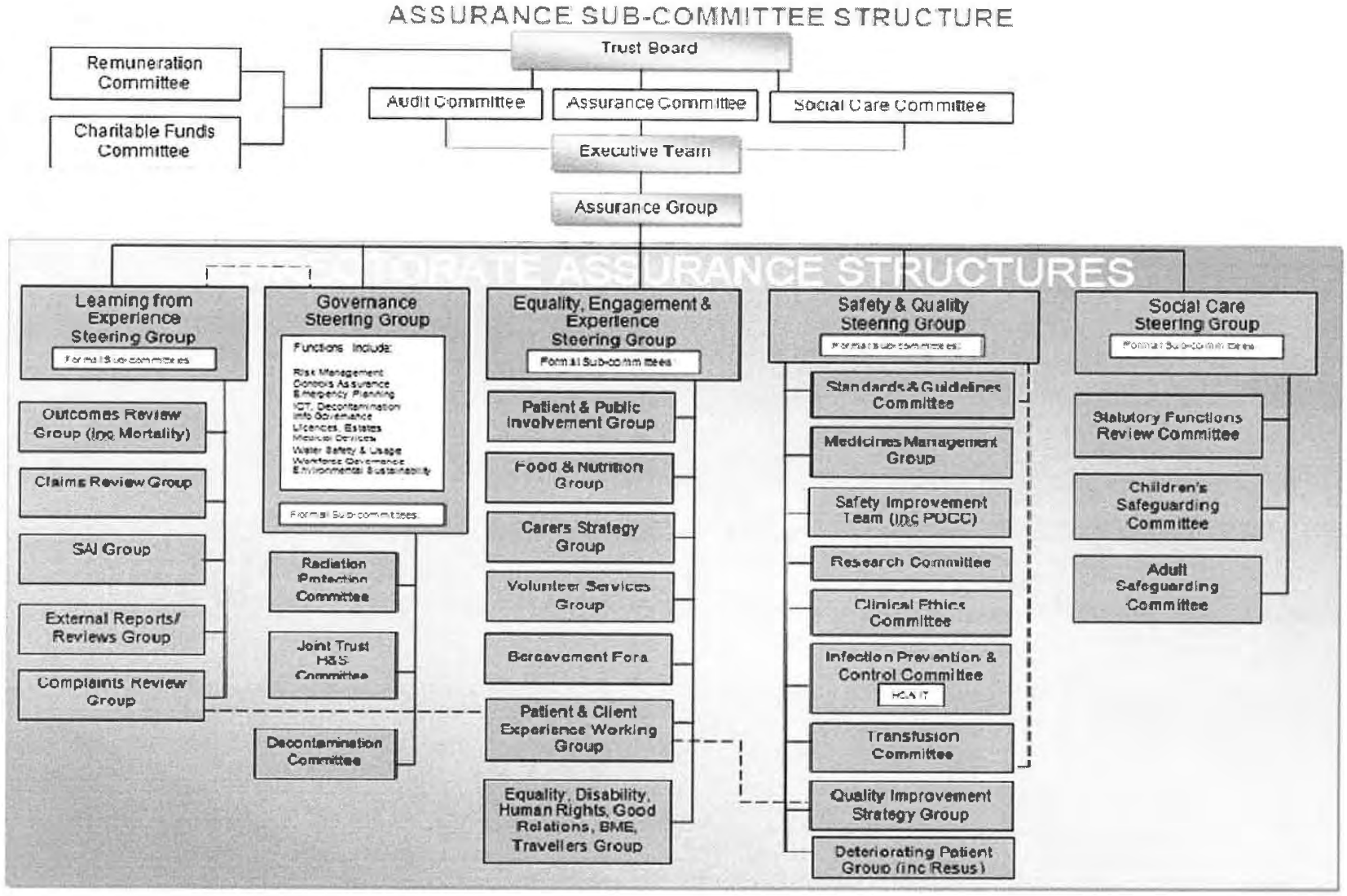
Area	Action	Responsibility	Timescale	Status
Assurance Framework	Maintain and review a comprehensive assurance framework reflective of all aspects of Trust business. Ensure the Assurance Framework structure optimises learning from patient experience and events and reflects developments in relation to Quality Improvement.	Directors	October 2017	Annual review and revision of the Assurance Framework is planned to be approved by Assurance Committee in July 2016
	Review the Principal Risk Document each quarter to ensure all risks to the organisation achieving key objectives are noted with detail on controls, gaps and actions.	Directors Co-Director Risk & Governance Senior Manager Corp Governance	March 2017	Review undertaken at Assurance Group and Assurance Committee
	Review two risks from the Principal Risk Document in detail at Assurance Committee to provide assurance that controls are adequate to mitigate the risk and that actions will address the gaps in control.	Assurance Committee	March 2017	A detailed review of Principal Risks at Assurance Committee commenced in November 2015. To date six risks have been discussed.
Committee Structures	The Assurance Committees' infrastructure will be continually reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation annually.	Assurance Group Committee Chairs	March 2017	Interim structure to be approved by Assurance Committee in July 2016. There will be on-going review of the Assurance Committee structure throughout 2016/17 in line with any changes to evolving structures and governance arrangements .
Risk Registers	We will ensure a safe working environment, and deliver a completion rate of 95% for BRAAT 2, with substantive compliance achieved in 75% of areas.	Directorates Co-Director Risk & Governance R&G Senior Managers	December 2016	Work is on-going with service areas to achieve substantive compliance.

Area	Action	Responsibility	Timescale	Status
	Review the Corporate Risk Register and local risk registers on a regular basis to identify and appropriately manage risk.	Senior Manager Corp Governance	March 2017	Risk Register Review Group meets quarterly to review corporate risks and to ensure Directorate Risk Registers are being appropriately managed. An extract from the Corporate Risk Register is reviewed at Assurance Committee each quarter.
Management of adverse incident reporting policy	Revise Trust policies including adverse incidents and management of SAIs in line with any changes to the DHSSPS SAI procedure following review of Donaldson Report and following the report from the regional Review of SAI Learning from RQIA/GAIN.	Senior Manager Corp Governance	March 2017	
	Revise Trust policies including adverse incidents and management of SAIs in line with any changes agreed following the Review of SAIs and SAI Workshop in April 2016.	Senior Manager Corp Governance	December 2016	Recommendations to be submitted to Executive Team in July 2016.
	Promote the Being Open eLearning package and establish monitoring arrangements for uptake	Senior Manager Corp Governance	December 2016	The Being Open elearning package is to be shared upon request with other HSC Trusts.
	Deliver adverse incident reporting training	Co-Director Risk & Governance Senior Manager Corp Governance	March 2017	Monthly Incident training established and available for all staff. E learning training is also available. Training also available in Datixweb Incident Reporting for Approving Managers and Datixweb for Safety Alerts and risks
	Review membership and ToR of the Forum for	Co-Director Risk &	March 2017	

Area	Action	Responsibility	Timescale	Status
	Trust Chairs of SAI Investigations (RCA Forum) by providing on-going appropriate training and support in completing investigations, writing reports, identifying and sharing learning.	Governance Senior Manager Corp Governance		
	Continue the processes of identifying and sharing learning across the organisation from incidents, complaints, litigation and external sources.	Directorates Co-Director Risk & Governance Senior Manager Corp Governance	March 2017	Continue to review and improve. Dissemination of learning in line with Trust Sharing Learning Policy. Further development of arrangements for teams to discuss learning through Mortality and Morbidity and other governance meetings.
Problem Sensing	Continue to develop a core data set that meets requirements of both front line specialty teams and also a data set for senior management. This data to inform local ownership of issues and governance, e.g. complaints, SAIs, incidents, HCAIs etc.	Co-Director Risk & Governance	March 2017	Data Triangulation Group established in May 2016.
	Implement the dashboard module on Datix which presents key data for individual managers on incidents, claims etc.	Senior Manager Corp Governance	December 2016	Datix Dashboards have been successfully piloted in three areas. Full rollout across the Trust to be completed.
	Continue focused improvement work regarding complaints management both corporately and at Directorate level to ensure that the process of complaints management maximises the learning and improvement of our services and service user experience which can be derived from effective use of feedback information.	Trust Board Directorates Senior Manager Complaints Co-Director Risk & Governance	March 2017	Action plans commenced closely monitored to progress IA recommendations during 2016/17. Final report from Independent Review expected in July 2016 and will be used to develop actions further. Link with Trust Board work stream developed to support maximising service user feedback

Area	Action	Responsibility	Timescale	Status
Evaluation, Monitoring and Audit of Policies	An annual review of the Risk Management Strategy and Action Plan will be undertaken.	Co-Director Risk & Governance	July 2016	Review and update completed. Approved by Executive Team in June 2016
	Maintain focus on update of policies and guidelines which are due for review.	Directorates Co-Director Risk & Governance Standards& Guidelines Dept	March 2017	Recommendations from IA report assigned and being monitored. Status of policies for review highlighted to Directorates for progress with identified policy authors June 2016. Continue monitor of progress via Safety and Quality Steering Group.

Appendix 3


ASSURANCE SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
CORPORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Governance Steering Group
Functions include:
Risk Management
Controls Assurance
Emergency Planning
ICT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Legal
Workforce Governance
Environmental Sustainability
Equality, Engagement & Experience Steering Group
Safety & Quality Steering Group
Social Care Steering Group
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc PUCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
HCAI IT
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

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Belfast Health and Social Care Trust

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RISK MANAGEMENT STRATEGY

2017 – 2020

CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2017-2018

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's Corporate Management Plan. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has identified five overarching corporate objectives:

- A Culture of Safety and Excellence - Open and learning culture and robust systems to provide safe, high quality effective care
- Continuous Improvement - Be a leading edge Trust through improvement
- Partnerships - Work collaboratively with all stakeholders and partners to deliver our purpose
- Our People - Show leadership and excellence through organisation and workforce development
- Resources - Make the best use of resources by improving performance and productivity

The Trust will manage risks by:

- Undertaking a quarterly assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Principal Risk Document;
- Ensuring there are appropriate systems to monitor and review risks which are delegated below Corporate level;
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;
- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;
- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;
- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and Organisational Development initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities. Appropriate risk assessment and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) supports staff development, knowledge and competency in relation to risk and ensures that the individual's role in risk management is linked to their job profile and incorporated within their KSF Post Outline under the Core Dimension for Health, Safety and Security. The KSF and its associated development review process apply across the whole Trust for all staff (except medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;
- establish priorities for the control of risks, based on a suitable assessment process;
- to be a problem sensing organisation that learns form past harm and identifies risks;
- minimise financial liability through effective Controls Assurance;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures and provide reports which identify learning and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are required to co-operate with this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

[2] Belfast HSC Trust "Board Assurance Framework –2016 -2017"

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this revised strategy to ensure that all groups/committee/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

6 Risk Management Process

[3] Belfast HSC Trust "Board Assurance Framework –2016 -2017"

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

> *"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".*[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DoH guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk;
- Likelihood descriptors for frequency and probability;
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales;
- Management authority for each level of risk (extreme, high, medium and low).

The license agreement for the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 expires at the end of 2017 and a replacement methodology is being sought regionally.

7 Delivering successful risk management

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DoH April 2006

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed action plan required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic risk registers at all levels of the organisation. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least four times a year.

Risk Tolerance

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

Risk Appetite

Risk appetite is the extent of exposure to risk that is judged tolerable. The concept may be looked at in different ways depending on whether the risk being considered is a threat or an opportunity.

Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1) for detail.

7.1.2 Principal Risk Document

The purpose of the Principal Risk Document is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The Principal Risk Document differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required.

The ongoing development and review of the Assurance Framework including the Principal Risk Document provides robust processes within the organisation to escalate concerns and risks adequately and supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.3 Corporate Risk Register

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Principal Risk Document. The Principal Risk Document provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. Both the Principal Risk Register and Corporate Risk Register will be reviewed and reported to Assurance Committee four times a year.

7.1.4 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems also include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues associated with reported incidents across directorates will be maintained. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon maintaining of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication. Each Directorate has established and will maintain a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Directorate will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant

risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways. The Trust has a Whistle Blowing Policy in recognition of the fact that individual members of staff in the Belfast Health and Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have. The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

The Trust has a large number of external partners including the DoH, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and is reflected in the Knowledge and Skills Framework for other staff under the Core Dimension for Health, Safety and Security.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of "working groups" will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.
The Risk Management, Governance and Finance Controls Assurance standards are monitored on an annual basis, the annual compliance

scores will be reported to the Assurance Committee, a subcommittee of the Trust Board. Gaps in control will be linked, to an appropriate risk register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

9 Related Risk Management Policies and Procedures

- Adverse Incident Reporting and Management Policy
- Being Open Policy
- Claims Management Policy & Procedural Arrangements
- General Health and Safety Policy
- Guidance on RIDDOR reporting
- Guidance on Writing a Witness Statement
- Guidance on General Health & Safety Risk Assessment Process
- Management of Complaints & Compliments Policy
- Management of Medical Devices Procedures and Guidelines
- Procedure for Grading an Incident
- Procedure for Investigating an Incident
- Procedure on Memorandum of Understanding
- Procedure for Reporting and Managing Incidents
- Procedure for Reporting and Managing Serious Adverse Incidents
- Risk Register Production and Management Guidance
- Whistle Blowing Policy
- Sharing Learning Policy

Appendix 1

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

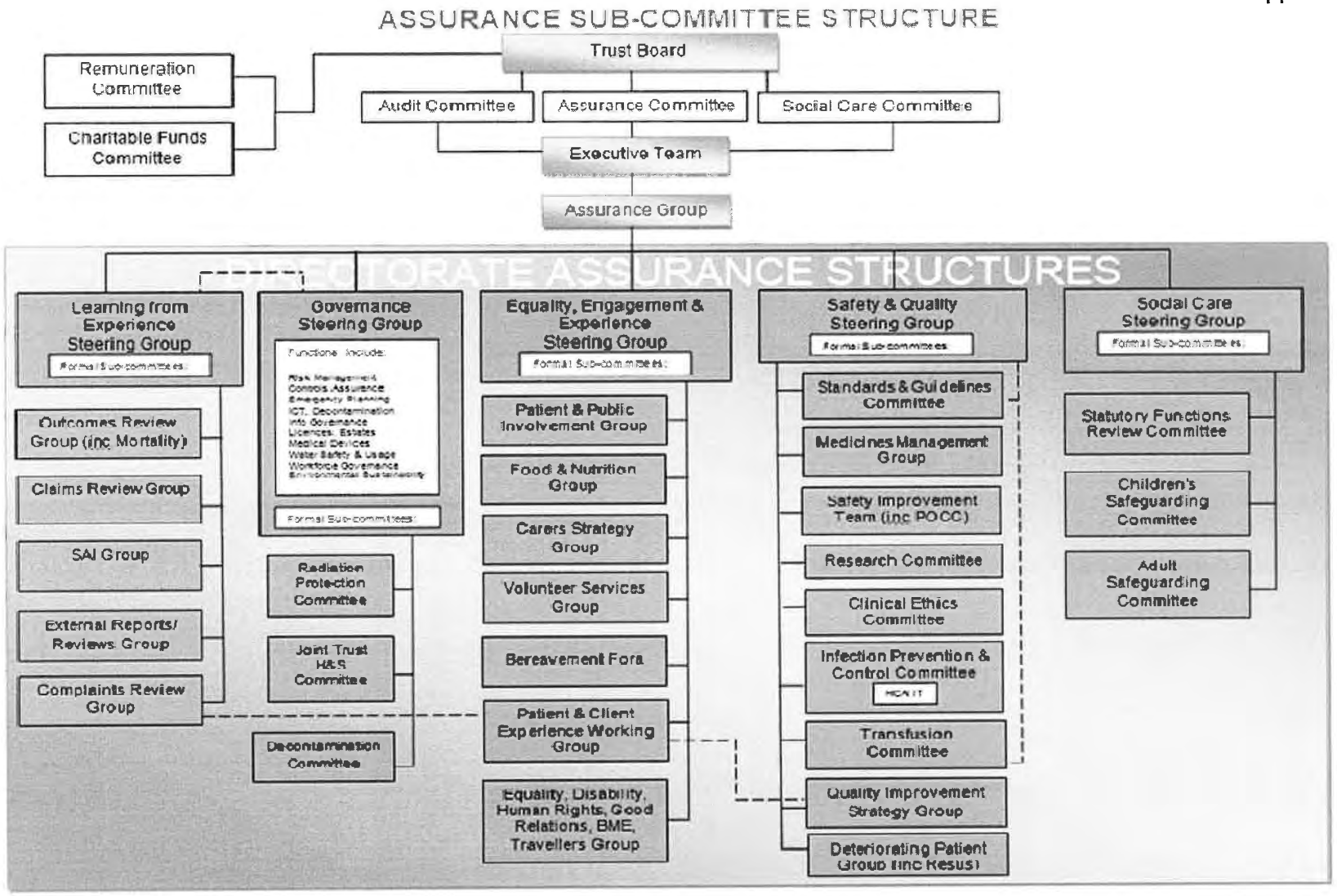
Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

➢ **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.**
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Appendix 2


ASSURANCE SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
DIRECTORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Formal Sub-committees:
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Governance Steering Group
Functions include:
Risk Management
Controls Assurance
Emergency Planning
ICT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Usage
Workforce Governance
Environmental Sustainability
Formal Sub-committees:
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Equality, Engagement & Experience Steering Group
Formal Sub-committees:
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Safety & Quality Steering Group
Formal Sub-committees:
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc POCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Social Care Steering Group
Formal Sub-committees:
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

Belfast Health and Social Care Trust

caring supporting improving together

RISK MANAGEMENT STRATEGY

2020 – 2021

**** This Strategy remains in place as an interim arrangement whilst a review is completed – due for completion Dec 2022****

CONTENTS

RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and just culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next year.

The Risk Management Strategy is closely linked to the Trust's Corporate Management Plan. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Management Plan, are achieved.

The Trust has identified five overarching corporate themes and associated objectives.

Corporate Themes:

- Safety, Quality and Experience - Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services.
- Service Delivery - Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors.
- People & Culture - Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams.
- Strategy & Partnerships - Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors.
- Resources - Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

The Trust will manage risks by:

- Undertaking a quarterly assessment of the organisation's corporate themes and objectives and identifying the principal risks to achieving these objectives. These will create the Assurance Framework;
- Ensuring there are appropriate systems to monitor and review risks which are delegated below Corporate level;
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;
- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;
- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;
- Developing an "open, honest and just" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open and just culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation of Services

The Trust continues to strive to provide the right care, at the right time, in the right place to our patients and service users. Our commitment to continuous improvement means that we will continue to modernise services, taking on board patient feedback, and in line with Trust and Regional priorities.

During the COVID 19 pandemic it has remained important that we listen to and learn from our staff, patients and service users, as at any time of crisis, considering what worked well, what didn't and how we can improve. Learning from COVID 19 is part of a Trust wide effort intended to help us reflect and learn, at pace and in an agile way to support and inform how we shape our plans moving forward and to help us shape our culture.

Appropriate risk assessment and management of change processes remain vital to ensure that established and developing initiatives will enhance organisational effectiveness whilst supporting the safe delivery of services and ensuring effective engagement with staff. This is important for short term changes to service delivery in response to COVID 19 and longer term permanent modernisation initiatives.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and just culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;

- establish priorities for the control of risks, based on a suitable assessment process;
- to be a problem sensing organisation that learns from past harm and identifies risks;
- minimise financial liability through effective assurance arrangements;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures and provide reports which identify learning and recommendations for action. They will also act as a resource for expert advice.

4.2 Senior Leadership Team

Senior Leadership Teams must ensure that all activities within their Division are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of risk action plans.

[2] Belfast HSC Trust Board Assurance Framework

4.2 Managers and Clinicians

All managers and clinicians must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the Senior Leadership Team and Director are advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee (including Bank staff) Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue. The matter should be raised in the first instance with their Line Manager or if they feel unable to do this then the Trust whistle blowing policy should be referred to. Staff are required to co-operate with this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Service User/Carer Responsibility

Patients and service users have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and service users are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this revised strategy to ensure that all groups/committee/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

Risk is the *"effect of uncertainty on objectives".*

Risk is also often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology in line with DoH guidance[4] and will work to the principles, framework and processes for Risk Management as contained in BSO IS0 31000: 2018

[3] Belfast HSC Trust Board Assurance Framework
[4] How to classify incidents and risk. DoH April 2006

for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in Directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk;
- Likelihood descriptors for frequency and probability;
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales;
- Management authority for each level of risk (extreme, high, medium and low).

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk Appetite

Risk appetite is the amount and type of risk the organisation is prepared to seek, accept or tolerate. This is difficult to define as the risk appetite will vary depending on each individual risk. No system can be risk free and this strategy is focused on the effective management of risk to support efficient service delivery.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1 for detail).

There is a clear recognition that we must accept a level of risk in order to meet the high standard we set ourselves. The Trust is committed to providing and safeguarding the highest standards of care for patients and service users. We will do our reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. We acknowledge our staff regularly accept and manage significant risk in order to help others.

The Trust recognises that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Trust may have to set priorities for the management of risk and risk appetite should align to strategic and/or directorate objectives. We will identify acceptable risks through a systematic and objective process.

There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm.

Each risk will be assessed individually. The following risk appetite principles will be applied.

a. Appetite for risks relating to patient safety and employee health and safety is very low, with controls required to reduce the risks so far as is reasonably practicable.
b. Appetite for risks relating to regulatory compliance, fraud, and information governance is also low, requiring appropriate risk controls.
c. Appetite for risks to non-critical functions and services is higher, whilst taking into account any potential impact on any strategic/business objectives.

Completing this assessment will require consideration of additional controls/actions to terminate, treat or transfer the risk.

7.1.2 Risk Tolerance

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk should not be tolerated if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

Ref Appendix 1 (Analysing & Evaluating Risk) Table 6
Where issues have been identified as LOW RISK (green) and where it is likely nothing further can be done to eliminate/reduce/control risk further, this is deemed acceptable. These risks will be added to Directorate/ Service Area / Speciality risk registers for monitoring and review unless already monitored via the general risk assessment process. These should be reviewed at least annually

7.1.3 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. Risks can be identified in a number of ways, for example, analysis of incidents, complaints, etc. This may occur alongside the completion of the Belfast Risk Assessment & Audit Tool (BRAAT). The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic risk registers at all levels of the organisation. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least four times a year.

7.1.4 Assurance Framework (formerly Principal Risk Document)

The purpose of the Assurance Framework is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

This document differs from the corporate risk register in that it is a high level summary of risk to delivery of key objectives, focusing on existing controls and confirming internal and external arrangements. This is to ensure that controls are adequate, identifying where there are gaps in controls and assurances, to enable the Trust Board to be assured that appropriate actions and timeframes are in place. The corporate risk register is a dynamic account of risks identified.

The ongoing development and review of the Assurance Framework supports robust processes to monitor and escalate concerns and risks associated with organisational objectives. This supports the need to

consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.5 Corporate Risk Register

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Assurance Framework. This provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. The Assurance Framework will be reviewed and reported to Assurance Committee four times a year.

7.1.6 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and

carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems also include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues associated with reported incidents across directorates will be maintained. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon maintaining of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication. Each Directorate has established and will maintain a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports and specific reports. The Medical Director's Directorate will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways. The Trust has a Whistle Blowing Policy in recognition of the fact that individual members of staff in the Belfast Health and Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have. The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

The Trust has a large number of external partners including the DoH, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and is reflected in the Knowledge and Skills Framework for other staff under the Core Dimension for Health, Safety and Security.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of “working groups” will be necessary to

address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.

The former Controls Assurance process was replaced from April 2018 with Organisational Assurance and follows a similar process for seeking assurance from the relevant lead assessors and Directors.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next year, which will build on this work and ensure that improvements are sustained. The Trust will focus on “closing the loop” and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust’s resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

9 Related Risk Management Policies and Procedures

- Adverse Incident Reporting and Management Policy
- Being Open Policy
- Claims Management Policy & Procedural Arrangements
- General Health and Safety Policy
- Guidance on RIDDOR reporting
- Guidance on Writing a Witness Statement
- Guidance on General Health & Safety Risk Assessment Process
- Management of Complaints & Compliments Policy
- Management of Medical Devices Procedures and Guidelines
- Procedure for Grading an Incident
- Procedure for Investigating an Incident
- Procedure on Memorandum of Understanding
- Procedure for Reporting and Managing Incidents
- Procedure for Reporting and Managing Serious Adverse Incidents
- Risk Register Production and Management Guidance
- Whistle Blowing Policy
- Sharing Learning Policy
- BSO IS0 31000: 2018

Appendix 1

Analysing & Evaluating the Risk

In keeping with the Trust's risk appetite, risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational / corporate if meets specific criteria
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

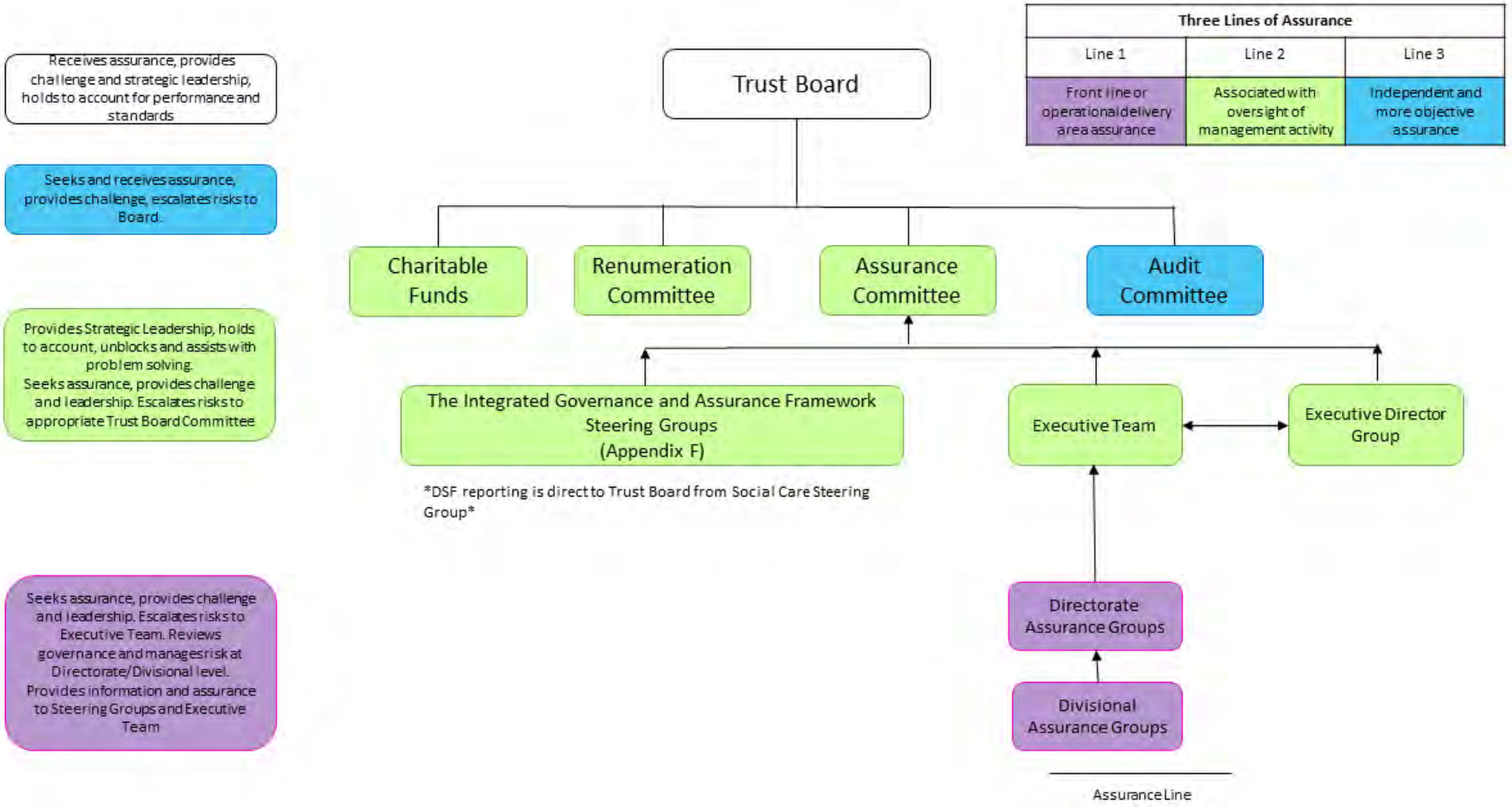
Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

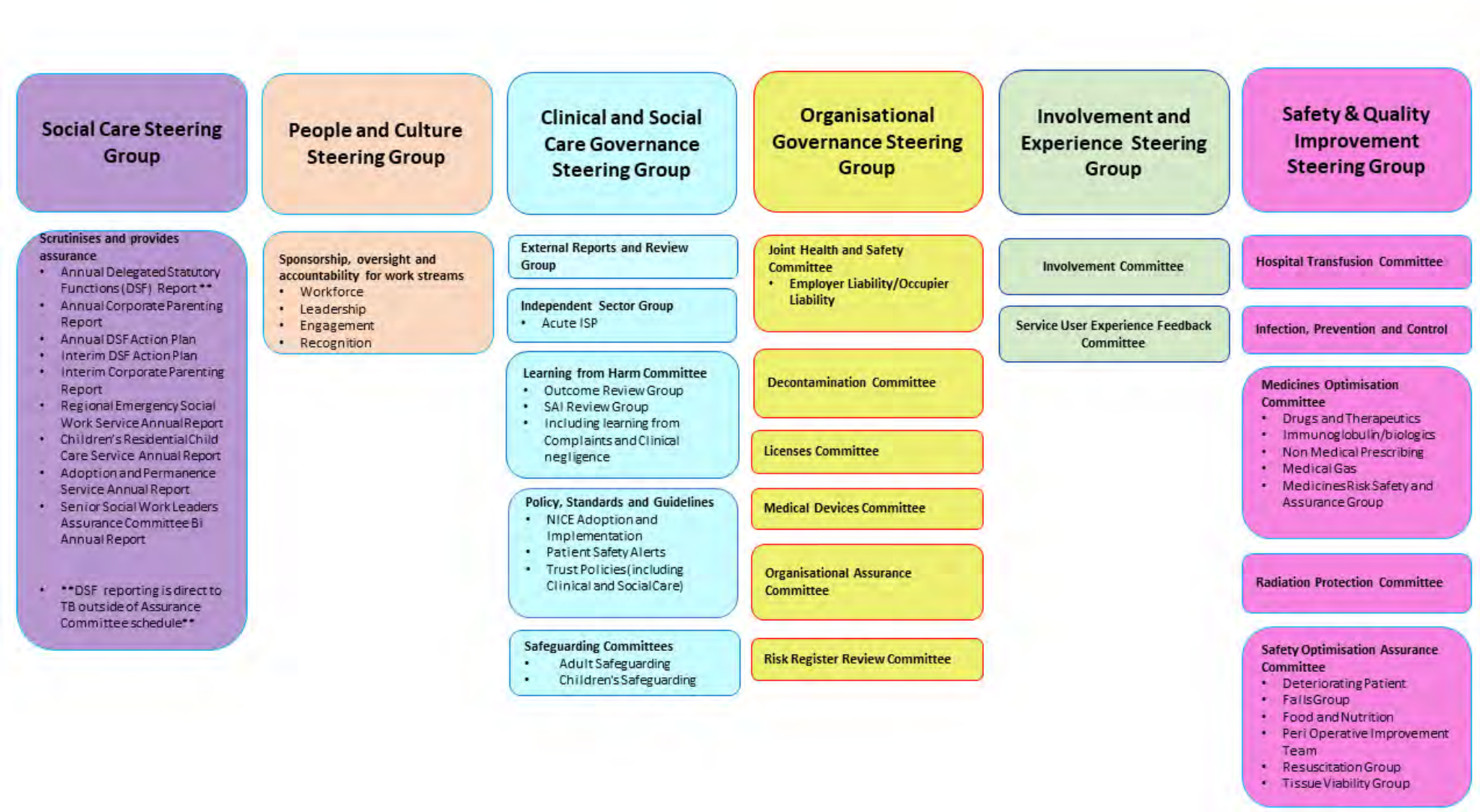
Table 6

- **EXTREME RISK. These must be referred to the Directorate Director and an action plan agreed to eliminate/reduce/control risk. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director. Corporate Governance must be informed of all extreme risks not already recorded on Datixweb.**
- **HIGH RISK. These must be referred to Senior management i.e., Directorate Director and Collective Leadership Team and an action plan agreed to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
- **MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process. If meeting one or more of the specified criteria they should also be considered for inclusion on the corporate risk register for monitoring by the Assurance Group.**
- **LOW RISK. It is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented.**
  A low risk of recurrence may remain and this is deemed ACCEPTABLE.
  These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.

Appendix 2A


Receives assurance, provides challenge and strategic leadership, holds to account for performance and standards
Seeks and receives assurance, provides challenge, escalates risks to Board.
Provides Strategic Leadership, holds to account, unblocks and assists with problem solving.
Seeks assurance, provides challenge and leadership. Escalates risks to appropriate Trust Board Committee
Seeks assurance, provides challenge and leadership. Escalates risks to Executive Team. Reviews governance and manages risk at Directorate/Divisional level.
Provides information and assurance to Steering Groups and Executive Team
Trust Board
Three Lines of Assurance
Line 1
Line 2
Line 3
Front line or operational delivery area assurance
Associated with oversight of management activity
Independent and more objective assurance
Charitable Funds
Renumeration Committee
Assurance Committee
Audit Committee
The Integrated Governance and Assurance Framework Steering Groups (Appendix F)
Executive Team
Executive Director Group
DSF reporting is direct to Trust Board from Social Care Steering Group
Directorate Assurance Groups
Divisional Assurance Groups
Assurance Line

Appendix 2B


Social Care Steering Group
Scrutinises and provides assurance
• Annual Delegated Statutory Functions (DSF) Report **
• Annual Corporate Parenting Report
• Annual DSF Action Plan
• Interim DSF Action Plan
• Interim Corporate Parenting Report
• Regional Emergency Social Work Service Annual Report
• Children's Residential Child Care Service Annual Report
• Adoption and Permanence Service Annual Report
• Senior Social Work Leaders Assurance Committee Bi Annual Report
• **DSF reporting is direct to TB outside of Assurance Committee schedule**
People and Culture Steering Group
Sponsorship, oversight and accountability for work streams
• Workforce
• Leadership
• Engagement
• Recognition
Clinical and Social Care Governance Steering Group
External Reports and Review Group
Independent Sector Group
• Acute ISP
Learning from Harm Committee
• Outcome Review Group
• SAI Review Group
• Including learning from Complaints and Clinical negligence
Policy, Standards and Guidelines
• NICE Adoption and Implementation
• Patient Safety Alerts
• Trust Policies (including Clinical and Social Care)
Safeguarding Committees
• Adult Safeguarding
• Children's Safeguarding
Organisational Governance Steering Group
Joint Health and Safety Committee
• Employer Liability/Occupier Liability
Decontamination Committee
Licenses Committee
Medical Devices Committee
Organisational Assurance Committee
Risk Register Review Committee
Involvement and Experience Steering Group
Involvement Committee
Service User Experience Feedback Committee
Safety & Quality Improvement Steering Group
Hospital Transfusion Committee
Infection, Prevention and Control
Medicines Optimisation Committee
• Drugs and Therapeutics
• Immunoglobulin/biologics
• Non Medical Prescribing
• Medical Gas
• Medicines Risk Safety and Assurance Group
Radiation Protection Committee
Safety Optimisation Assurance Committee
• Deteriorating Patient
• Falls Group
• Food and Nutrition
• Peri Operative Improvement Team
• Resuscitation Group
• Tissue Viability Group

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What is YOUR Risk Appetite?

Welcome and Introductions
Ursula McCollam

Facilitator: June Champion, Associate Consultant, HSCLC

Session Objectives

- Explore risk appetite in the context of risk management guidance (including a brief overview of legislative frameworks and emerging guidance);
- Consider assurance in HSC settings
  - Assurance mapping
  - Three lines of assurance
- Discuss the Trust's BAF template.

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Key messages for 2021 …

Acceptance that there is a significant amount of inherent risk associated with providing health and social care services, therefore boards will want to ensure themselves that they receive assurance that the controls associated in delivering safe care pathways are working and that the risks are being managed.

Inquiries into failings in health and social care have challenged the ability of public boards to adequately handle current and potential risks, including reputational risk.

Boards increasingly need to take an eclectic view of risk, seeking positive assurance that services are safe, cost effective and fit for purpose. This is difficult in times of financial constraint and health and social care systems upheaval.

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Key messages for 2021 ….

Whilst risk practices have improved over time the volatility, complexity and ambiguity of our operating environments has increased.

As with all aspects of good governance, the effectiveness of risk management depends on the individuals responsible for operating the systems put in place. Our risk culture must embrace openness, support transparency, welcome constructive challenge and promote collaboration, consultation and co-operation.

We must invite scrutiny and embrace expertise to inform decision-making. We must also invest in the necessary capabilities and seek to continually learn from experience.

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Context for Governance and Risk Management …

legislative framework and emerging guidance :

- FAQ – what are the legal requirements for our risk and governance systems?

COMPLY OR EXPLAIN !

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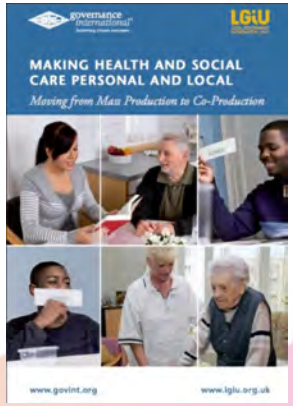
Legal frameworks – brief overview

- Health and Social Care (Reform) Act (NI) 2009 subsequently amended;
- Health and Social Care (Amendment) Act (NI) 2014;
- Health & Safety Legislation and EU Directives.



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Integrated Governance

Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisation objectives and the safety, quality and value for money of services as they relate to patients, carers, the wider community and partner organisations

Clinical governance is an aggregation of service improvement processes that are regulated by a single ideology.

Cadbury Report (1992)

- Wider use of INDEPENDENT DIRECTOR
- Introduction of AUDIT COMMITTEE
- Separation between CHAIRMAN and CEO
- Adherence to detailed code of BEST PRACTICES.

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Governance

Governance is the system by which organisations are directed and controlled. It defines accountabilities, relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. This includes establishing, supporting and overseeing the risk management framework.

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Background to Risk Management & Governance

- a potted history of key milestones that have shaped our systems and processes ….

- Best Practice, Best Care 2002;
- Circular (HSSPPM) 10/2002 Governance in the HPSS – guidance on implementation
- Circular 8/2002 – Risk Management in the HPSS
- Circular 13/2002 – Governance in the HPSS – Risk Management

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Background for Governance Risk Management – potted history cont/d ….

- Circular HSS (PPM) 5/2003 Risk Management & Controls Assurance
- HPSS Quality, Improvement and Regulation (NI) Order 2003 defines the arrangements for improving the quality of provision measured through clinical and social care governance;
- Circular HSS (PPM) 8/2004 Controls Assurance standards

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Background cont/d ….

- HTM 'The Orange Book'. 2004
- DHSSPS Guidance on the implementation of a Board Assurance Framework. January 2006.
- Safety First: A Framework for Sustainable Improvement in the HPSS March 2006
- DoH, Integrated Governance Handbook February 2006
- DHSSPS 'An Assurance Framework: a Practical Guide for Boards of DHSSPS Arms' Length Bodies'. March 2009

Emerging guidance ….

Assurance and the dog that didn't bark

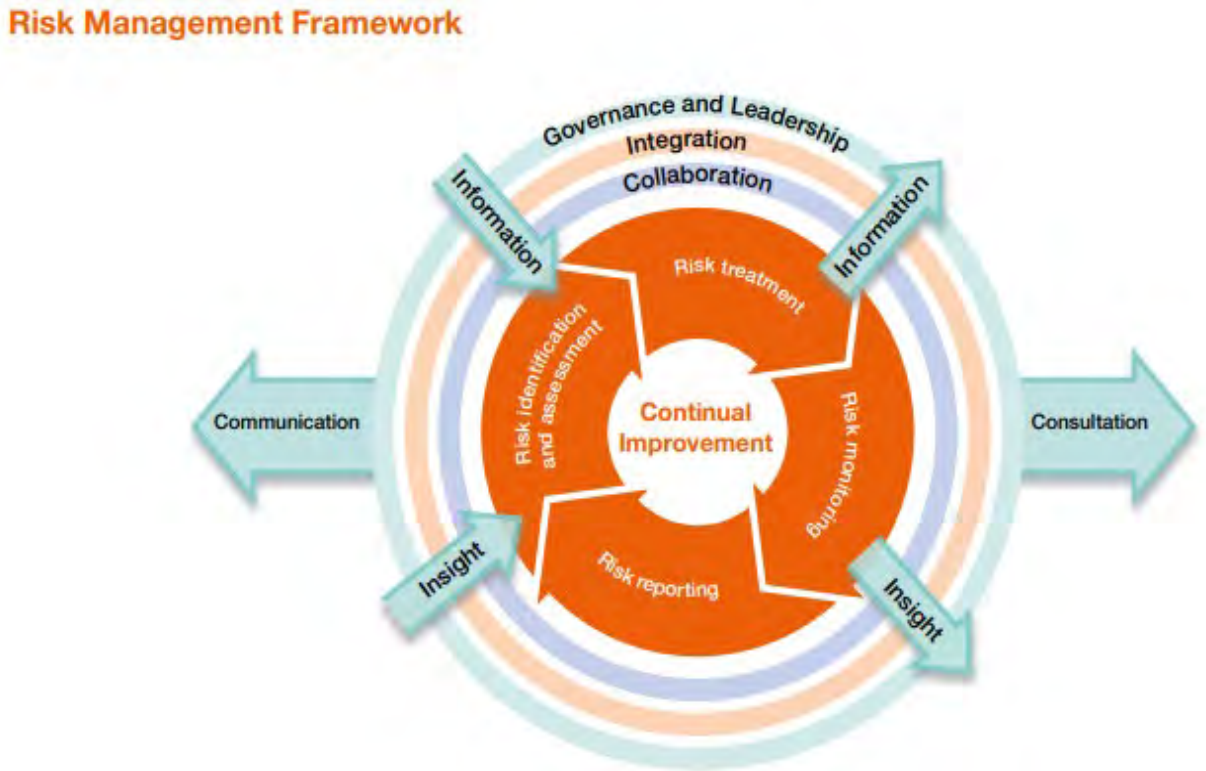
02 June 2020

Good Governance because it's time to think again 2020

'The survivors of existential crises have huge wisdom, won at high cost, about what we need in order to endure when the unexpected arrives. Just because we don't know the future doesn't mean we're helpless.[1].

As we come into the reset there is grand agreement that the dramatic cutting back on many assurance meetings was rather nice, and that there is not much of an appetite for just returning to how governance was. Guillotined meetings, reduced agendas and fewer assurance papers have worked very well for the last ten weeks and the 'assurance industry' has not been missed.

Emerging guidance …..



The Risk Management Framework

- Risk management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels.
- Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives.
- Risk management shall be collaborative and informed by the best available information and expertise.

Supporting Principles

- Each public sector organisation should establish governance arrangements appropriate to its business, scale and culture. Human behaviour and culture significantly influence all aspects of risk management at each level and stage. To support the appropriate risk culture, the accounting officer should ensure that expected values and behaviours are communicated and embedded at all levels.

Supporting Principles

- The accounting officer, supported by the board, should periodically assess whether the leadership style, opportunities for debate and human resource policies support the desired risk culture, incentivise expected behaviours and sanction inappropriate behaviours. Where they are not satisfied, they should direct and manage corrective actions and seek assurances that the desired risk culture and behaviours are promoted.

A strategic choice about the style, shape and quality of risk management…

CS Code/Brilliant CS values

Brilliant CS

CS Code

'integrity' is putting the obligations of public service above your own personal interests

'honesty' is being truthful and open

'objectivity' is basing your advice and decisions on rigorous analysis of the evidence

'impartiality' is acting solely according to the merits of the case and serving equally well governments of different political persuasions

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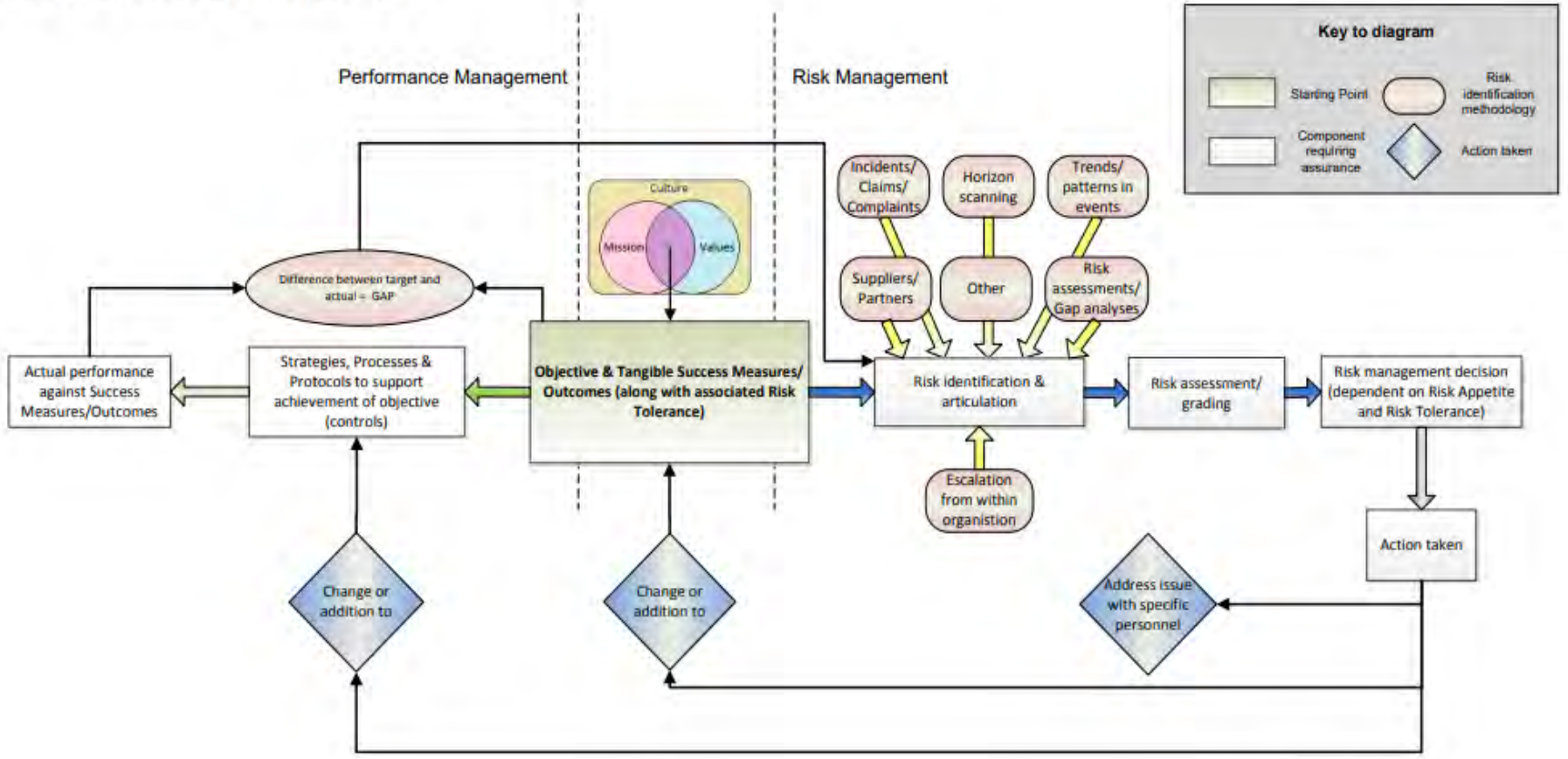
Risk Management

Shall be an integral part of all organisational activities to support decision-making in achieving objectives …..

Supporting principles …

- Setting strategy and plans;
- Evaluating options and delivering programmes, projects or policy initiatives;
- Prioritising objectives;
- Supporting efficient and effective operations;
- Managing performance;
- Managing tangible and intangible assests; and
- Delivering approved outcomes.

The Components of Governance



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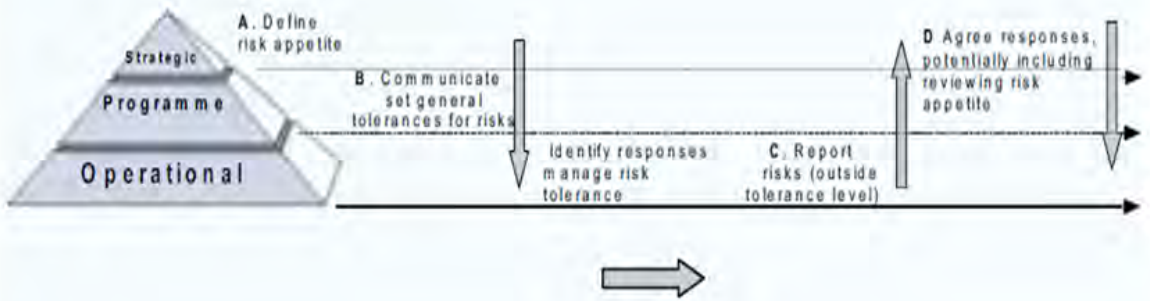
Why do we have to define our risk appetite?

Managing Your Risk Appetite, A Practitioner's Guide. November 2006)



Risk appetite is '*The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time*' (HMT Orange Book definition 2004).

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Why do we need to know our risk appetite?

- If the organisations does not know what it's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development;
- If organisational leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

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Risk Appetite

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

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Risk tolerance *v* risk appetite

Risk tolerance describes the maximum amount of risk the Trust is prepared to tolerate above the risk appetite. As with risk appetite risk tolerance will be influenced by a number of factors.

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GGI Jargon Buster …

Risk appetite is how much risk you want; risk tolerance is how much risk you can live with.

Risk Appetite Matrix

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. Only willing to accept the low cost option. 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 focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Avoid anything which could be challenged, even unsuccessfully. Play safe.	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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Sample risk appetite statements against corporate objectives

CLINICAL EFFECTIVENESS

- We will provide high quality services to our patients and not accept risks that could limit our ability to fulfil this objective. This key value is a driver that directly supports our core objective to improve our patients' care outcomes, and that of their family and friends, by providing personalised and responsive services.

- We will not accept risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

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Sample risk appetite statements against corporate objectives

PATIENT SAFETY

- We will hold patient safety in the highest regard and will not accept any risk that may jeopardise it. This key value is a driver that directly supports our core objective to improve the safety of our services to patients.

- It can be in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk.

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Sample risk appetite statements against corporate objectives

WORKFORCE

- We are committed to recruit and retain staff that meet the high quality standards of the organisation and will provide on-going training to ensure all staff reach their full potential. There are few circumstances where we would accept risks associated with the delivery of this aim.
- We will not accept risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely and, nor any incidents or circumstances which may compromise the safety of any staff members and patients, or contradict our values.
- For patient safety, quality care, service delivery and financial sustainability reasons we are prepared to consider risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models.
- We will not accept any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

BHSCT

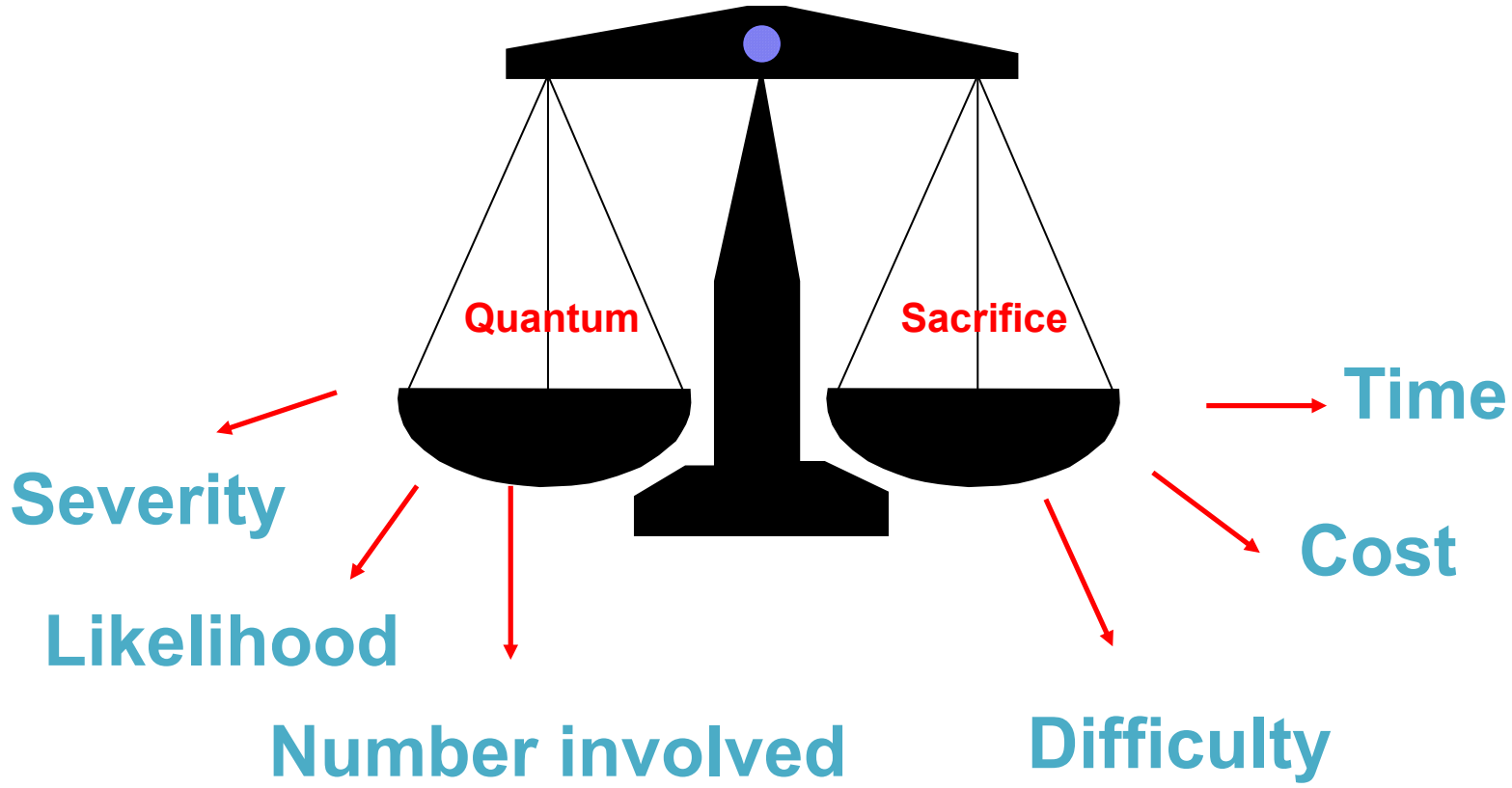
Corporate objectives

- **Safety, Quality and Experience:** Working with service users and carers to continuously improve safety, quality and experience for those who access and deliver our services.
- **Service Delivery:** Driving improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors.
- **People and Culture:** Supporting a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams.
- **Strategy and Partnerships:** Working to innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors.
- **Resources:** Working together to make the best use of available resources and reduce variation in care for the benefit of those we serve.

Sample BAF Risk

- Adult Safeguarding – risk to the safety of service users and Trust (corporately) due to a lack awareness and understanding of obligations in relation to adult safeguarding, as stated in regional Policy, Procedures and Joint Protocol.

"REASONABLY PRACTICABLE" and Acceptable Risk



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HSC organisations adopt a risk based approach to developing board assurance arrangements

The risk based approach looks at providing assurance over the key controls in place that mitigate the strategic or key risks that threaten (or provide opportunity for) achievement of your objectives, and should build on the foundation laid by your existing risk management process.

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Board Assurance Framework- GGI back to basics ….

The board assurance framework (BAF) is, in GGI's view, the original invest-to-save scheme for boards. Time spent on getting the various elements of their BAF right will help boards streamline assurance, locate where and how assurance is tested, and develop proportionality in board reporting. Key to developing an effective BAF is identifying the organisation's risk appetite and risk tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the risk appetite, the more controls should be put in place to avoid or mitigate risk

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Assurance Frameworks

The adaptation of an Assurance Framework by each HSC organisation has been mandatory since 1 April 2009. A key observation from an Audit Commission review of how boards get their assurance is 'that there has been no lack of guidance... the challenge for boards is therefore not finding out what to do, but instead translating the theory into an approach that works in their Trust and then following through with appropriate rigour'.

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Definition of Assurance

‘A positive declaration that a thing is true. Assurances are therefore the information and evidence provided or presented which are intended to induce confidence that a thing is true amongst those who have not witnessed it for themselves. For an individual to ‘be assured’, they must trust the assurance(s) they have been provided with and therefore be confident themselves that the thing is true’.

Good Governance Institute 2013

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Assurance, reassurance and performance

Boards have had to become more reliant on what they hear from regulators and stakeholders to scrutinise and challenge the narrative presented at committee and board meetings without visiting or speaking with frontline staff as would have happened pre-COVID.

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Balancing assurance and reassurance?

Another key aspect in developing assurance frameworks is ensuring a balance between assurance and reassurance. Assurance is based on information, evidence and triangulation. Reassurance is based on opinion, professional expertise and trust. Boards should not purely be getting assurance nor reassurance but a balance. This ensures that information has been analysed and turns data into intelligence. It means boards are not overrun with statistics but also that they are not just reliant on what the executive say is happening.

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Providing assurance to Trust Board and the escalation of risk

More assurance is not necessarily a good thing. Providing reports can overburden staff, leaving less time to concentrate on actions to make the necessary improvements. Part of the answer is appropriate escalation – staff at the front line dealing with the day-to-day issues and the full detail in their areas. Any areas of concern should then be escalated through the organisation. Only the areas of greatest concern should be escalated to the executive; less concerning issues are dealt with lower down in the organisation. This ensures appropriate accountability.

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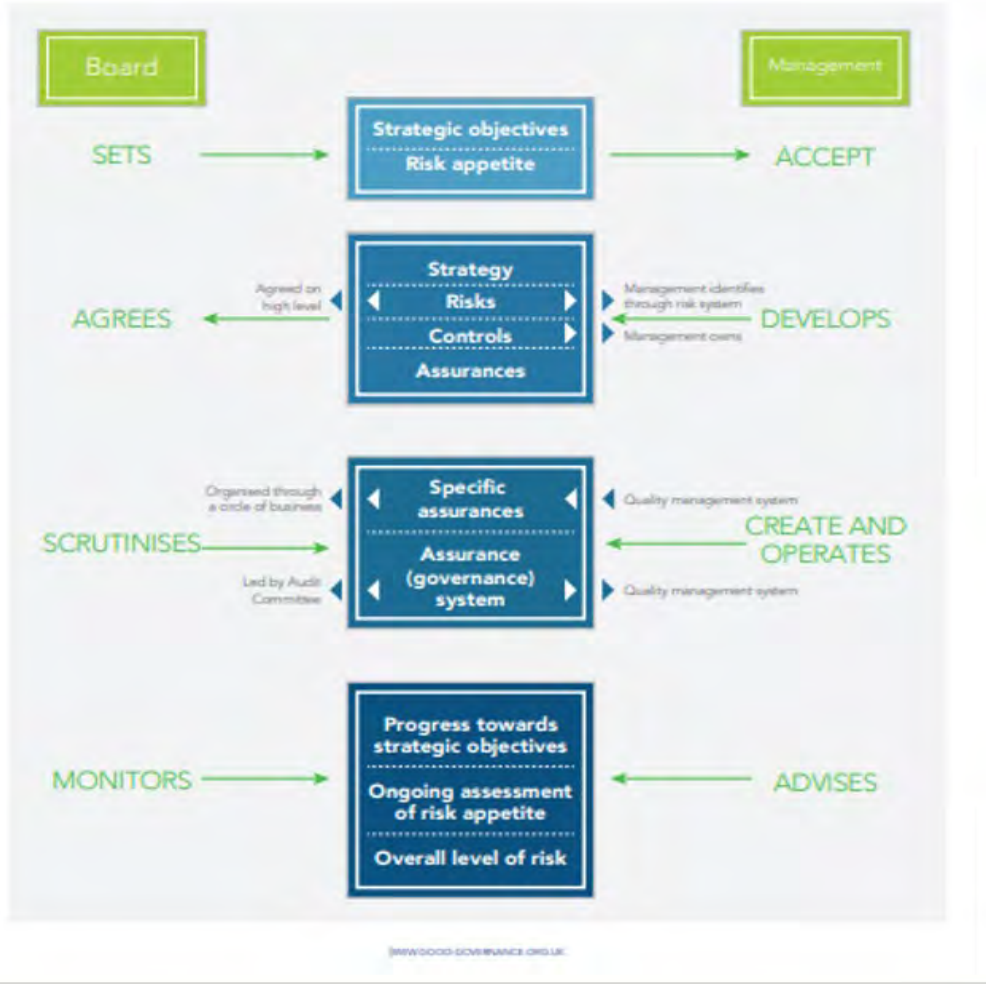
Performance metrics

GGI advise that performance metrics are just one form of assurance a board can receive. Action plans, strategy updates, service user feedback, and divisional deep dive presentations are all forms of assurance and all play a key part in understanding whether the controls for strategic risks are working. Key performance metrics therefore may be linked to providing assurance about a particular risk, but should not be solely relied upon.

GGI model for Board Assurance



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Seeking assurance that the systems of control are robust and reliable

Principle of reasonable assurance

We operate on the principle of reasonable rather than absolute assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

Emerging ‘assurance’ guidance and Trust work …

- GGI has long campaigned for lean governance, with precious board time focused on strategy rather than overwhelmed with assurance. We felt that Sir William Wells, the former chair of the Appointments Commission, had the ratio right at 70% strategy and 30% assurance, with non-executives able to deliver their jobs in 2.5 days a month.

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What is assurance mapping?

Assurance mapping is a key part of developing and maintaining board assurance arrangements and producing a board assurance framework. It provides an organisation with an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps. The assurance mapping process and the way of illustrating the results using a BAF can give confidence to senior management and the board that they 'really know what they think they know'.

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What are the foundations for assurance mapping?

- Clear and concise risk descriptions;
- Risks explicitly aligned or linked with strategic objectives;
- Detailed cause and effect analysis;
- Detailed list of key controls;
- 'Inherent' (gross) assessment (before controls) and 'residual' (net) assessment (after controls) of the risk; and
- Details of planned action and implementation dates.

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Map assurances for each control

Prioritise what to focus on, especially as resources are finite and the board assurance framework should be seen as adding, not detracting value.

Likelihood severity occurs	Potential Severity Rating: Minor	Moderate	Significant	Catastrophic
Very Likely	Moderate	High	Extreme	Extreme
Likely	Low	Moderate	High	Extreme
Unlikely	Very Low	Low	Moderate	High
Rare	Very Low	Very Low	Low	Moderate

Suggested risk classification drivers for assurance

Inherent risk classification	Residual risk classification	Action and/or assurance activities
High	High	Management attention should be focused on implementing actions to improve existing controls or introduce new ones within an agreed timescale.
	Medium	Sign off of the existing control effectiveness by management and monitor progress of the implementation of further mitigating actions. Independent assurance obtained within the next six months.
	Low	Sign off of the existing control effectiveness by management. Independent assurance obtained within the next six months.

Suggested risk classification drivers for assurance

Inherent risk classification	Residual risk classification	Action and/or assurance activities
Medium	Medium	Depending on the organisation's risk appetite and ability to further influence risk mitigation attention should be focused on identifying and implementing actions within the next six months.
	Low	Six monthly sign off of the existing controls effectiveness by management. Independent assurance obtained within the next 18 months.
Low	Low	Little/no assurance required.

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Sources of Assurance …

- 1-1 Meetings (manager and staff member)
- Peer review of a piece of work
- Self-assessment return
- Performance Report
- Complaints Report
- Management Report
- Budget Report
- Internal Audit Report
- External Audi Report
- RQIA Review/Report
- Professional/Regulatory Bodies e.g. NISCC, Royal Colleges etc

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What is the three lines of assurance [defence] model?

The ‘three lines of assurance’ approach is a model for assurance that pulls risk management and compliance into a **common and robust framework**. Its underlying concepts of **significant ownership by frontline staff; their accountability to corporate and executive processes**; and **separate scrutiny** lie at the heart of this model.

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Three lines of assurance …

When an organisation has properly structured the lines of assurance and they operate effectively, it should understand how each of the lines contributes to the overall assurance required and how those involved can best be integrated and mutually supportive. There should be no gaps in coverage and no unnecessary duplication of effort. Importantly, the accounting officer and the board should receive unbiased information about the organisation's principal risks and how management is responding to those risks.

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Three lines of assurance ….

Everyone in an organisation has some responsibility for risk management. The three lines of assurance model provides a simple and effective way to help delegate and coordinate risk management roles and responsibilities within and across the organisation.

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Three lines of assurance impacted by COVID-19?

The three lines of assurance have also been impacted by COVID-19 – with many corporate teams working from home, a rationalisation of meetings and auditors having to work virtually.

Despite these constraints, boards can still gain assurance from these lines but it will need to be focused on the areas of strategic importance for the organisation.

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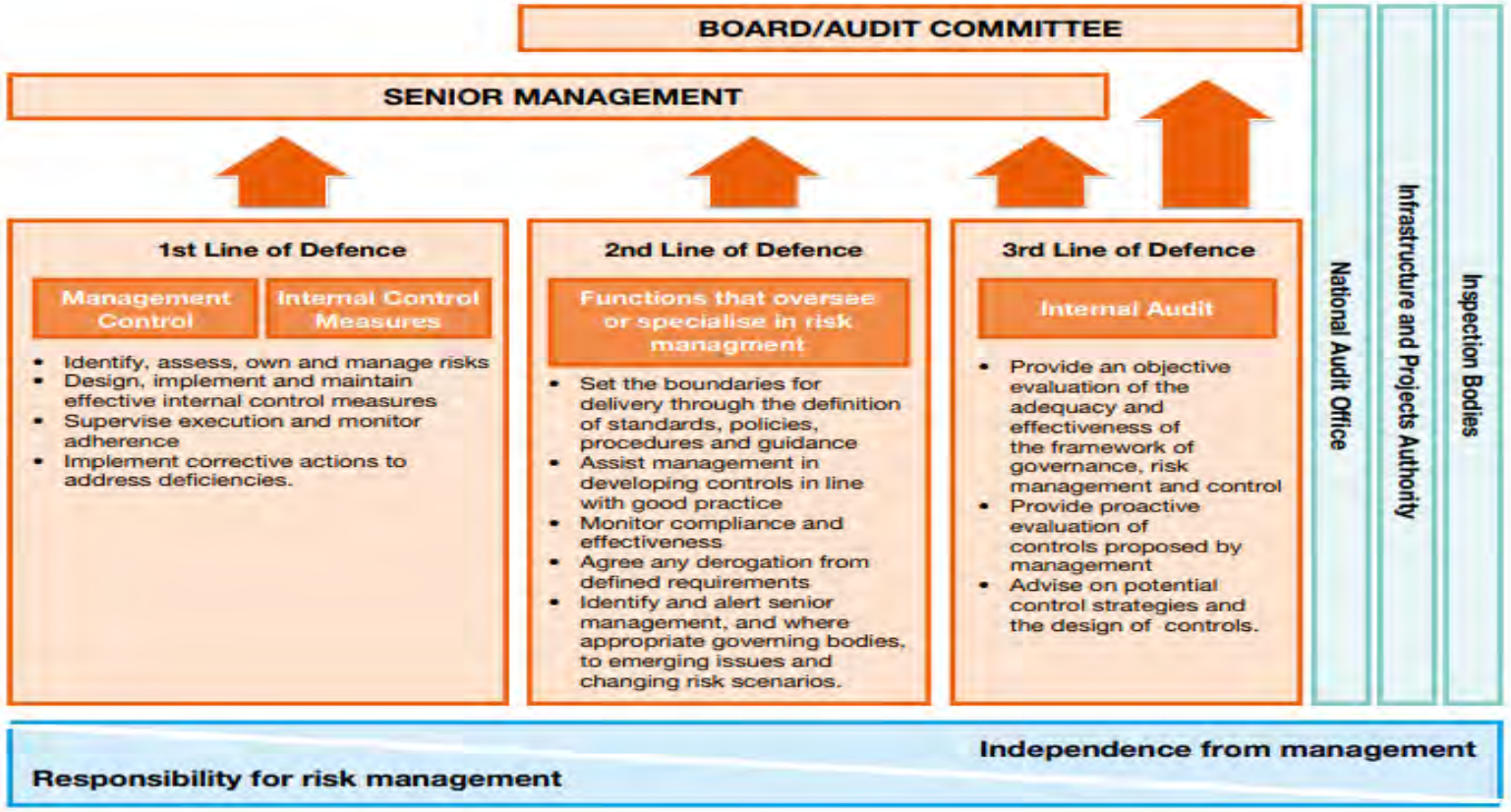
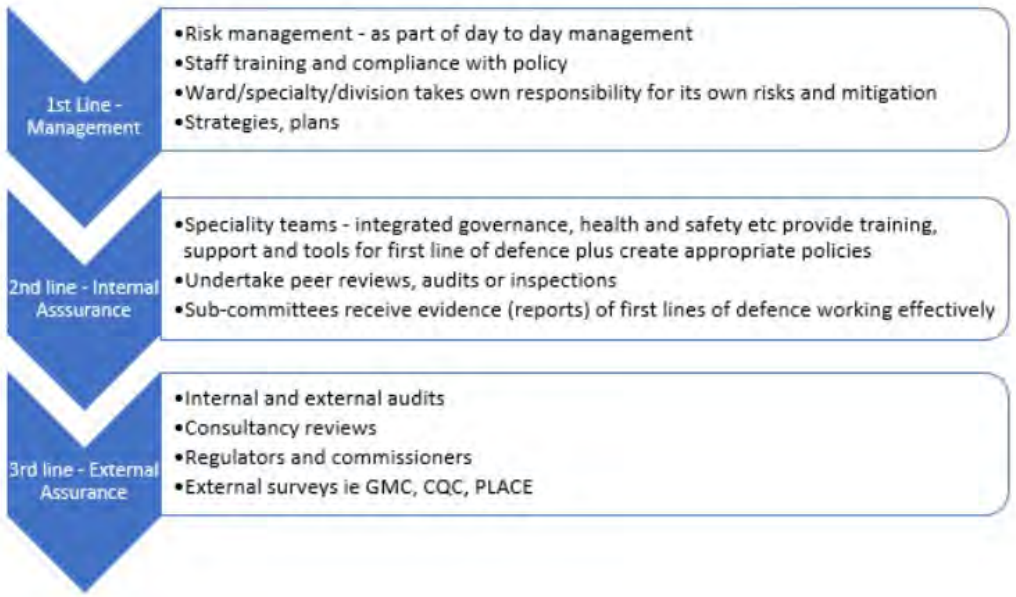
Three lines of assurance and escalating risk - impacted by COVID-19?

It is therefore important that, as much as possible, organisations return to a fully functioning management assurance structure, partly as best practice but also in anticipation of regulatory oversight returning to normal levels. **It may present a good opportunity for a review of management group structures to ensure they are aligned to strategic objectives and key areas of operational delivery.**

Three lines of assurance



Three lines of assurance



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First line of assurance …

Under the first line of assurance, management have primary ownership, responsibility and accountability for identifying, assessing and managing risks. Their activities create and/or manage the risks that can facilitate or prevent an organisation's objectives from being achieved.

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First line of assurance ….

The first line ‘own’ the risks, and are responsible for execution of the organisation’s response to those risks through executing internal controls on a day-to-day basis and for implementing corrective actions to address deficiencies.

Through a cascading responsibility structure, managers design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise effective execution.

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First line of assurance …

There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, variations in or inadequate processes and unexpected events, supported by routine performance and compliance information.

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Second line of assurance …

The second line consists of functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down the organisation. The second line should support management by bringing expertise, process excellence, and monitoring alongside the first line to help ensure that risk are effectively managed.

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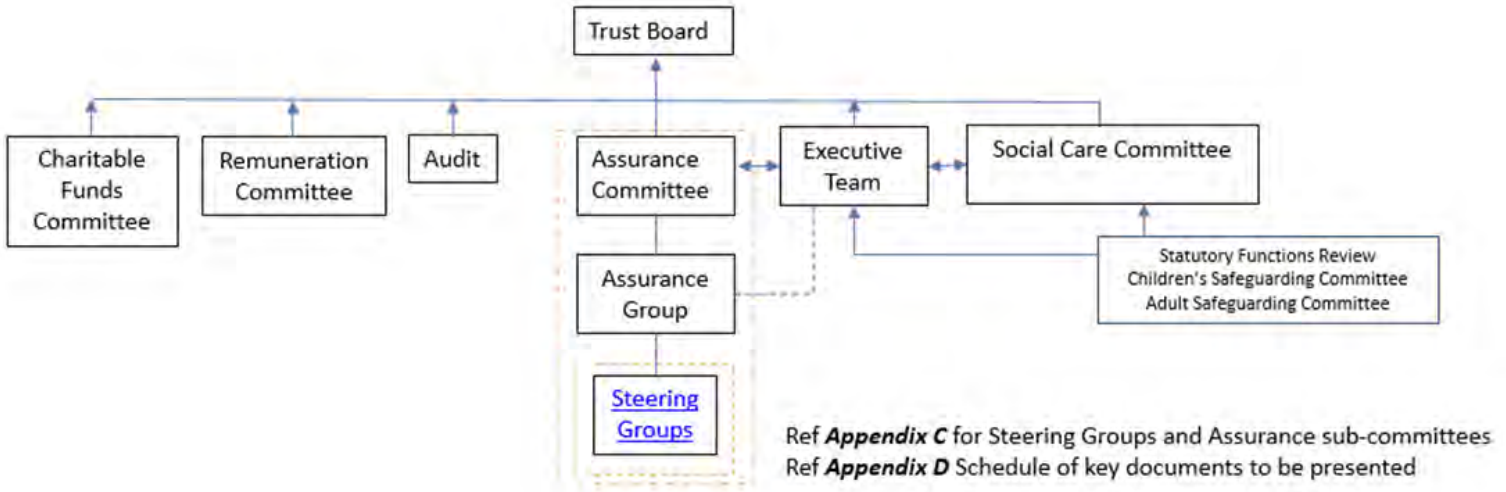
Second line of assurance ….

The second line should have a defined and proportionate approach to ensure requirements are applied effectively and appropriately. This would typically include compliance assessments or reviews carried out to determine that standards, expectations, policy and/or regulatory considerations are being met in line with expectations across the organisation.

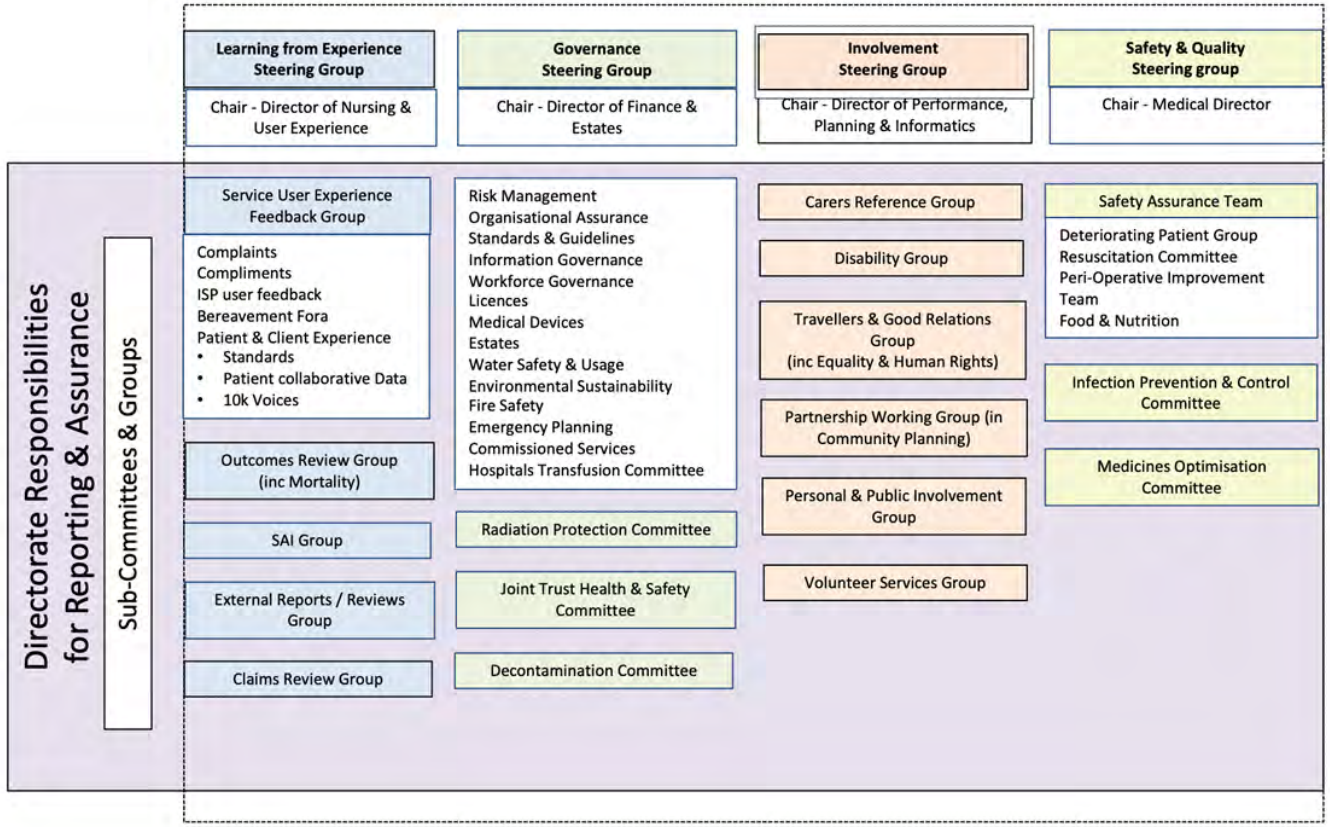
Emerging guidance and Trust work …

- GGI has supported organisations looking to cull committees and find better ways of seeking assurance than sitting in a room watching the managers describe their work. A ‘tell’ of poor governance, we would say, is an organogram with multiple governance layers populated by far too many meetings at which the same issues are discussed again and again with little understanding of what the added value should be at each stage.

Second and Third Lines of Assurance ….



Second line of assurance – integrated governance structure



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Third line of assurance …

Internal audit form the organisation's third line of assurance. An independent internal audit function will, through a risk-based approach to its work, provide an objective evaluation of how effectively the organisation assesses and manages its risks, including the design and operation of the first and second lines of assurance.

It should encompass all elements of the risk management framework and should include in its potential scope all risk and control activities. Internal audit may also provide assurance over the management of cross organisational risks and support the sharing of good practice between organisations, subject to considering the privacy and confidentiality of information

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External Assurance …

Sitting outside of the organisation's own risk management framework and the three lines of assurance, are a range of other sources of assurance that support an organisation's understanding and assessment of its management of risks and its operation of controls

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What is a Board Assurance Framework?

‘An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.

It is common practice across the UK public health and social care sector for the term ‘board assurance framework (BAF)’ to be used to refer to the key document used to record and report an organisation’s key strategic objectives, principal risks, controls and assurances to the board.

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The BAF should be used by HSC organisations as a:

- strategic but comprehensive method for the effective and focused management of the principal risks to meeting an organisation's objectives;
- structure for the evidence to support the Annual Governance Statement;
- method of aggregated board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management;
- document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.

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The board assurance framework (BAF) is, in GGI's view, the original invest-to-save scheme for boards. Today we go back to basics to explain some key terms. The board assurance framework (BAF) is, in GGI's view, the original invest-to-save scheme for boards. Time spent on getting the various elements of their BAF right will help boards streamline assurance, locate where and how assurance is tested, and develop proportionality in board reporting. Key to developing an effective BAF is identifying the organisation's risk appetite and risk tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively.

The BAF is an agreement between the board and the trust's management which summarises:

- the organisation's strategic objectives
- the risks to achieving these
- the controls management are to put in place to minimise the likelihood or effect of those risks materialising
- the assurances the board needs to be confident that the controls are operating effectively.

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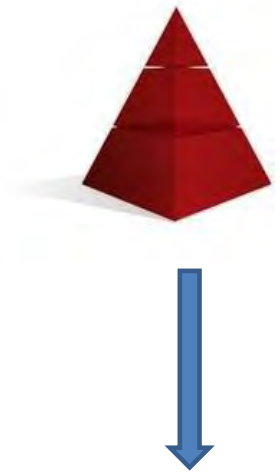
Risk Registers

System based on bottom-up top-down approach leading the BAF populated by principal risks.

What are common issues with risk registers?

- Do not link with the objectives of the organisation
- Poorly defined risk description
- Risk owner when risk crosses multiple directorates
- Risk control heavily reliant on training and modification of behaviours not defined and not updated over time
- No/limited scrutiny of efficacy of risk control
- Risk action not commensurate and timescales not met
- Residual risk – trend does not move over a significant period of time.

Reminder of the Hierarchy of Risk Control



- Elimination of risk
- Procedural control measures
- Behaviour modification
- Use of PPE

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BHSCT BAF Template

For discussion ……

BHSCT BAF Example

Board Assurance Framework					2021-2022
QMS					
Organisation Theme/ Objective	Safety and Quality				
Risk Grade	Impact	TBC	likelihood	TBC	Risk Grade	TBC
Risk Appetite	None to Low				

Principal Risk Reference & Description	Quarterly Assurance Rating	Rating rationale, Gaps in Assurance and Control Reports		Lead Director CD	Assuring Committee & Reports	Direction of Risk Level
SQ54 Adult Safeguarding Created Apr 2021 Updated Jun 2021 Risk to the safety of service users and Trust (corporately) due to a lack of awareness and understanding of obligations in relation to adult safeguarding, as detailed in regional Policy, Procedure and Joint Protocol.	1 2 3 4			**Actions- Timeframe** Date of Next review/ scheduled date for Date Actions planned to be completed and Action Plan Status		
Additional Information There are concerns that not all staff and services have a comprehensive understanding of their roles and responsibilities in relation to safeguarding adults at risk of harm and adults in need of protection. This may lead to harm in the context of missed opportunities for early preventative interventions and the potential that harm may not be recognised and reported, with potential missed opportunities for protection intervention. At service level risk may include:		**Controls**	Regional Adult Safeguarding Policy and Procedures are in place and have been adopted by the Trust. Referral pathway flowchart for staff has been developed where safeguarding concerns are identified and resource packs have been compiled for teams. Trust Adult Safeguarding Committee in place and working to a comprehensive action plan Adult and Child Safeguarding Training is currently provided to social work/care staff and on a more limited basis for nursing, medical, AHP staff. Safeguarding is included in some departments daily/weekly safety briefings. Safeguarding is included as a Standard on the third version		Incident &SAI – Qrtly Complaints – Qrtly QMS – weekly/ Qrtly Real time patient experience reporting Social Care Committee,	

BHSCT BAF Example

Failure to identify, report and respond to any safeguarding concerns. Failure to provide safe care for patients/service users whilst being cared for in our facilities/hospitals through the following: **Malnutrition** Food being left in front of patients who required help with feeding and none offered. Uneaten meals being disposed of without question. Staff declining to check if 'challenging' patients have received meals. Staff not answering call bells. **Assistance with Daily Living Issues** Staff failing to wash patients. Staff failing to reposition patients. **Communication issues** Staff verbally abusing a patient. Staff making inappropriate comments to vulnerable adults. **HCAI** Staff failing to follow PPE policy. **Physical harm** Staff causing physical harm to patients through misuse of holding and/or restraint techniques or through mishandling.						of the Belfast Risk Audit and assessment tool (BRAAT 3). Safeguarding Liaison Nurses in place in Outpatients. Safeguarding link nurses established in Outpatients.		including Adult Safeguarding Committee	
					Assurance	Level 1: - Directorate teams' regular surveillance and reporting Level 2: - Weekly governance meetings with SMT & QMS Divisional schedule to Exec Team - QMS Director exception reporting to Trust Board and Board - Committee Reporting (if approved Clinical & Social Care safety committee) Level 3: - RQIA routine inspections and commissioned reviews BSO Internal Audit			
					Gaps in Control	Lack of recognition, awareness, understanding of safeguarding across many parts of the organisation and lack of awareness of Trust ASG policy and procedures to be followed. Not all staff trained in accordance with the Regional Training Framework. Lack of capacity currently to provide relevant levels of training to all staff. Lack of join up across Adult Services with single point of entry for referrals not consistently used for all external and internal referrals Safeguarding is only included in some departments daily /weekly safety briefings. Inconsistent thresholds applied across the Divisions Learning from key areas such as Outpatients and MAH has not yet been fully disseminated across the organisation. Wards/Facilities/teams- Areas of vulnerability for the Trust remain unknown. Difficulties in recruiting to DAPO and IO roles across some			
						areas in the Trust leading to potential delays in investigation.			

BHSCT BAF Example

					Actions planned Controls	Additional trainers to be recruited into L&D Social Care Team to provide training on ASG for wider staff groups and an implementation plan to be developed to ensure adherence to the regional framework. One additional trainer is now in place and is commencing training for managers. Level 2 training package to be developed on line- business case to be submitted to Charitable funds Committee to cover cost of development. Business case has been submitted for consideration by charitable funds. Scoping tool developed to identify areas of vulnerability across divisions. Tool is currently out for completion by divisions to be returned by 5th June 21. Focused piece of work to be completed in relation to the collation of data across the organisation. This work is underway and is linked to developments in PARIS. Learning from MAH, Outpatients etc to be shared across the Adult Safeguarding Committee for dissemination. The learning from MAH has been shared with members of the adult safeguarding committee on 13.5.21. A further workshop is to be arranged to ensure tools etc are shared. Additional temporary staff to be recruited to support areas of vulnerability develop full range of safety measures.	August 2021 June 2021 May 2021 Sept 2021 June 2021 July 2021		
					Gaps in Assurance	Adult safeguarding Committee currently is expected to report into the SCC- further work is required to identify how this is undertaken. Current review of Assurance arrangements to be completed including revised committee structure and BAF and integration with QMS to ensure monitoring and auctioning planning at all levels	June 2021 August 2021		
						Absence of independent review providing level 3 assurance. The need for a central point of referral for all referrals to be reviewed along with reporting structures for ASG across the Trust. Workshop took place on 14.6.21 to discuss this further across adult services. Follow up workshop is planned for 2.8.21.	June 2021		
					Actions planned Assurance	Agree inclusion of adult safeguarding arrangements in Internal Audit programme	2022-2023		

Thinking about risk

Managing your risk appetite: A practitioner's guide

November 2006

HM TREASURY

HM TREASURY

Thinking about risk

Managing your risk appetite: A practitioner's guide

November 2006

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ISBN-10: 1-84532-232-0
ISBN-13: 978-1-84532-232-8

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Contents

Overview

1.1 It is essential that the Board's attitude to risk is communicated to the whole organisation and applied in decision making regarding the prioritisation of policies, workstreams, programmes, projects, operational service delivery and the funding that goes with them.

1.2 With the rapid improvement of risk management across Whitehall, many Departments have already introduced a number of innovative and effective approaches to incorporate risk management into their day-to-day business and reform delivery management arrangements.

1.3 The aim of this guide is to help you to refine the application of your organisation's risk appetite so that risk judgements are more explicit, transparent and consistent. As a practitioner you also need to understand your own risk appetite and how it aligns to that of your organisation. We do not seek to replicate methodologies that have already been covered by other publications, in particular the Orange Book[1] and Green Book,[2] which this guide is designed to complement.

What is Risk Appetite?

1.4 There are numerous definitions of organisational 'risk appetite', but they all boil down to how much of what sort of risk an organisation is willing to take. Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of your organisation, its performance and its reputation.

> For the purpose of this guide we have adopted the Orange Book definition of Risk Appetite, being:
>
> 'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.'

1.5 Risk appetite is about taking well thought through risks where the long-term rewards are expected to be greater than any short-term losses. Indeed, it may even be appropriate in some instances to incur a loss if this paves the way to success in the long-run.

1.6 It is worth noting that the Public Accounts Committee supports well-managed risk taking, recognising that innovation and opportunities to improve public services requires risk taking, providing that we have the ability, skills, knowledge and training to manage those risks well.[3] This support has also been endorsed by the House of Lords Economic Affairs Select Committee, which is concerned that the public sector reward and assessment systems may emphasise the adverse impact of failure rather than the gains from success and so encourage excessive risk aversion.[4]

[1] The Orange Book: Management of Risk – Principles and Concepts.

[2] The Green Book: Appraisal and Evaluation in Central Government.

[3] Public Accounts Committee Report – HC444 – Managing Risks to Improve Public Services – March 2005

[4] House of Lords Select Committee on Economic Affairs Report – HL Paper 183/1 – Government Policy on Management of Risk.

1.7 By enhancing your approach to determining risk appetite you will be raising your organisation's capability to deliver on challenging targets to raise standards, improve service quality, system reform, and provide more value for money. Risk appetite needs to be considered at all levels of the business- from the Ministerial view, which may be influenced by the political climate, down through the business from strategic decisions to operational delivery.

Why do you need to determine your risk appetite?

1.8 If the managers are running the business with insufficient guidance on the levels of risk that are legitimate for them to take, or not seizing important opportunities due to a perception that taking on additional risk is discouraged, then business performance will not be maximised, and business opportunities will not be taken. At the other end of the scale an organisation constantly erring on the side of caution (or one that has a risk averse culture) is one that is likely to stifle creativity and is not necessarily encouraging innovation, nor seeking or exploiting opportunities. You need to be steering a course where risk taking is clearly calculated with a view to achieving defined rewards.

Clearly articulating your risk appetite will have definite business benefits through:

1. Supporting and providing evidence of the decision-making processes.
2. Demonstrating how each element of the business contributes to the overall risk profile.
3. Showing how different resource allocation strategies can add to or lessen the burden of risk.
4. Supporting the approvals process.
5. Identifying specific areas where risks should be removed.
6. Transparency and consistency of business decisions.
7. Improved understanding of risk-based budgets.

1.9 This Guide is the second part of a set of 3 documents.

1.10 The first part, a Board Paper entitled "Thinking About Risk – Setting and Communicating Your Risk Appetite" explains what risk appetite is and how it depends on the aims of the business. It needs to be considered not only for individual programmes/projects, but also across business areas, units, functions, and in its totality, to ensure that an organisation's overall portfolio of risks is appropriate, balanced and sustainable.

1.11 This second part, a Practitioner Guide entitled "Thinking About Risk – Managing Your Risk Appetite" explains how to apply risk appetite and provides a guided walk through of an assessment process at Chapter 2 that will:

- ≠# Help you to incorporate risk appetite into your risk framework
- ≠# Use the risk appetite when assessing whether risks are being appropriately addressed.

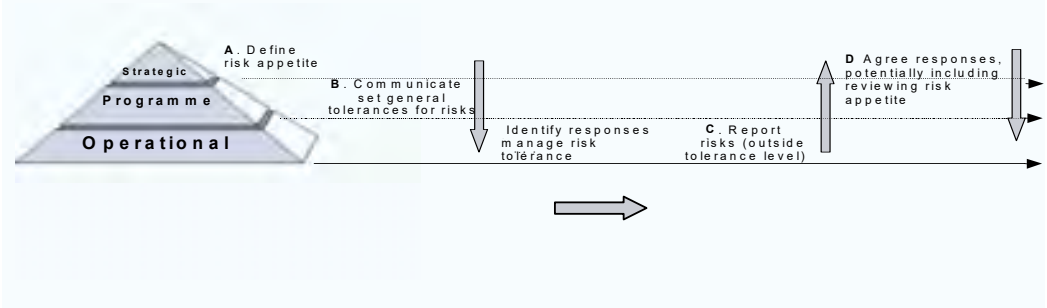
1.12 Annexes D-G provide graphical illustrations of how you might like to diagrammatically represent your risk appetite in relation to the risks of your business. Annexes H and I provide basic information that will help you to further refine those judgements to quantify your risk appetite, if appropriate.

1.13 The final, third part "Thinking About Risk – Managing Your Risk Appetite: Good Practice Examples" illustrates how some Departments have approached their own risk appetite. Whilst no example will be suitable for adoption without modification, we hope that they provide you with useful food for thought.

2 Applying risk appetite

Introduction

2.1 Each level of the organisation needs clear guidance on the limits of risk that they can take. Risk appetite should be expressed in the same terms as those used in assessing risk. An organisation's risk appetite is not necessarily static; in particular the Board will want to vary the amount of risk that it is prepared to take depending on the circumstances at the time. The model below sets out these concepts in more detail:



2.2 Risk appetite is not a magic number, nor always quantifiable. It is dependent upon the aims of the business and what risks have to be taken to achieve those aims. However, those risks must be well-considered and well-managed. To be so, an organisation must provide guidance on the acceptable level of risk that it considers appropriate across the breadth of its business (i.e. risk appetite). Risk appetite needs to be considered not only for individual programmes/projects, but also across operational delivery areas and, in its totality, for the overall portfolio[5] of risks to ensure that an organisation's risks are appropriate, balanced and sustainable.

2.3 At the organisational level risk appetite can become complicated, but at the level of a specific risk it is more likely that a level of exposure[6] (consequences) that is acceptable can be defined in terms of both an impact if a risk occurs, and the frequency of that impact. It is against this that the residual risk[7] has to be compared to decide whether or not further action is required. What is tolerable may be affected by the value of assets lost or wasted in the event of an adverse impact; stakeholder perception of such an impact; the cost of implementing actions to further manage the risk; the likelihood of the risk occurring; and the balance of potential benefit to be gained.

Need for Guidance

2.4 If your Organisation has not made a formal statement on its risk appetite, you will have a control problem. Without such a statement managers are running their business with insufficient guidance on the levels of risk that they are permitted to take, or not seizing important opportunities due to a perception that taking on additional risk is discouraged. Your role is to help the board set and communicate the risk appetite as

[5] The overall portfolio of risks that the organisation is exposed to = Risk Profile

[6] Exposure = the consequences, as a combination of impact and likelihood, which may be experienced by the organisation if a specific risk is realised.

[7] Residual Risk = the exposure arising from a specific risk after action has been taken to manage it and making the assumption that the action is effective.

set out in the Board Paper "Thinking About Risk – Setting & Communicating Your Risk Appetite".

2.5 The need for guidance was underlined in the PAC Report,[8] concluding that:

- Departments should signal clearly their commitment at Board-level to taking managed risks that can deliver tangible improvements in services; and
- Departmental management boards need to form an overall view on the one hand, greater risk taking is justified (for example in new policy initiatives) and where they need to minimise risks (for example in essential service delivery on which citizens depend).

2.6 There is also a need for a management culture and supporting processes that allow due consideration of risk before major decisions are taken to begin new policy projects or corporate change initiatives and during the development and implementation of programmes of work.

Steps towards embedding the Board's Risk Appetite

2.7 At its simplest, each risk needs to be assessed against the risk appetite that must be determined by the Board and communicated. A framework is needed for describing and analysing risks and assessing them according to a common currency or set of metrics. An overview of the three issues of communication, assessment and metrics is given at Annex C. This approach will give you the basis for improving the consistency of risk decisions.

2.8 It is helpful to have risks classified into categories and mapped to business areas. This allows you to see the way in which risks impact different parts of the business and to what extent some parts of the business have an unacceptable level of risk (either too high or too low). Risk registers that simply list risks individually with their ratings may not indicate how the ratings compare to the risk appetite. They may also fail to facilitate the identification of pressure points, imbalances and inconsistencies in approach.

2.9 One solution is to assign risks to risk categories and then produce a matrix relating categories of risk, such as operational or reputational, to the type of response, on a scale of risk averse to risk hungry, which the different categories of risk would typically evoke.

2.10 Annex A provides a basic framework for doing this showing the factors to consider against each risk category. It also gives examples of the sorts of scales that can be used to distinguish levels of risk appetite. Example 1 in "Thinking About Risk – Managing Your Risk Appetite: Good Practice Examples" shows how DTI have applied this technique.

2.11 Annex B shows a framework that describes the attitudes and behaviours the risk appetite should give rise to for each risk category. This framework may be useful when assessing the adequacy of the responses to risk and in communicating the Board's risk appetite to the whole organisation.

[8] Public Accounts Committee Report – HC444 – Managing Risks to Improve Public Services – March 2005

2.12 With the risk appetite so defined individual risks can be assessed against the risk appetite descriptors and decisions can be made about whether the optimum level of residual risk has been reached. There are many techniques now in use for illustrating this graphically and these are shown in Annexes D & E. A variety of tools are given at Annexes F to I showing how the application of risk appetite can be demonstrated by explicit decisions about the acceptability of specific levels of risk.

A PRELIMINARY CONSIDERATIONS TO TAKE INTO ACCOUNT PRIOR TO DETERMINING RISK APPETITE

1. Identify the group(s) of risks that you have:

For example:

Grouping / Business Area	Factors to consider prior to determining your risk appetite include:
Policy / Guidance / Strategic / Political / Change	Business Objectives. Extent of Innovation. Robustness of Control Framework.
Operational Delivery / Service Delivery / People / Equality and Diversity Internal Systems / Health & Safety	Constraints imposed by existing controls & systems. Skill remits, stakeholders Implementation of new systems/procedures and the risks that will be ran to realise their full benefits. Need to continue to deliver 'business as usual'
Regularity / Propriety / Compliance / Accountability / Financial Loss or Cost	Spending limits. Regularity & propriety. Value for money. Accountability to Ministers and Parliament.
Reputation / Credibility / Public Perception /Confidence	Degree of experience. Historical evidence. Lessons learned from past crises.
External Factors / Environmental /Social	The extent and robustness of continuity and contingency plans, to ameliorate exposure to external factors, over which there is limited control.

2. Describe your Risk Rankings:

For example:

Ranking	Description and Action Needed
Very High	This is above the organisation's defined tolerance level. The consequences of the risk materialising would have a disastrous impact on the organisation's reputation and business continuity. Comprehensive action is required immediately to mitigate the risk.
High	The consequences of this risk materialising would be severe but not disastrous. Some immediate action is required to mitigate the risk, plus the development of a comprehensive action plan.
Medium	The consequences of this risk materialising would have a moderate impact on day-to-day delivery. Some immediate action might be required to address risk impact, plus the development of an action plan. Status of the risk should be monitored regularly.
Low	The consequences of this risk materialising would have a minor impact. No immediate action is required, but an action plan should be actively considered. Status of the risk should be monitored periodically.
Very Low	The organisation accepts this risk / impact of risk would be insignificant. Status of the risk should be reviewed occasionally.

3. Articulate your classifications of Risk Appetite:

For example:

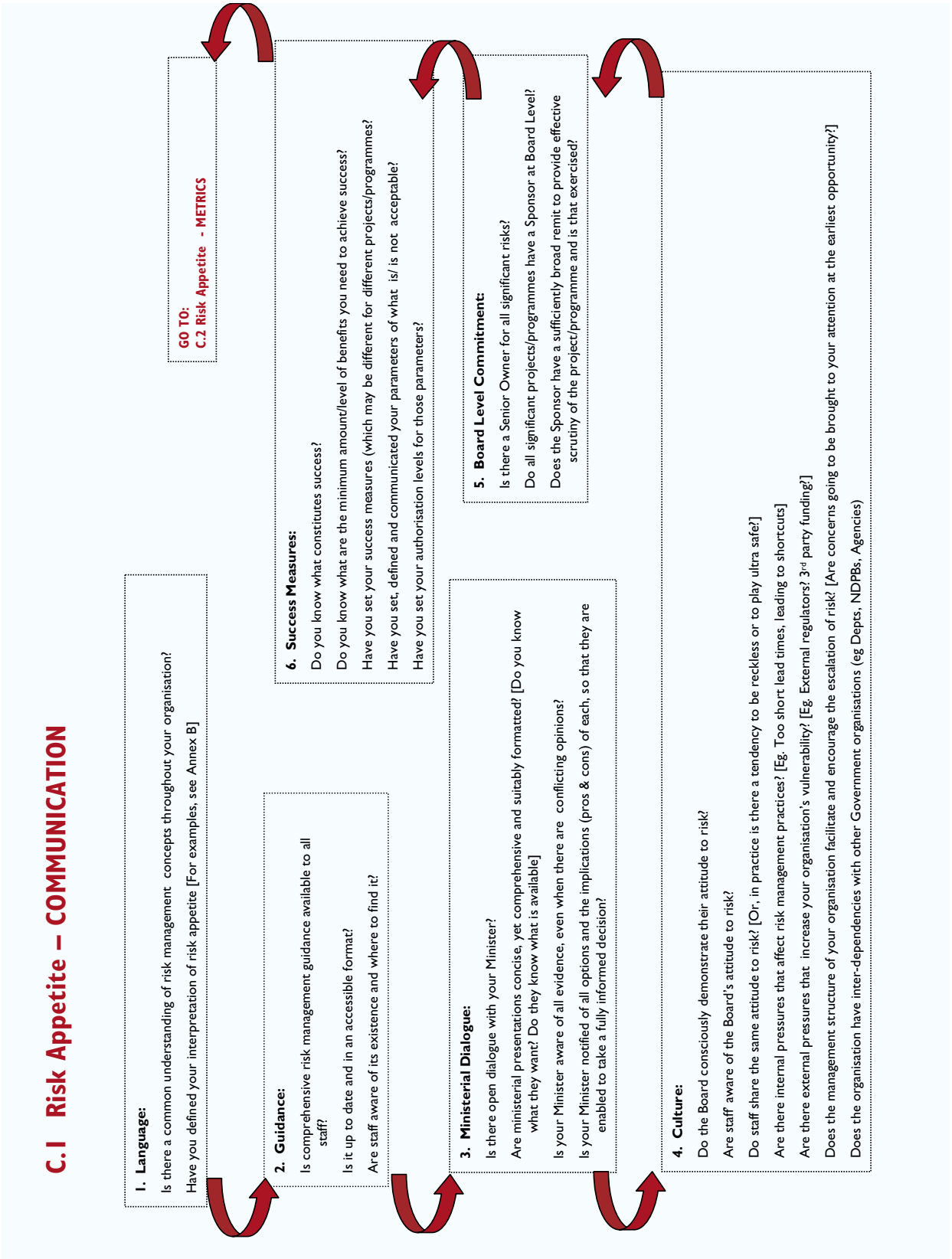
Classification	Description
Averse	Avoidance of risk and uncertainty is a key Organisational objective.
Minimalist	Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
Cautious	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
Open	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.).
Hungry	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

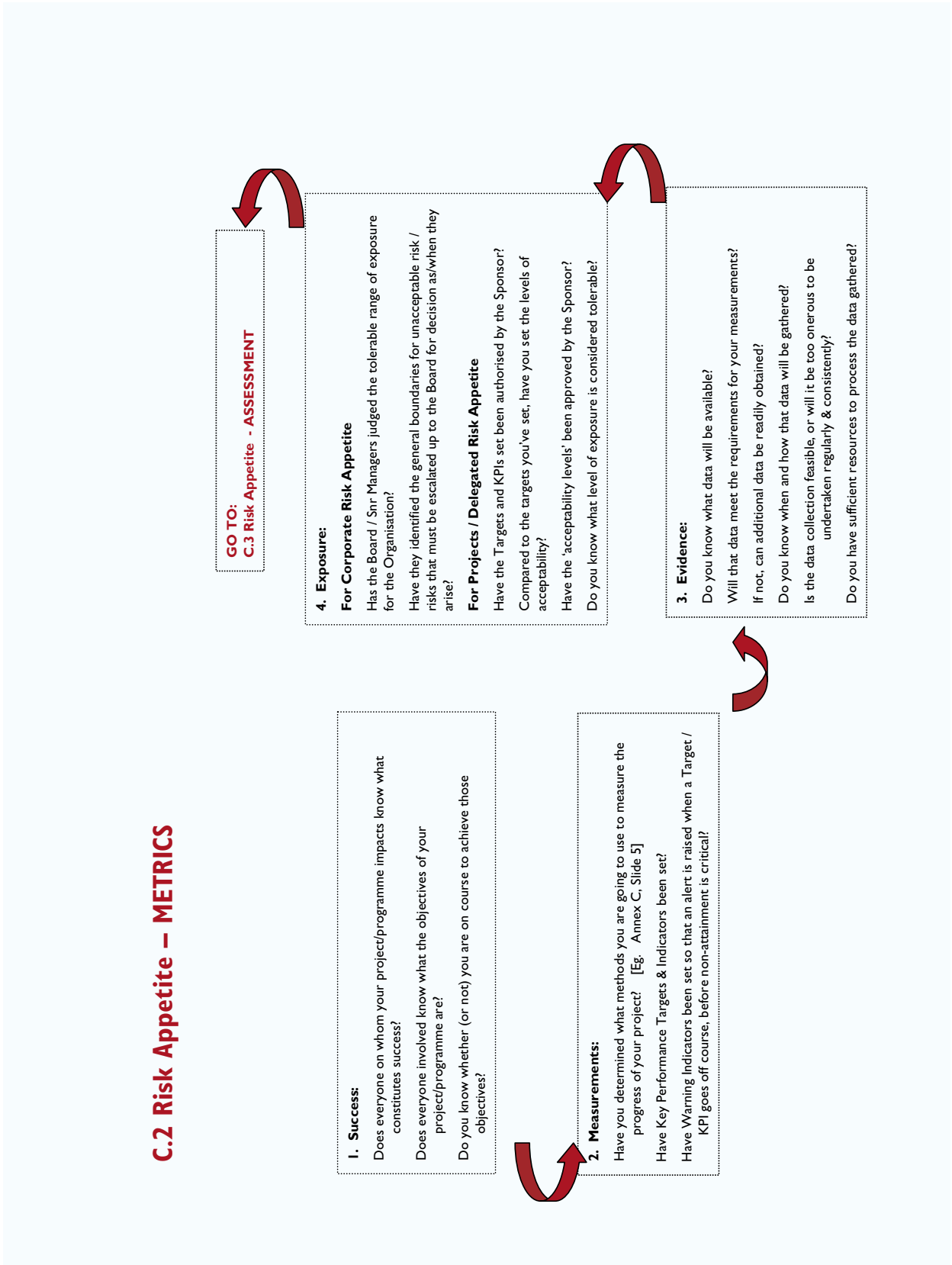
B

DISCUSSION FRAMEWORK

	1 Averse	2 Minimalist	3 Cautious	4 Open	5 Hungry
	Avoidance of risk and uncertainty is a key Organisational objective	**Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.**	**Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.**	**Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.).**	**Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).**
Category of Risk	**Example behaviours when taking key decisions…**				
Reputation and credibility	≠Minimal tolerance for any decisions that could lead to scrutiny of the Government or the Department.	≠Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the Government or the Department.	≠Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the Government or the Department should there be a failure.	≠Appetite to take decisions with potential to expose the Government or Department to additional scrutiny but only where appropriate steps have been taken to minimise any exposure.	≠Appetite to take decisions that are likely to bring scrutiny of the Government or Department but where potential benefits outweigh the risks.
Operational and policy delivery	≠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 making authority. ≠General avoidance of systems / technology developments.	≠Innovations always avoided unless essential. ≠Decision making authority held by senior management. ≠Only essential systems / technology developments to protect current operations.	≠Tendency to stick to the status quo, innovations generally avoided unless 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 considered 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.
Financial/VFM	≠Avoidance of financial loss is a key objective. ≠Only willing to accept the low cost option. ≠Resources withdrawn from non-essential activities.	≠Only prepared to accept the possibility of very limited financial loss if essential. ≠VfM is the primary concern.	≠Prepared to accept the possibility of some limited financial loss. ≠VfM still the primary concern but willing to also consider the benefits. ≠Resources generally restricted to core operational targets.	≠Prepared to invest for reward 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 potential opportunities.	≠Prepared to invest for the best possible reward and accept the possibility of financial loss (although controls may be in place). ≠Resources allocated without firm guarantee of return – 'investment capital' type approach.
Compliance – legal / regulatory	≠Avoid anything which could be challenged, even unsuccessfully. ≠Play safe.	≠Want to be very sure we would win any challenge.	≠Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	≠Challenge will be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	≠Chances or losing are high and consequences serious. But a win would be seen as a great coup.

C A GUIDED WALKTHOUGH OF THE ASSESSMENT PROCESS TO DETERMINE RISK APPETITE




C.2 Risk Appetite – METRICS
1. Success:
Does everyone on whom your project/programme impacts know what constitutes success?
Does everyone involved know what the objectives of your project/programme are?
Do you know whether (or not) you are on course to achieve those objectives?
2. Measurements:
Have you determined what methods you are going to use to measure the progress of your project? [Eg. Annex C, Slide 5]
Have Key Performance Targets & Indicators been set?
Have Warning Indicators been set so that an alert is raised when a Target / KPI goes off course, before non-attainment is critical?
3. Evidence:
Do you know what data will be available?
Will that data meet the requirements for your measurements?
If not, can additional data be readily obtained?
Do you know when and how that data will be gathered?
Is the data collection feasible, or will it be too onerous to be undertaken regularly & consistently?
Do you have sufficient resources to process the data gathered?
4. Exposure:
For Corporate Risk Appetite
Has the Board / Snr Managers judged the tolerable range of exposure for the Organisation?
Have they identified the general boundaries for unacceptable risk / risks that must be escalated up to the Board for decision as/when they arise?
For Projects / Delegated Risk Appetite
Have the Targets and KPIs set been authorised by the Sponsor?
Compared to the targets you've set, have you set the levels of acceptability?
Have the 'acceptability levels' been approved by the Sponsor?
Do you know what level of exposure is considered tolerable?
GO TO:
C.3 Risk Appetite - ASSESSMENT

C.3 Risk Appetite – ASSESSMENT

1. Tolerability:
Do you know what level of risk you consider to be tolerable, given the exposure?
Are the risks uncertain?
If so, do you know why?
Can the project/programme be considered radical/innovative?
Does your project/programme give rise to an opportunity to exploit positive impacts?
Does your project / programme give rise to an opportunity to exploit positive impacts?
If the inherent risks are tolerable, can they be accepted as they stand?

2. Address Risks:
If the inherent risks are not acceptable –
Is there a positive Cost/Benefit Analysis to support taking on the risk(s) of the project?
Are you able to 'treat' , 'transfer' or terminate the risk?
[See boxes 3, 4 & 5]

3. 'Treat':
Can risks be treated?
If yes –
Will/have mitigating management controls be put in place?
Will the residual risks be acceptable?

4. 'Transfer':
Can the project/risks be transferred?
Are you aware of the residual responsibility you will have for the project?
Will the contract be closely managed?
Will there be monitoring of project progress against the business objectives?
Can you handle any on-costs or ramifications of outsourcing the project/programme?

5. 'Terminate':
Can the project/risk be terminated? If yes - Will the impact be significant? Are you aware of the consequential risks?
If no – Are you a provider of last resort? Can the service provision be changed? Can the means of delivery be changed? Will any changes need innovation?

6. Reputation:
Are you fully aware of the reputational risks associated with the project/programme?
How much impact will the project/programme have on your Organisation?
Can you wholly abdicate responsibility for the project/programme?
What are the public & media perceptions of your risks – do you need better communication?

7. Resource Availability:
Can you readily finance the project/programme?
Will you be dependent upon 3rd party funding?
Is this funding secure?
Do you have enough people, with the right skills in-house, to be able to service the project/programme in addition to their current workloads?
If not - Can existing work be deferred or delegated? Can you afford to outsource/buy-in skills?
Are you dependent upon key personnel?
Are you providing sufficient training & work experience to provide for succession planning?
Are you dependent upon new/innovative technology or systems?
Do you have sufficient time within which to comfortably deliver the project/programme, allowing for contingency arrangements?

8. Decision Making:
Does the project/programme fit with the business's priorities?
What type of project is it – speculative, pilot or standard?
Is it mission critical?
Is delivery reliant upon inter-dependencies with other Govt orgns, contractors or other 3rd parties?
Is the size of the project relative to the the size of the business?
How good is your delivery performance?
Is there a history of legacy issues to be tackled?
Do you have a tendency to repeatedly face the same difficulties (ie PIR lessons are not being learnt / there is little embedded learning.

C.4 Risk Appetite – Examples of Metrics and Risk Analysis Techniques

See C.2 Risk Appetite – Metrics

Data analysis:

- Statistical Means, Variance, etc.
- Distributions – Gaussian distribution (normal), Poisson (e.g., radioactive decay), etc.
- Correlation coefficient (-1 to 1)
- Regression analysis (R^2)
- Rate & Quotient analysis
- Delphi analysis (qualitative)

Risk analysis and quantification:

- Event Bow Tie (Cause-Event-Effect)
- Failure Mode Effects [and Criticality] Analysis (FMEA)
- Critical Path Analysis
- Bayesian Belief Networks
- Traffic light systems
- Monte Carlo simulation

Human resources:

- Average age
- Average salary
- Ratio of managers to staff
- Retention/turnover rates
- Absence rates
- Training spend per employee
- Diversity indicators
- Number of vacancies filled internally/externally
- Number of staff to number of pensioners
- Pension liabilities
- Loss Time Injury Rate

Financial:

- Value of transactions
- Volume of transactions
- Value of income
- Value of expenditure
- Capital employed
- Risk ratings

For further information please refer to:

The Green Book – Appraisal & Evaluation in Central Government

D GRAPHICAL ILLUSTRATIONS

1 A Single Matrix Approach - where risk appetite is scored against a number of broad categories that are specific to the Organisation/Area/Activity being assessed

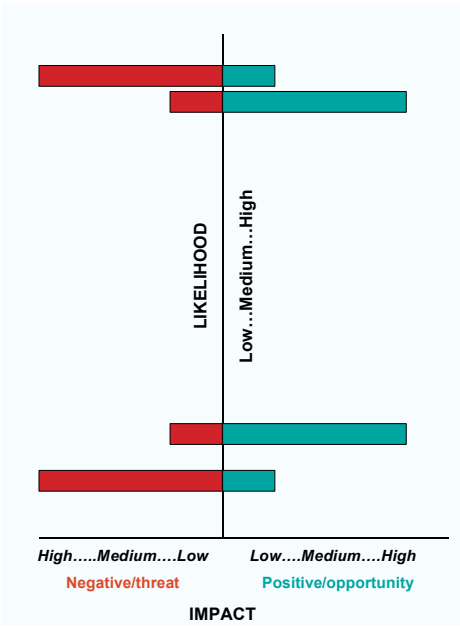
2 A Hierarchical Matrix Approach - which recognises that risks occur at different levels in an Organisation (from strategic down to operational). Unacceptable exposure to risk can occur at any level and an effective escalation procedure needs to be in place to ensure that these risks can be escalated to senior managers quickly.

1. RISK APPETITE - Single Matrix

Single-Matrix Approach [Graphical Method]

At root level, this can be used to plot each of the risks associated with a particular programme/project.

Collectively, it can be used to plot the overall rating of each programme/project, to illustrate the portfolio risk



Single-Matrix Approach [Tabular Method] - Version 1

At root level, this can be used to plot each of the risks associated with a particular programme/project.

Collectively, it can be used to plot the overall rating of each programme/project, to illustrate the portfolio risk

	IMPACT				
Likelihood	1 = VL = Insignificant	2 = L = Minor	3 = M = Moderate	4 = H = Major	5 = VH = Catastrophic
5 = VH = Almost					
4 = H =					
3 = M = Possible					
2 = L =					
1 = VL = Rare					

=> Tolerability Level

Key: **[Example - Would need to be adjusted to reflect delegation levels appropriate to each level]**

VH =	Catastrophic Consequences / Almost Certain to happen / Unacceptable unless external approval gained - eg. Govt Minister, OGC	Control: Urgent Remedial Action, Senior Level Monitoring
H =	Major Consequences / Likely to happen / Acceptable only with Board Authorisation	Control: Remedial Action, Senior Level Monitoring
M =	Moderate Consequences / Possible Occurrence / Acceptable with Group Director Approval	Control: High Level Monitoring
L =	Minor Consequences / Unlikely to happen / Head of Team or Dept Approval	Control: Low Level Monitoring
VL =	Insignificant Consequences / Rare Occurrence / Line Mgr or Staff Approval	

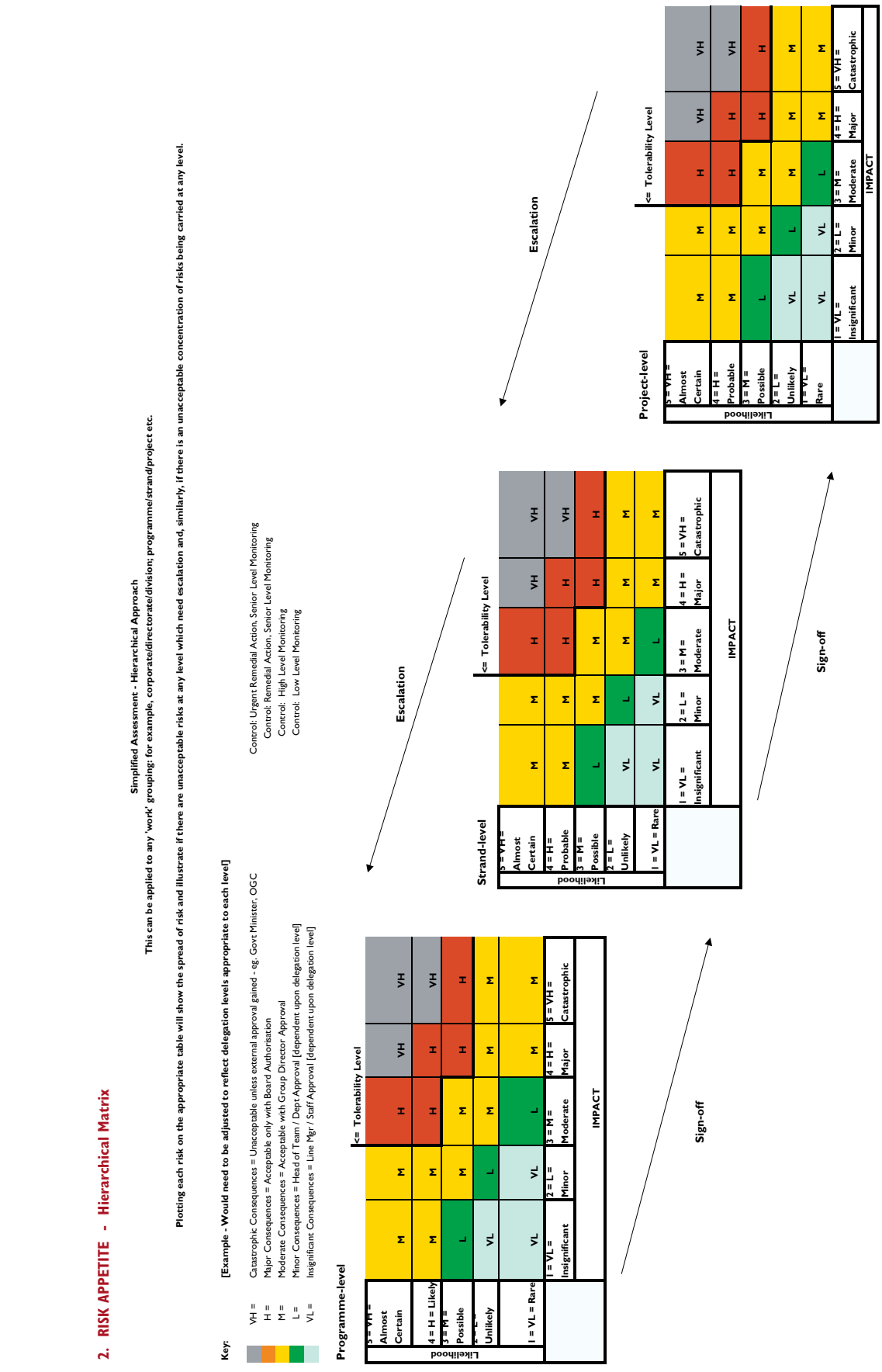
D GRAPHICAL ILLUSTRATIONS

2. RISK APPETITE - Hierarchical Matrix

Simplified Assessment - Hierarchical Approach

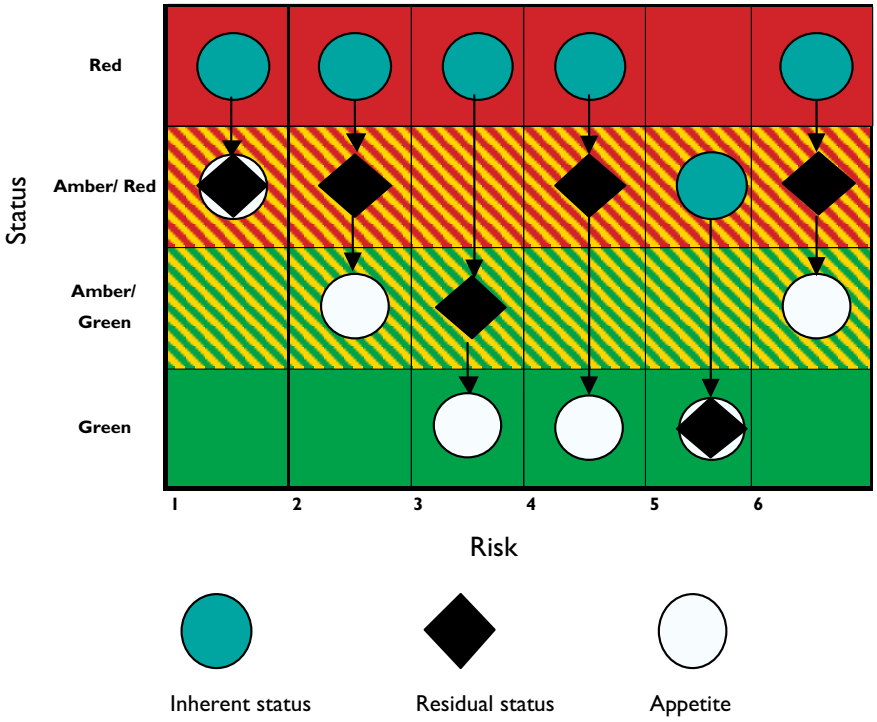
This can be applied to any 'work' grouping: for example, corporate/directorate/division; programme/strand/project etc.

Plotting each risk on the appropriate table will show the spread of risk and illustrate if there are unacceptable risks at any level which need escalation and, similarly, if there is an unacceptable concentration of risks being carried at any level.

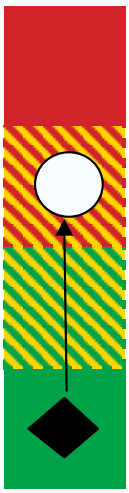


E OGC's Risk Dashboard

OGC's Risk Dashboard provides a pictorial representation of risks – individually or in portfolio – showing the appetite for each and their relationship to the risk status inherently [ie before management actions taken to control / mitigate the risk(s)] and residually [ie after management actions have been implemented].



Or



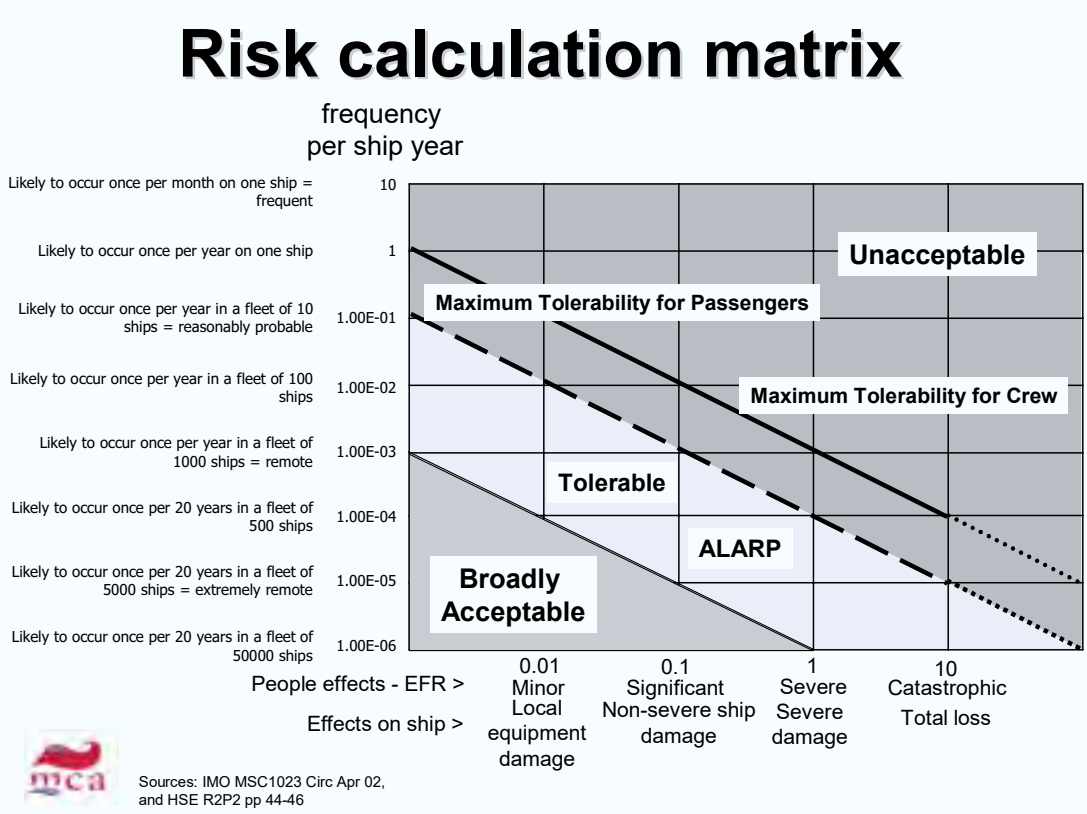
Where the appetite is higher than the residual risk, resulting in too much being spent on risk reduction due to averse perception,

F MCA Risk Matrix

The Maritime and Coastguard Agency (MCA) is an executive agency of the Department for Transport and is responsible for implementing the government's maritime safety and environmental protection policy. The MCA is also responsible for co-ordinating search and rescue at sea through Her Majesty's Coastguard, and checking that ships meet UK and international safety rules.

In undertaking assessments of risk for technical maritime safety risk in the commercial shipping sector the MCA follows good practice in the maritime sector. Other approaches are currently used for assessing risk against appetite for cargo losses and environmental harm.

One broadly acceptable measure is the equivalent fatality rate (EFR). This uses the computation that 100 minor injuries and 10 major injuries are each equivalent to a single fatality. The notion of an equivalent fatality rate is drawn from the 'value of preventing a fatality' (VPF) and 'willingness to pay' (WTP), concepts which underpin the economic evaluation of casualties in the UK. Coupling EFR with the As Low As Reasonably Practicable (ALARP) and tolerability principles expounded by the Health and Safety Executive, and the Formal Safety Assessment principles agreed by the International Maritime Organization, provides a framework to explore the MCA's risk appetite for commercial shipping, that is, whether a particular position on risk is acceptable. As such the framework is also a useful tool for communication and discussion with stakeholder groups. The framework is illustrated below.



MCA'S 'COST, PERFORMANCE, REPUTATION, PROBABILITY CRITERIA

Financial impact (In a given Financial Year)

Low 1	Medium 2	High 3
Costing <£100k (as a guide) It is likely to cost this much to manage this risk/gain as much as this from the opportunity compared with similar projects or programmes. Significant stakeholder interest in the level of loss/gain. Impact on/improvement to service delivery in other areas to due to financial impact of this occurrence. It is very likely that the MCA Executive Board will wish to exercise management of this risk until its financial impact is reduced to medium or below. The head of Finance and Contracts is to be alerted when a risk reaches cost impact 3.	**Costing £100k to £1m (as a guide)** It has often cost around this sum to manage this risk/ gain as much as this from the opportunity in similar projects or programmes. Moderate stakeholder concern. Some impact on/improvement to service delivery in other areas due to the financial impact of this occurrence. The Head of Finance and Contracts is to be alerted when a risk reaches Cost Impact Level 2.	**Costing > £1m (as a guide)** It is likely to cost about this much to manage an occurrence of this risk/we might gain as much as this from the opportunity. Little stakeholder concern and can normally be managed in the directorate/division/branch concerned, with normal reporting to the Head of Finance. Little impact on/improvement to service delivery in other areas due to the financial impact of this occurrence.

Performance impact

Performance		
Low 1	**Medium 2**	**High 3**
Has a low level impact on the ability of the Agency to deliver key services. Not the end of the world… The impact would be significant at the branch or area level, but would be controllable and would not affect the wider Agency. An aspect of a Ministerial Target may be affected but the overall target is likely to remain unaffected.	Has a medium level impact on the ability of the Agency to deliver key services. Minor legislative or policy requirement may not be transposed/delivered. Key milestones to major project or initiative slip. Would have a significant impact at the directorate or regional level that may lead to a wider Agency impact.	Has a high level impact on the ability of the Agency to deliver key services. Major legislative requirement is not delivered with potentially serious implications. Major failing in the delivery of a key project or initiative. Significant impact on the delivery of Agency major projects and initiatives.

REPUTATION IMPACT (formerly TIME IMPACT)

Likelihood

Performance		
Low 1	**Medium 2**	**High 3**
Negligible criticism/negativity. A low level interest in a particular activity of the Agency. A sideline in specialist press. Managed situation, with the Department and the Minister informed with briefings.	**Medium level criticism/negativity.** Some national public or media criticism lasting a week. Sustained criticism over 3-4 months amongst local press and public and/or specialist press e.g. Lloyds List or NAUTILIS Telegraph. Could take up to 3 months to restore credibility with parent department or external stakeholder such as shipping companies. Reputation tarnished in the longer term, the Minister maybe criticised for actions undertaken by the Agency.	**High level criticism/negativity.** Widespread criticism originating from all quarters of the press, the General Public and other Ministers in Government. It will take more than 6 months to restore creditability amongst stakeholders and the parent department. Reputation is irreparably damaged. A massive downturn in flagging-in and confidence amongst existing stakeholders for future decisions we take. The future of the Agency could be at stake.

Probability

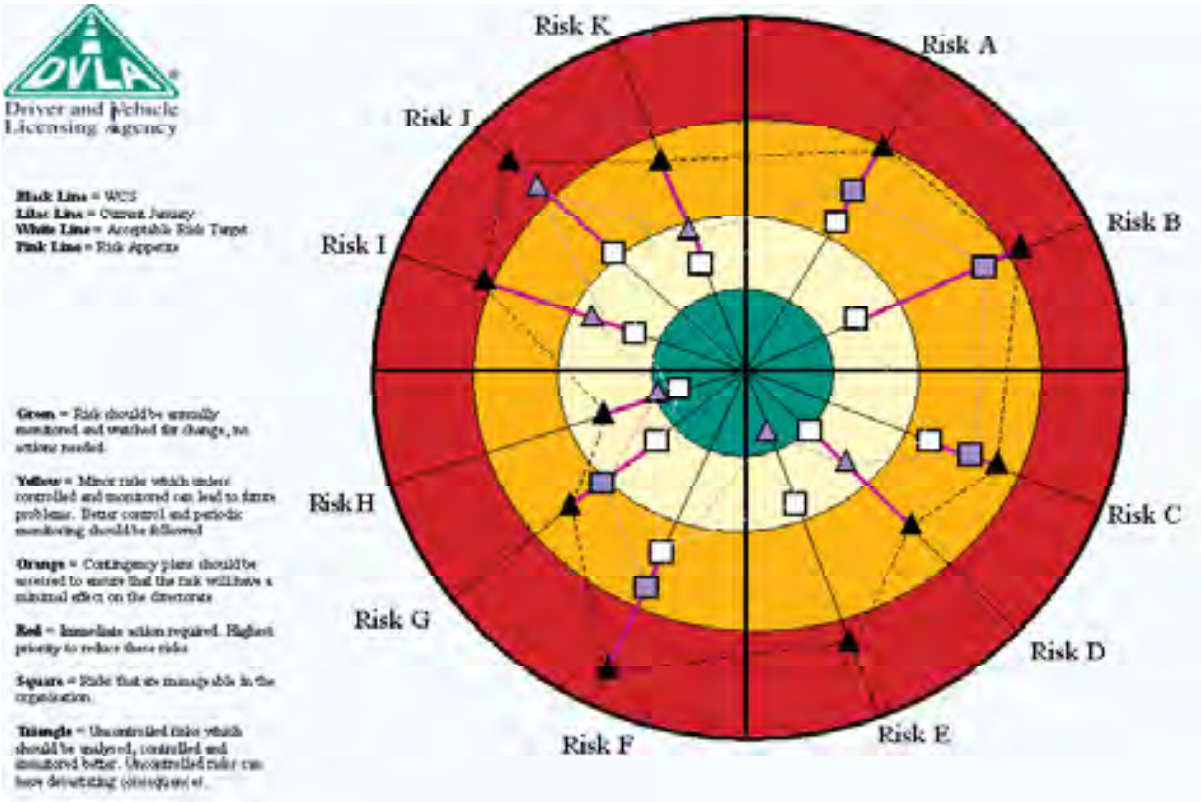
3	There is more than a 50% chance of this risk occurring.	It is highly likely that the risk will materialise. This occurrence is known to occur in similar projects and programmes. It happens frequently in other Government Departments. There is a strong and public history of occurrence. It has happened before in the MCA. It is likely to happen more than once in the financial year. It has happened recently and publicly. It is more likely to occur than not to occur. Should have seen it coming. The occurrence of this risk could be associated with poor management and failure to judge the likelihood of it happening despite strong and public evidence of its existence and the rate of incidence. Alternately, this might be a risk that is completely unavoidable despite all management intervention; effort is directed to minimising its impacts rather than its likelihood of occurrence. The emergence of this opportunity is associated with good management and is an example of best practice and the ability to learn from past programmes and to apply a careful analysis of the potential outcomes. There was a clear opportunity that can be relied upon with reasonable certainty. It has taken considerable work to accrue the benefits.
2	There is between 25-50% likelihood of this risk occurring.	It is reasonably likely to occur. More likely not to occur than to occur. Much less public history of occurrence. Does not often occur in the MCA. Not normally associated with these types of programmes and projects. It sometimes happens in other government departments. Might have seen it coming. No data and very difficult to predict. This could have turned out to be a risk or an opportunity depending on many other factors.
1	There is below 25% likelihood that this risk will occur.	This has never occurred and it is very unlikely to occur. Has not occurred in the MCA. Unlikely to occur. Not associated with this type of programme and project. Little public history of occurrence. It does not often happen in other government departments. Could not have seen it coming. Most unfortunate if this risk occurs despite analysis and strong evidence of it being very unlikely. Nasty shock. Very lucky to have this opportunity emerge from a situation where there was little expectation of such a favourable outcome. Nice surprise. Alternately this could be an opportunity that is definitely there, but where there is a low chance of reaping the benefits in full, or an opportunity that cannot be clearly defined at this stage.

G DVLA's Dartboard

This is a prototype diagram that DVLA are currently looking to trial. Whilst this looks complex hopefully the explanation will reveal how simple this is!

Think of the circle as a classic risk management traffic light (but with 2 ambers!!) each of the lines relates to a specific risk off the corporate risk register, the 3 markers relate to, 1. The worst case scenario- the black triangle is the inherent risk, 2.the white square is the best case scenario – think of this as minimising the residual risk, and the purple symbol, gives the current position.

So to take specific examples, is risk E being over managed as the activity, purple symbol, is being managed down to a target that may exceed the organisations requirement. Similarly, for risk J do we want to manage this more aggressively, or perhaps be more realistic on how much risk to accept?



H QUANTIFICATIONS AND ILLUSTRATIONS

H.1 Monetary quantification is not always possible or desirable. However, if you would like to refine the judgements that you have made through following the Practitioner Guide (Chapter 2) it is possible to rate or rank those judgments according to the likelihood that the risk will occur, and the impact that it will then have on your business.

H.2 The preliminary considerations that you will need to take into account prior to attaching numerical values to risk appetite are:

1. How do you describe the likelihood that a risk will occur?

For example:

Rank	Rating	Description
1	Rare	<W% (say less than 5%) likelihood of impact happening
2	Unlikely	W% to X% (say 5 to 20%) likelihood of occurrence
3	Possible	X% to Y% (say 20% to 50%) likelihood of occurrence
4	Likely	Y% to Z% (say 50% to 80%) likelihood of occurrence
5	Almost Certain	>Z% (say over 80%) likelihood of impact happening

2. How do you describe the impact of the risks on your business?

For example:

Rank	Rating
1	Insignificant
2	Minor
3	Moderate
4	Major
5	Catastrophic

3. How do you illustrate your Risk?

For example, pictured as black, red, amber/red, amber/green, or green

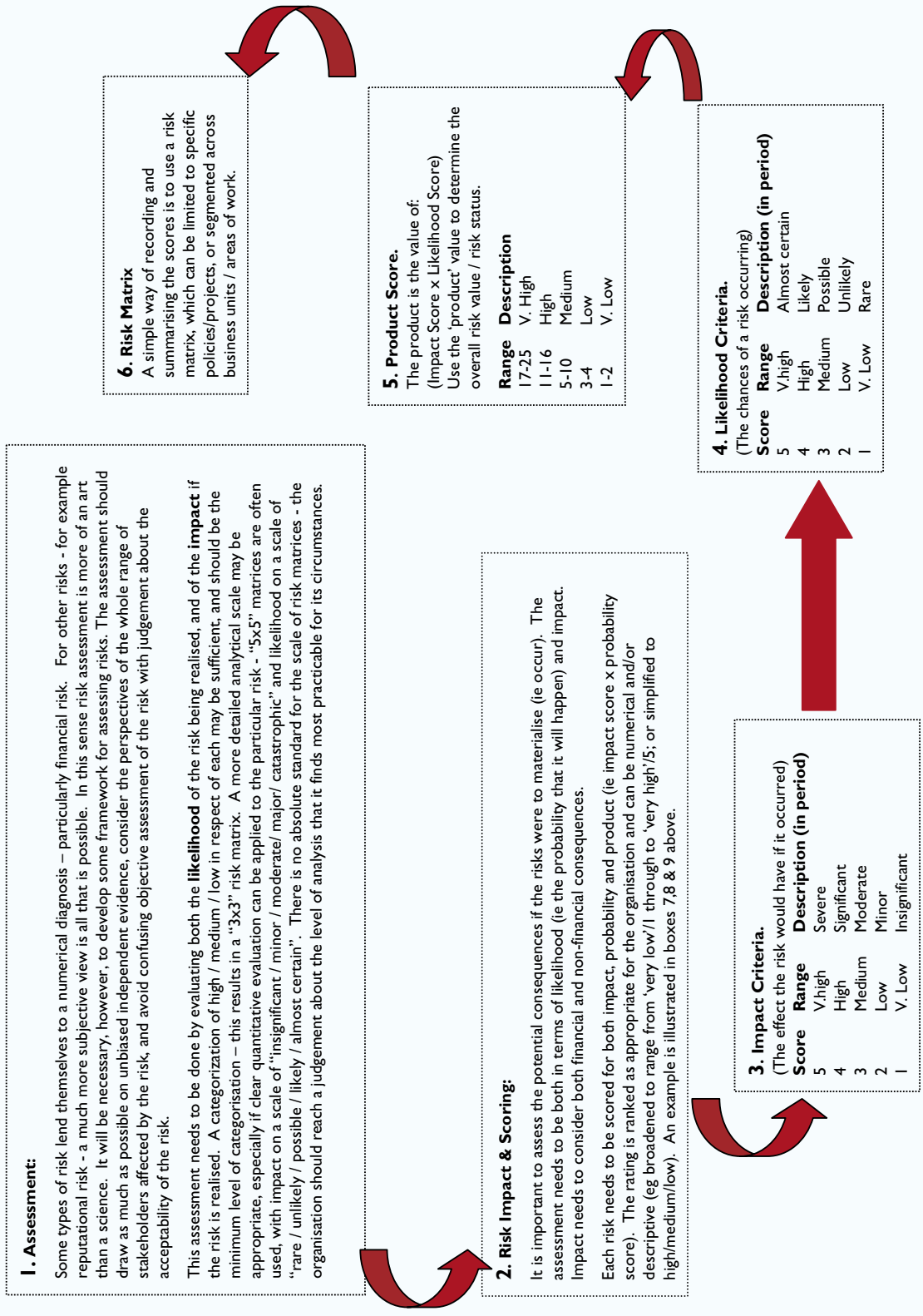
Before controls, the risk is classed as inherent. After controls/management actions the risk is classed as residual. The inherent risk will determine the original status of the risk, as below: (first rating is impact; the second is likelihood)

Colour (Status)	Rating [impact / likelihood]
Black	5/5, 5/4, 4/5
Red	5/3, 3/5, 4/4, 4/3, ¾
Amber/Red	5/2, 4/2, 3/2, 3/3, 2/3 2/4, 2/5
Amber/Green	5/1, 4/1, 2/2, 1/4, 1/5
Green	3/1, 2/1, 1/1, 1/2, 1/3

Risk Owners need to use this to assess whether their current exposure is reasonable or is in need of attention - eg is "green" or "amber/green" acceptable? – and if so for how long?

If the Residual Risk following management actions remains higher than the Organisation's Risk Appetite, it indicates that further actions are required.

NUMERICAL DIAGNOSIS - OVERVIEW



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Promoting Quality Care

Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

As revised May 2010

Contents

Glossary of Terms

Care Coordinator	The individual responsible for overseeing the work of several Key Workers.
Disengagement	Loss of contact with mental health and learning disability services by the service user.
Dual diagnosis	Used to describe people with a combination of drug and alcohol misuse and mental illness.
Key Worker	The individual with responsibility for co-ordinating the care of mental health or learning disability service users with complex needs and for communicating with others involved in the service user's care.
Mental illness	A range of diagnosable mental disorders that excludes learning disability and personality disorder.
Risk	See Annex C
Risk Assessment	See Annex C
Risk Factor	See Annex C
Service User	An individual who is treated and cared for in secondary mental health and learning disability services for his/her mental health, behavioural or psychological problems. Such individuals may live in their own homes, are staying in care, or are being cared for in hospital.
Vulnerable Adult	A person, aged 18 or over, who is, or may be, in need of community care services, or resident in a continuing care facility by reason of mental or other disability, age or illness, or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

1.0 Introduction and Purpose

1.1 Introduction

A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that an individual may present forms part of his/her overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Risk assessment and management is a fundamental part of care within mental health and learning disability services, the responsibility for which is part of the practice of all service providers. Currently, the understanding and practice of good risk assessment and management is becoming increasingly important as local mental health and learning disability services continue to develop a more community-based model of provision. There is, however, great variation in process and procedure between service providers, yet the repetitive nature of serious adverse incidents and the findings of Independent Inquiries suggest a certain consistency to the failures in the system and highlight the need for a more standardised approach, as proposed by this regional guidance.

Whilst it is unrealistic to expect that all adverse incidents can be prevented, the risks for each individual can still be identified, managed and adverse outcomes possibly avoided. In the vast majority of cases, the safe and effective care and good professional practice provided by mental health and learning disability services minimise any risks identified.

However, a significant number of Serious Adverse Incidents (SAIs) do occur, particularly in mental health services and, therefore, a mechanism must be put in place to ensure learning is shared and acted upon. Local mental health and learning disability services report SAIs as part of routine practice, in keeping with the ethos of openness and “learning the lessons”.

1.2 Purpose

This guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public).

Not all risks posed by people with mental health problems are linked to their mental health condition: it is predominantly the latter which fall within the ambit of mental health professionals to influence.

This guidance aims to embed risk assessment and management into daily practice and ensure that all individuals who require treatment, care and support from secondary mental health and learning disability services receive this, based on an individual assessment of their care needs. It highlights good practice in the assessment and management of risk for all service users.

The experiences of those working in the field of mental health and learning disability, key lessons from Independent Inquiry reports and SAIs have been drawn together into this document. It details elements and processes that mental health and learning disability service providers should include in their operational protocols and procedures to ensure that effective assessment, care planning and discharge planning take place within the context of risk assessment and management.

Whilst this document replaces *'Discharge From Hospital And The Continuing Care In The Community Of People With A Mental Disorder Who Could Represent A Risk Of Serious Physical Harm To Themselves Or Others'* (DHSSPS 2004a), considerable work has already been undertaken within Health and Social Care (HSC) Trusts since the publication of the 2004 guidance to put in place relevant protocols and procedures. It is important that such work is built upon by the implementation of this new guidance.

1.3 Which Services Does This Guidance Apply To?

Adult Mental Health Services

This guidance and its principles of risk assessment and management are applicable to all secondary mental health services operating within all treatment environments (including hospital inpatient and community-based settings). It is also to be applied across services for co-morbid substance misuse and services for functionally mentally ill older people.

This guidance applies equally to people in contact with mental health services but without a defined functional mental illness, such as people with a personality disorder. Similarly, the guidance is applicable to those in contact with mental health services and who are in settings outside the health and social care sector, such as police stations or prisons.

Specialist Mental Health Services and Learning Disability Services

The broad principles of this guidance should be applied to any individual receiving care and treatment from learning disability and specialist mental health services, i.e. child and adolescent mental health services (CAMHS), forensic mental health and learning disability services and specialist substance misuse services. Supplementary guidance in relation to these services is contained in the addenda in this document.

Services Provided by Non-statutory Organisations

It is the responsibility of HSC organisations to ensure that this guidance is implemented within those non-statutory organisations contracted to provide care and treatment to service users. HSC organisations must also ensure that staff in these organisations receive appropriate training. All agents making a referral to secondary mental health and learning disability services must adhere to this guidance in communicating the appropriate risk information.

1.4 Objectives

The overarching aim of this document is to act as supportive guidance for health and social care staff within mental health and learning disability services to proactively manage the risk of harm and to deliver safe, effective care provision for service users, their families, their carers and for staff.

The objectives which this guidance sets out to achieve are to:

(1) Improve the safety and quality of services available to service users and their families/carers;

(2) Promote consistency and standardisation of best practice which is evidence-based across all care settings in Northern Ireland;

(3) Support fully integrated mental health and learning disability services and interfaces between these services and other service areas, such as family and child care;

(4) Facilitate regional reporting of adverse incidents and dissemination of associated learning; and

(5) Promote good practice which recognises the strengths of service users.

In achieving these objectives, it is necessary to take account of other developments including the modernisation and reform of mental health and learning disability services following the *"Bamford Review of Mental Health and Learning Disability (Northern Ireland)"* (The Bamford Review) and support for the safety and quality of services through the development of Mental Health and Learning Disability Service Frameworks for Northern Ireland.

This guidance will inform the future work of the Regulation and Quality Improvement Authority (RQIA) within mental health and learning disability services, both in terms of governance reviews and in relation to the future discharge of its functions under the Mental Health (Northern Ireland) Order 1986, through assessment of the application of the risk assessment and management principles it contains.

In preparing this document, account was taken of the statutory duties imposed on public bodies by Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998. An Equality and Human Rights screening exercise was carried out which showed that a full Equality Impact Assessment was not required.

2.0 Good Practice Principles

There are several principles for good practice upon which the development of this guidance has been based.

Each of the principles below should be integrated into the everyday practice of individual mental health and learning disability care professionals and the multidisciplinary teams within which they work. Mental health and learning disability provider organisations should ensure that staff work in an environment conducive to applying these principles.

Working With Service Users and Carers

(1) Risk management should be person-centred and facilitated in collaboration with the service user and his/her family/carers;

(2) Service users must be assisted to harness their strengths and protective factors to contribute to their own risk reduction;

(3) Assessment of risk needs to include highlighting both the negative and positive aspects of any situation.

Team Working

(4) Risk assessment and management is the shared responsibility of all health and social care professionals. It requires balancing the opinions of different individuals and organisations;

(5) Risk management should be part of a coordinated approach with the relevant services and agencies which combine their efforts to care for service users;

(6) Individual practitioners must be confident to make positive risk management decisions within a supportive organisational culture;

(7) Both clinical and managerial supervision are fundamental to developing safe and effective risk management practice;

(8) A clear system of organisational learning is necessary to ensure key risks in mental health and learning disability services are identified, shared and acted upon. In so doing, services must strive to achieve positive risk management.

Risk Management Process

(9) Risk can only be minimised and not completely eliminated or avoided. It must be recognised, assessed and managed, as far as is possible;

(10) Risk strategies must adhere to evidence-based practice, where available, and should use a formulation approach with structured professional judgement to translate risk assessment information into appropriate risk management plans;

(11) Risk is dynamic and occurs in a context resulting from the interaction between individuals, situation and environments. Assessment is an ongoing process, recognising that risk factors will vary in significance for each individual service user as his/her circumstances change;

(12) Risk assessments and management plans should be regularly updated and reviewed as part of the overall care plan;

(13) As risk assessment is part of routine practice, training must be ongoing to ensure staff competency is maintained.

Communication

(14) Effective verbal and written communication is fundamental to risk minimisation. Systems should be in place to ensure that communication processes are sufficient to minimise potential breakdown;

(15) Good record-keeping and appropriate sharing of risk information are vital components in the management of risk. Confidentiality within accepted parameters should not be a barrier to effective communication (see Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf*);*

(16) Communications should be in a format that optimises the likelihood of service user comprehension and participation. For clients who do not have the capacity to fully understand the risk management process, it is good practice to consider the appointment of an independent advocate.

3.0 Fundamentals of Risk Management

3.1 Recovery and Positive Risk-Taking

The concept of *"recovery"* recognises that people with a long-term mental illness should not be defined by it alone: they have the right to lead a meaningful life beyond their illness. Mental health services must support personal recovery, move beyond risk avoidance and towards positive risk taking, by providing effective care that is personally meaningful to the individual service user and his/her family/carers.

Such recovery-based practice aims to empower the service user through supporting choice, responsibility and self-management and emphasises that treatments, interventions and support must be delivered in consideration of how the service user wishes to live his/her life[1,2]. This involves a shift from the traditional 'assessment-treatment-cure' model of mental health care to engaging, negotiating and collaborating with the service user in the self-management of his/her mental illness[3]. It is important to encourage the service user to take personal responsibility for his/her care.

From a learning disability perspective, this approach reflects the social model of disability recognised within learning disability services.

Positive risk management acknowledges that it is not possible to eliminate all risk of harm, and that risk management plans will inevitably include decisions regarding care and treatment options that carry with them some risks[4]. Reasonable risks must be taken to develop an appropriate positive risk management plan, which is in keeping with the service user's plans for recovery.

It is important that there is an awareness of the risks that must be minimised (i.e. harm to self, harm to others, harm to children/vulnerable adults, and harm from others) and the risks that people have a right to experience in order to progress towards their goals of recovery[5].

Positive risk management is characterised as including[6]:

[1] *Robert et al (2008)*
[2] *Shepherd et al (2008)*
[3] *RPsych / SCIE / CSIP (2008)*
4 DH (2007a)
[5] *See 6*
[6] *Morgan, S. (2007)*

- *Collaborative working between mental health professionals, the service user and his/her family/carer;*
- *A clear understanding of the responsibilities and consequences for actions that a service user can be reasonably expected to follow;*
- *Taking decisions based on a range of choices available;*
- *Full appreciation of the service user's strengths and weaknesses – based on previous experience;*
- *The availability of support should the positive risk management plan breakdown.*

3.2 Recognising the Strengths of Service Users

Whilst recovery-orientated services may increase risks, it is sometimes necessary in order for the service user to learn and grow. Avoiding all risk is not possible or desirable for either the service user or the general public. Choosing the safest possible option for care and treatment can be dis-empowering for the service user and counter-productive for his/her recovery.

Overstating risks and being overly risk averse carries with it human rights implications for the service user and resource implications for mental health and learning disability services. It can lead to unnecessary exclusion from services, stigmatisation and breakdown in the relationship between the service user and the mental health team.

A balance has to be struck between risk and the individual service user's ability to recover and participate in a normal life. Service users should receive treatment in the least restrictive environment to allow them to take personal responsibility for managing their own condition and avoid creating complete dependency on mental health and learning disability services.

Defensive practice is inappropriate, as it creates a focus on staff rather than the service user. Treatment should always be based on the values of holistic service user-centred care. Mental health and learning disability professionals must ensure that their practice is defensible rather than defensive[7].

[7] *See 4*

"As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time" (DH 2007, 8).

3.3 Safety

The central focus of mental health and learning disability services should be individual and personal autonomy. Risk assessment and management is the proportionate modification of and interference with that autonomy to promote the safety of the service user, his/her family/carers, the general public and mental health staff.

There is always the need to achieve a realistic balance between risk and restrictive practice. An excessively lenient or paternalistic approach serves to dis-empower clients and professionals.

3.4 Partnership Working With Service Users and Carers

Partnership working with service users and their family/carer(s) is one of the most important elements in effective risk assessment and risk management planning. A three-way collaboration of the service user, his/her family/carer and the mental health/learning disability team is essential to planning care[8]. Positive working relationships are based on knowing the service user and his/her individual circumstances. Family members and carers know the service user best and have first-hand information about his/her history, behaviours and situation.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment. In order to determine if the arrangements are working, specific measures of success and intended positive outcomes must be documented.

On certain occasions, individual service users may choose not to cooperate, or even obstruct the implementation of a care plan. On these occasions it must be recognised that such uncooperative behaviour will have significant implications for services attempting to manage and ameliorate risk.

[8] *DH (2007a)*

3.5 Effective Risk Communication

Good communication processes in mental health and learning disability services (both statutory and non-statutory) are particularly important when working with risk. Findings from the various Independent Inquiries in recent years have highlighted serious failings in the communication of service user information which have contributed to the tragic outcomes. Often information indicating an increased risk existed but had either not been communicated and acted upon, or had been overlooked or played down[9].

Therefore, it is essential that information available is recorded and communicated to all those who need to have access to it in order to care for the service user and protect him/her from harming him/herself or others. In completing assessments of risk, information should be shared with other agencies/individuals, where necessary, due to specific risks and in keeping with policies and professional guidance in respect of confidentiality. In recording and sharing such information, clarity is crucial.

[9] *Morgan S. (2000)*

4.0 Working with Risk as Part of Everyday Practice

Working with risk in mental health and learning disability services as part of the overall care planning process should have two main components: risk assessment, which seeks to identify the specific risks in an individual; and risk management, which is a statement of the plans of treatment and support for the service user as well as individual responsibilities within the multidisciplinary team.

Risk can be minimised but not eliminated. It is dynamic, continually changing according to the individual service user's circumstances. Assessment, therefore, can only have a short-term time perspective and must be subject to review as frequently as the situation demands.

Risk relates to the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others[10].

This guidance focuses on four categories of risk:

- *Risk of harm to self (e.g. deliberate self harm/suicide/self neglect);*
- *Risk of harm to others (e.g. homicide/violence/aggression);*
- *Risk of harm to children/vulnerable adults (either through acts of omission or commission);*
- *Risk of harm from others (e.g. domestic abuse/sexual, physical, emotional abuse/exploitation).*

4.1 The Risk Assessment Process

Risk assessment contains the following tasks:

- *collecting and communicating information on risk behaviour(s);*
- *identifying causes and consequences of risk behaviour(s);*
- *considering individual static and dynamic factors;*
- *identifying external risk factors (e.g. service issues);*
- *formulating a risk statement based upon risk factors and protective factors;*

[10] *Morgan S (2000)*

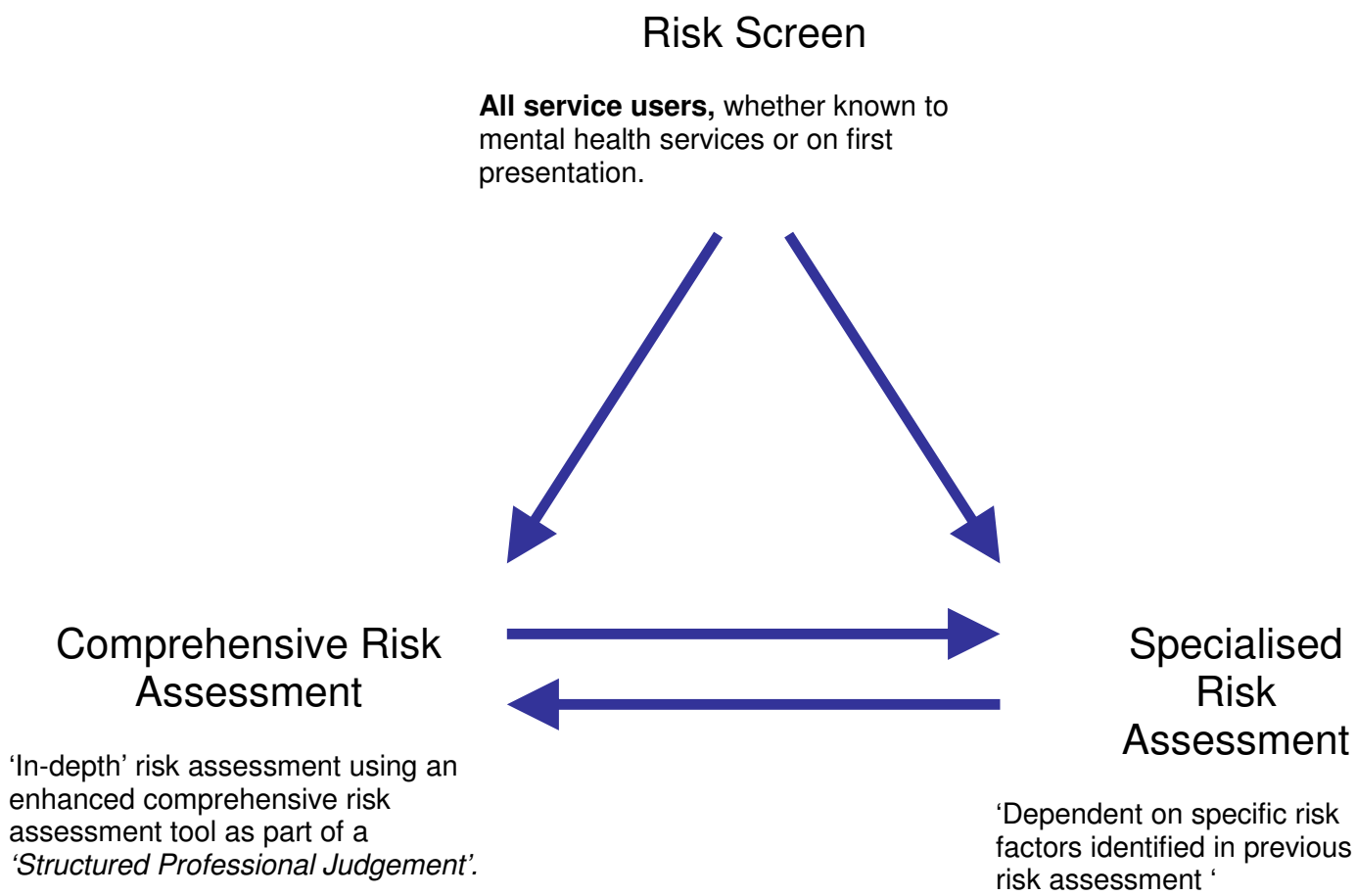
- *developing risk reduction and management plans; and*
- *monitoring, feeding back, evaluating and modifying plans.*

Risk assessments should build on information collated at each step rather than being separate exercises, otherwise there is duplication for users and carers and important information may be lost at each assessment point.

It is good practice that EVERY individual referred to secondary mental health services should receive an initial screening for risk. This is considered to be part of routine mental health assessment[11].

Service users will vary in the degree to which they will require a formal risk assessment and management plan, and there is neither the capacity nor the necessity to carry out an in-depth risk assessment for every service user. Where necessary, service users will be identified as a priority for more in-depth assessment and intervention and scarce resources can be targeted appropriately towards these individuals, proportionate to the level of risk that they pose to themselves or others.

The process for completing risk assessments should be as follows (supporting information for this can be found in **Annex C**):



[11] *(DH 2007a)*

Risk Screen

Everyone referred to mental health services should receive a Risk Screen, including:

- *People entering services for the first time in all settings; and*
- *All service users currently known to mental health services, i.e. both inpatient and community mental health services.*

All professionals making a referral to secondary mental health services, including General Practitioners, secondary care and community care staff, must provide risk information in an appropriate form, as required by their local mental health services.

A Risk Screen provides a quick overview of the broad areas of potential risk for the service user, and prompts professionals to specify their understanding of risks present on initial contact. The aim is to:

- *Ask pertinent questions about his/her history and current situation;*
- *Identify the risk factors specific to the individual service user;*
- *Enable the multidisciplinary team to make initial decisions regarding the service user's care plan;*
- *Identify those service users presenting with high risk factors which would indicate further examination and a 'Generic Risk Assessment'.*

Screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need and not a separate exercise. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Whilst it is recognised that a risk screen may be completed by an individual practitioner, particularly in community-based services, a joint multidisciplinary risk screen, carried out by at least two or more disciplines, should be undertaken for all mental health inpatients, taking note of relevant information available from the family/ carers, the Approved Social Worker and any other professionals involved in the decision to admit.

In the case of non-statutory organisations contracted by the Board and Trusts to provide care and treatment to service users, it is expected that, where any risk has been identified prior to an individual engaging with these services, the risk assessment would be carried out by secondary mental health and learning disability services "referring" the service user. From this, a risk management plan should be drawn up to support the placement. This would be regularly monitored and reviewed within the placement.

Comprehensive Risk Assessment

According to the risk factors identified in the risk screen, a clinical decision may be taken, as appropriate, to progress to a comprehensive risk assessment where it is needed for reasons of complexity, history or high risk potential[12]. The value which can be gained from this more thorough level of investigation and reflection should be determined on an individual basis.

Assessment should commence as soon as a professional judgement about its need is made. Individual multidisciplinary teams will work to consider relevant risk factors as they carry out the comprehensive risk assessment.

It is important that the widest possible range of sources (i.e. corroborative evidence from all professionals, agencies and sectors) contribute to comprehensive risk assessments.

Specialised Risk Assessment

Dependent upon their history, some service users will require specific risk assessments. Some specialised risk assessment tools are already used within specialist services to assess, for example, violence and aggression, sexual violence, anti-social or offending behaviour and suicide/self-harm. A clear and approachable overview of the main tools available can be referred to in the document *'Best Practice in Managing Risk'* (DH 2007a).

As general mental health and learning disability services and specialist services will have different levels of experience in conducting specialised risk assessments, these services should work closely together to ensure the appropriate level of assessment is carried out.

4.2 Care Planning and Risk Management

The care planning process is underpinned by information gathering and sharing. The Care Plan should provide details of the full range of support services required, focus on the service user's strengths and seek to promote his/her recovery and independence.

Key information about a service user's medical, psychological and social care needs are necessary to inform development of an appropriate care package. The Care Plan specific to each individual service user must be drawn up, as appropriate, following comprehensive assessment of his/her:

- *mental state;*
- *past behaviour;*

[12] *Morgan S. (2007)*

- *social functioning; and*
- *social circumstances.*

Identifying risk and formulating a management plan to mitigate that risk is an integral part of the care planning process and should not be seen a separate entity.

Indeed, a risk assessment is only useful if it enables the multidisciplinary team to develop an appropriate management plan to address identified risks for the individual service user[13]. Without this, a practitioner can feel stranded with nowhere to move on to.

Good clinical practice dictates that risk assessments should:

- *Be person-centred and prepared in collaboration with the service user and his/her family/carer;*
- *Involve live documents which follow the patient through their treatment journey and are updated regularly;*
- *Be reviewed routinely at regular intervals AND any time there are new concerns;*
- *Be contributed to by the entire multidisciplinary team;*
- *Be an ongoing and dynamic process, recognising that service users' risk status may vary;*
- *Inclusive of factors which reduce risk;*
- *Note any limitations of the risk assessment;*
- *Note the potential effects of not intervening and the possible unintended consequences of intervention;*
- *Inform discharge planning and the Care Plan; and*
- *Be disseminated to the service user and those involved in his/her care.*

Risk Management is the organised attempt to assess, reduce and manage identified risk to service users, their families/carers, healthcare staff and members of the public. A Risk Management Plan is an explicit statement of the planned interventions, treatment and support for the individual service user, based on the recorded risk assessment. The goal is to prevent or, where this is not possible, to minimise the likelihood of adverse incidents occurring which may result in harm to the service user and/or others.

[13] *DH (2007a)*

This is achieved by formulating a flexible Care Plan, informed by a structured risk assessment and associated risk management plan, contributed to by the widest possible number of health and social care professionals to enhance the accuracy of clinical judgement, and including the input of the service users and their carers. It is recognised that risk assessment and management processes rely on clinical judgement and cannot predict with complete certainty whether harmful outcomes will occur. It is suggested that formalised tools are used as part of risk assessment as they support effective and consistent risk management decision-making.

The outcome of risk assessments and the resulting options for managing any identified risks should be discussed with the service user and, where appropriate, his/her family/carers and advocate. Efforts must be made to include carers, and to actively encourage a partnership with the service user in contributing to formulation of a Care Plan.

The Care Plan will:

- *Identify specific interventions and anticipated outcomes;*
- *Be drawn up in collaboration with the service user and, where appropriate, his/her family/carer and advocate;*
- *Detail the contributions of all named individuals, services and agencies involved in care delivery;*
- *Record all the actions necessary to achieve agreed recovery goals;*
- *Specify a timescale by which the outcomes will be achieved or reviewed; and*
- *Include contingency and crisis plans, where appropriate.*

Efforts must be made to ensure that the service user and his/her family/ carers understand each element of the Care Plan, including the possible outcomes. The Care Plan should be countersigned by the service user and his/her family/carers to show that they have read, understood and agreed it and the associated risk management plan. Where they have not signed, a reason for this should be recorded.

A written copy of the Care Plan must be provided to all staff on the team directly responsible for delivering care and, with the consent of the service user, to any other relevant parties (including external agencies). Any individual named in a Care Plan should be involved in its development and agree his/her role in providing the services recorded in it. The Care Plan should clearly show the name of the Care Coordinator and Key Worker.

Care plans for patients in the community should be available to the patient's General Practitioner so that he/she can see the plan of interventions and

anticipated outcomes, can monitor the patient and be aware of any contingency and/or crisis plan.

The Care Plan must recognise the diverse needs of the service user reflecting his/her age, gender, ethnicity, sexuality, disability and culture. Where the service user's first language is not English, or where he/she has shown visual or hearing impairment, all reasonable steps must be taken to ensure that appropriate support is provided and that he/she fully understands the content of his/her Care Plan.

Contingency and Crisis Plans

Contingency arrangements, used to plan for known situations and prevent circumstances escalating into a crisis, should be incorporated into the Care Plan. It should detail the steps to be taken where, for example, the Key Worker/Care Coordinator is unavailable, part of the agreed Care Plan cannot be provided, or the service user is beginning to disengage from care and treatment.

A crisis plan should also be included in the Care Plan and should specify an explicit plan of action when a crisis situation is developing, i.e. the service user's mental state is rapidly deteriorating. As such crises frequently occur out-of-hours, it is beneficial to plan ahead for such an eventuality to ensure that appropriate action is taken. The Plan should detail specific triggers which are likely to exacerbate a service user's individual risk factors. Speaking to the service user and his/her family/carers about managing a crisis situation is essential, as they know their situation best, and what is most likely to alleviate any problems.

The involvement of any individual in crisis and contingency plans should be agreed with the named person, including family/carers and external agencies.

4.3 Review

Regular review dates for risk assessments and management plans must be incorporated into the Care Plan: the level of risk should dictate the frequency of review. Details as to who should take responsibility for communicating changes to the risk management plan must also be clearly recorded. Here there is a clearly defined co-ordination role for the Key Worker (community setting) and the Named Nurse (hospital setting).

Reviews are particularly necessary in the following circumstances:

- *Prior to discharge from inpatient care;*
- *At a change or transfer of care from one treatment environment to another;*

- *At a change in legal status (e.g. detention under the Mental Health (Northern Ireland) Order 1986);*

- *Following a crisis/relapse of illness/significant change in mental health condition; and*

- *Following a serious adverse incident or near miss.*

4.4 Multidisciplinary Team Meetings

Regular multidisciplinary team meetings, often also known as Team Assessment Meetings, must be held with the purpose of reviewing the service user's progress with care and treatment, including discussion of risk assessments and risk management plans. It is important that these team reviews have two or more disciplines present and that the service user and his/her family/carers are encouraged to contribute, where possible. Discussion amongst the various team members is essential for sharing information and forming a holistic view of the service user and his/her current circumstances.

Good practice suggests that ideally service users in general mental health inpatient facilities should have a formal weekly team review. All team reviews must be recorded in the patient's notes and should document the progress of the patient and agreed actions for named individuals with corresponding timescales for their completion. It is important that every professional has an equal opportunity within the team to participate in formulating the Care Plan for managing the service user's care and identified risks.

4.5 Roles and Responsibilities

It is important that individual mental health and learning disability services and their staff have clearly defined roles and responsibilities that address the key elements required for ongoing assessment and management of risk. Every member of the multidisciplinary team caring for a service user must be aware of his/her individual responsibilities in assessing and managing identified risks and the delivery of the agreed care package.

Key roles must be explicitly defined in operational policy documents, and in accordance with local arrangements, e.g. for Key Worker and care coordination roles. It is acknowledged that local arrangements have to be made for designation of such roles, nevertheless their functions and purpose must be consistent in all HSC Trusts.

The following, whilst not exhaustive, outlines the main responsibilities of each.

Named/Primary Nurse

For patients in hospital, the role of the Named/Primary Nurse is pivotal at the point of admission and onwards in identifying key issues and ensuring that care planning with acute inpatient links with all relevant community practitioners. They are also best placed in making and developing links with relatives and significant carers at an early stage of the admission process.

Key Worker

For patients in the community, the role of the Key Worker is pivotal in organising and monitoring the mental health and learning disability services needed by service users under his/her care. The Key Worker may be from any professional background within the multidisciplinary team, e.g. community psychiatric or learning disability nurse, social worker, psychiatrist, psychologist, occupational therapist. The appointment of the Key Worker, where required according to level of assessed risk, should be a formal item on the agenda of the initial care planning meeting.

The decision to appoint a Key Worker will be taken after a Generic or Specialised Risk Assessment and be allocated proportionate to the identified need, complexity and risk. The Key Worker must be named in the Care Plan.

The Key Worker should draw up a written Care Plan which addresses the holistic needs of the service user with his/her involvement and, where appropriate, his/her family, carers and/or advocate. It is vital that the Key Worker represents a single point of contact in mental health and learning disability services for the service user and his/her family/carers.

It is the duty of the Key Worker to ensure that all the necessary elements of the Care Plan are in place prior to discharge including medication, therapy, supervision and accommodation. The Key Worker is responsible for sending a copy of the patient's (written) Care Plan to all the professionals involved in providing care, including the GP and, where appropriate, to the service user and his/her family/carers.

The Key Worker must remain in regular contact with the service user and his/her family/carers, reviewing the Care Plan at frequent intervals to ensure that it is being carried out and to update it, as necessary. The Key Worker must advise other members of the multidisciplinary team when the service user’s circumstances change, particularly when this might require a review or modification of the Care Plan.

Particular efforts must be made by the Key Worker to maintain contact with service users who might pose a risk to themselves or others if they became unwell. At times, an assertive approach to care will be required when the service user is unable or unwilling to maintain contact because of the nature of his/her mental illness: the Key Worker should not rely on service users

contacting them. Arrangements for such an eventuality should be discussed with the service user and his/her family/carers at the earliest opportunity.

Where the service user is non-compliant with his/her Care Plan, e.g. not taking medication or attending clinic appointments, all practical and reasonable efforts should be made by the Key Worker and other members of the multidisciplinary team to contact the service user and resolve the situation. It is the responsibility of the Key Worker to lead and coordinate action, as well as to alert and share information with members of the multidisciplinary team and others, e.g. GP, family/carers, voluntary sector agencies who could resolve the situation or anyone who may be at risk of harm (as appropriate). Where there are serious concerns regarding the safety of the service user or the public, then immediate consideration should be given to admission to hospital and informing the police.

The caseload of Key Workers must be carefully managed to ensure the necessary level of support can be provided to all service users. Further, it is the responsibility of the person coordinating care, in liaison with the Key Worker and, if appropriate, the team leader, to have in place arrangements for a deputy who will cover both planned and unplanned absences.

Care Coordination Role

The person fulfilling the care coordination role should be a senior manager responsible for providing health and social care services in the community where the service user resides. His/her role is to support and facilitate the Key Worker and multidisciplinary team in the delivery of agreed Care Plans, to ensure that appropriate services are available, where possible, and to communicate unmet need to commissioning organisations.

The person coordinating care must maintain a close working relationship with community mental health team leaders in their capacity to organise 'deputies' and support Key Workers.

The person coordinating care must have knowledge of community services, relevant legislation, the roles of other statutory and voluntary agencies and have access to resources. He/she will oversee several Key Workers and should undertake case supervision for each. He/she should chair multi-agency reviews at intervals of six months or more frequently, as necessary, for each service user who is subject to a comprehensive risk assessment and management plan.

4.6 Recording Information

Working with risk is all about the effective communication of information. The most accurate method of ensuring that information gathered is communicated to all members of the multidisciplinary team is by documentation in a service user's notes. It is, therefore, an essential part of standard good record-keeping practice for all professionals to document information available to them.

Documentation should describe what has happened and the reasoning for taking chosen responsive actions. It should not be seen as 'defensive' practice, but as an important safeguard to explain why actions were taken in response to particular circumstances. Individual clinical risk assessments naturally suffer from limited reliability and predictive validity, but it is not a test of accuracy: rather, of how reasonable the decisions made are in terms of the clinical situation, current knowledge and standards of good practice. Therefore, a system for recording the rationale for decisions relating to the risk, both supporting action and/or inaction, must be recorded.

Risk assessment and management plans must be documented clearly and legibly, kept up-to-date and be accessible to all professionals directly involved in the care and treatment of the service user concerned. Every agreed action should have a named individual responsible for seeing it through. This should be recorded in the service user's risk management plan along with a timescale for completion.

The information available, including the efforts made to seek all sources of additional information regarding the service user, should be documented. If information is sought but not received, or there is no response from the professional contacted, this should be documented including the time, date and the person with whom contact was attempted. Information acquired from the service user, his/her family/carers and other professionals for the purpose of assessing risk is usually reliable, but not always[14]. The professional must make every effort to substantiate information received, particularly if it is received from an unknown or unreliable source.

Basic principles for recording information include:

- *Seeking any information not available and recording delays in receiving such information;*
- *Recording and accounting for decision-making;*
- *Recording information in line with record-keeping guidelines issued by professional bodies; and*
- *Adhering to organisational policies and procedures relating to report writing and record-keeping.*

4.7 Confidentiality and Disclosure of Information

The use and sharing of service user information is an essential part of providing optimal care and treatment within health and social care[15]. However, when it comes to communicating information about 'risk' many mental health and learning disability professionals are unclear about what they can share and with whom, whilst fulfilling their duty of confidentiality.

[14] *Morgan S. (2007)*
[15] *DHSSPS (2008)*

Concern stems from having to balance the need to safeguard the service user's right to confidentiality as part of a trusting relationship and the requirement for disclosure of relevant personal, identifiable information to manage the risk of harm that may arise for the individual service user or others.

The Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf should be referred to for more detailed information on any aspect of confidentiality.

General principles of good practice in relation to information sharing which should be adhered to include:

- *At the earliest opportunity explain to the service user why you may need to share certain information with other professionals to care for him/her appropriately - Duty To Warn;*
- *Gain the service user's written consent to share information;*
- *Explain to the service user that in some cases, the need to protect the public might take precedence over the duty of confidence, e.g. child protection; protection of vulnerable adults; prevention of serious harm to third parties;*
- *Only share information on a "need to know" basis i.e. the recipient will be involved with the patient's care or treatment, or he/she may be at risk of harm from the service user; and*
- *Record the reasons for any information sharing.*

4.8 Involving Service Users and Carers

"Few of us would relish being labelled as a risk" (Morgan S. 2007), therefore it is particularly important that staff are open and honest about the purpose of risk assessment and management, and encourage service users' participation in the process. Family members/carers and service users generally know themselves when something is not quite right, i.e. changes in a mental state[16]. Their concerns should be listened to and recorded, as they can help prevent or minimise behaviours likely to increase risk.

Service users may refuse permission for information to be shared with particular family members and relatives for a variety of personal reasons: such wishes should always be taken into account. Family/carers should be given sufficient knowledge to enable them to provide effective care, i.e. the provision of general information about mental illness, emotional and practical support for carers which does not breach confidentiality[17]. Carers

[16] *Langan and Lindow (2004)*
[17] *Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004)*

should always be provided with the essential contacts and information necessary to allow them to provide care and access support from mental health professionals, both day-to-day and in times of crisis.

Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Clearly mental health professionals will need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986. If a service user requires the support of an advocate and/or nominated person, this service should be provided.

The needs of the service user will almost certainly affect the lives of his/her family and those who provide regular care and support to him/her. Therefore, carers should be offered an assessment of their caring, physical and mental health needs, which should be reviewed on a regular basis. This is particularly important where the service user has young children who may provide care to their parent: their welfare must be addressed.

4.9 Transfer and Transition

There are certain points in a service user's care pathway at which there is an increased potential for communication failures and a risk of information being lost or mis-communicated.

The most common is during **transition**, e.g. admission to hospital, discharge from hospital care to community services, and from child and adolescent services to adult mental health and learning disability services[18]. The need to effectively manage such transitions of care is essential.

It is particularly important that, where possible, all service users, their families and carers are introduced to and linked properly with continuing care and support services prior to moving from one form of care to another. This is particularly important in maintaining continuity of risk management and care planning. Protocols governing the movement of service users between services should be developed by mental health and learning disability service providers to create clear guidance for practitioners in reviewing risk management and care plans.

Transfers between mental health and learning disability services and other general healthcare services are a common occurrence. In addition, transfers between mental health and learning disability services in different provider organisations are becoming increasingly frequent: hence there is a need for explicit policies regarding the process for transfer of clinical responsibility. Services also need to consider the management of interfaces external to the healthcare system, e.g. with housing.

Guidance from the Royal College of Psychiatrists (1996) states that "if the responsibility for care of a service user is passed on to another clinician or

[18] *DHSSPS (2007b)*

service it must be handed over effectively and accepted explicitly" [19]. All known information which might be relevant to the risk assessment and management plan must be transferred, as should patient records and other relevant documentation to ensure the effective exchange of information. Key Workers can play a pivotal role in the safe management of transfers.

All HSC Trusts have developed their own local protocols based on the principles within the *'Protocol for the Inter Hospital Transfer of Patients and Their Records'* (CREST 2006). In addition, the Department has recently issued to Trusts recommended good practice principles on the transfer of patients of all ages and their records between psychiatric hospitals and has asked the Trusts to review their local arrangements to ensure that they comply with these principles. Provisions should be made for the transfer of service users to agencies external to the HSC system.

4.10 Interface Issues

Service users within mental health and learning disability services often have a range of care needs which no one treatment, service, or agency can meet. When care needs stretch across service boundaries, a holistic approach is required to view the many complex interfaces between mental health and learning disability services and other service areas in the healthcare system. It is necessary, therefore, for a coordinated approach among the relevant services and agencies which combine their efforts to care for the individual service user.

For instance, where mental health and learning disability services staff are working with a parent, in whatever capacity, they will need to take account of the welfare of the child(ren) in the household. This could mean interacting with family and child care services, as appropriate, to ensure that any perceived risks to children from a parent who has a mental disorder are recognised and assessed. This must meet with the new, strengthened child protection procedures and single assessment process established as part of the Understanding the Needs of Children In Northern Ireland (UNOCINI). Mental health and learning disability services staff have a crucial role in highlighting any child protection concerns and intervening to protect children.

HSC Trusts should make use of the training resource *Crossing Bridges: Learning Materials To Support Mentally Ill Parents and Their Children* (DH, 1998) produced by the Department of Health in England to inform the development of local protocols to manage the interface between mental health and family and childcare services.

4.11 Discharge Planning

Discharge planning should be initiated as soon as possible after the service user is admitted to a psychiatric or learning disability inpatient facility.

[19] *Royal College of Psychiatrists (1996)*

Where possible, an assessment of his/her risk of harm to him/herself or others needs to take place prior to discharge involving members of the multidisciplinary team (including the clinician, nurse, social worker, and key worker) and the service user, his/her family/carer, and advocate, where necessary. This is dependent on the assumption that risk assessment is regularly carried out throughout the inpatient stay and is used to inform suitability for discharge.

If the appropriate level of risk assessment is not achievable by discharge, one must be completed at the first follow-up appointment with the service user. Prior to discharge from hospital, service users and those who care for them need to be introduced to and linked with those providing ongoing care in the community.

The National Confidential Inquiry report, *Avoidable Deaths*[20], recommends the following action to ensure the safe transition from the inpatient environment to the community:

- *Regular assessment of risk during the period of discharge planning and trial leave;*
- *Agreed plans to address stressors that will be encountered on leave and on discharge;*
- *The patient to have ways of contacting services if a crisis occurs during leave or after discharge;*
- *Early follow-up on discharge, including telephone calls immediately after discharge […] and face-to-face contact within a week of discharge [for high risk patients];*
- *Support arrangements for people who discharge themselves from wards.*

4.12 Promoting Service User Engagement

There is the need for agreed action to be taken when a service user begins to disengage from services. A plan to engage effectively with service users and action to be taken for 'loss of contact' situations is essential. A history of disengagement is clearly an increased risk factor for recurrence: when service users with such a history are identified, mental health staff should proactively try to build engagement by talking with the service user and asking him/her[21]:

- *What are your usual early warning signs for relapse?*
- *What are your usual trigger factors for relapse?*

[20] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*
[21] *Morgan S. (2007)*

- *How would you normally cope when you feel that your mental state is declining?*

- *Who would you like to be involved in your care when you are in crisis? i.e. which family members/carers should be informed?*

The answers to such questions allow the service user to identify his/her own risks, influence the plan for dealing with difficult situations and create the opportunity for him/her to indicate the type of support that they would prefer and feel would suit him/her best. As noted previously, the service user's Care Plan should include crisis and contingency plans, as necessary, to guide professionals, family/carers and others involved in caring for him/her as to what to do when he/she disengages from services.

There will be some service users who do not wish to engage with mental health and learning disability services, despite encouragement. Their right to decline this input and pursue their recovery through other means should be acknowledged, with relevant parties notified, when necessary, of their circumstances.

4.13 Dual Diagnosis

Dual diagnosis is the combination of mental illness and a substance misuse problem. Risk assessment and management plans need to address specific factors relevant for individuals with a dual diagnosis. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose, suicide, violence and/or homicide.

According to the National Confidential Inquiry report[22], service users with a dual diagnosis have high rates of previous violence and self-harm, and are more likely to be inpatients at the time of death than those without the condition. For those in the community, one third had missed their last appointment.

The Department of Health *'Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide'* (DH, 2002) advises that exploration of the possible association between substance misuse and increased risk of aggressive or anti-social behaviour is an integral part of risk assessment, and should be explicitly documented, if present.

The Bamford Review recommends developing expertise within mental health services for the management of dual diagnosis. The Department recognises dual diagnosis services as an area of need for future service development.

[22] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*

4.14 Awareness of the Mental Health (Northern Ireland) Order 1986

It is important that the level of restriction to which the service user is subject is proportionate to the risk that he/she presents. The emphasis should always be on recovery and working with the service user to determine how best to manage any problems that he/she might encounter.

Healthcare staff need to be aware of the powers available to them under the Mental Health (Northern Ireland) Order 1986 that can, if necessary, be used to minimise risk. Detention should always be used as a last measure where a service user is considered a significant risk to him/herself or others. Mental health and learning disability staff should not unduly restrict a service user by detention under this Order.

Where a voluntary inpatient, deemed to be at serious risk of causing harm to him/herself or others, indicates an intention to discharge himself or herself against medical advice, and a package of care has not been arranged, every effort should be made to persuade him/her to remain in the hospital until a package is agreed. In some cases the use of holding powers and detention may be appropriate.

Where holding powers and detention cannot be invoked, e.g. where a service user has been diagnosed as having a personality disorder only and he/she leaves the hospital before a suitable package of care can be put in place, it is essential that the hospital alerts those in the community who need to be aware of the situation. The responsible multidisciplinary team should agree a Care Plan in retrospect and identify a Key Worker and a person to carry out a care coordination role. Service users who discharge themselves against advice may still require and accept aftercare.

5.0 Learning from Adverse Incidents

In 2003, a statutory duty of quality was imposed on the services commissioned and provided by Health and Social Services Boards and Health and Social Care Trusts. Accordingly, these organisations are required to organise their structure to achieve integrated governance[23] in order to give equal priority to corporate, financial, clinical and social care matters.

Since 2003, HSC organisations have been required to comply with the core risk management controls assurance standard. The standard requires that there is "an agreed process for reporting, managing, analysing and learning from adverse incidents"[24].

Safety First: a framework for sustainable improvement in the HPSS (DHSSPS, 2006) sets out the Department's policy on safety. This includes the need to raise awareness of risk and to promote timely reporting of adverse incidents and sharing the learning across HSC environments.

In addition, the *Quality Standards for Health and Social Care* (DHSSPS, 2006) set out standards that the Department considers people should expect from HSC services. The standards are represented in five quality themes applicable to all HSC services and are "essential", i.e. the absolute minimum action necessary to ensure safe and effective practice. They are used by the RQIA to assess service quality and promote quality improvement across organisations.

In the context of this guidance, Theme 2, *Safe and Effective Care* – Criteria 5.3.1, *Ensuring safe practice and the appropriate management of risk and 5.3.2, Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses* have particular relevance to and impact upon risk assessment and management. The rationale for the theme states:

> *"Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence" (DHSSPS 2006, 12).*

Accordingly, all adverse incidents involving service users known to mental health and learning disability services must be reviewed in such a way that enables lessons to be learnt and steps taken to reduce the likelihood of future similar events recurring.

Internal multidisciplinary reviews must be held as soon as practicable following an incident, to examine what happened and to make

23 Establishing an Assurance Framework: A practical guide for management boards of HPSS organisations (DHSSPS, 2006)
24 Criterion 4 of the Risk Management Controls Assurance Standard

recommendations as to how the service can be improved. These reviews should be in keeping with existing Departmental guidance *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports* (DHSSPS 2007b) and regional good practice[25].

Dissemination of the key lessons learned along with the suggested evidence-based practice improvements should be communicated to frontline practitioners and disseminated through governance fora. As part of this, learning from adverse incidents should be targeted by sharing specific themes which occur regularly. It is also advisable that regular reviews of "near miss" untoward incidents take place as a "non-threatening" learning tool. A forum should be provided for all disciplines to record incidents and near misses to promote best practice.

There have been several local Independent Inquiries in recent years following homicides by people with a mental illness. The benefits for relatives in a thorough and transparent process have been apparent. Regional learning and the promotion of public confidence in the service are paramount.

5.1 Organisation and System-wide Learning

As previously stated, risk management is not just the responsibility of individual mental health and learning disability practitioners: it is the collective accountability of the multidisciplinary team and the wider organisation. Many adverse incidents occur as the result of a series of systems failures. However, it is not simply a matter of shifting responsibility from an individual to a blurred collective[26]. Rather, a reasonable balance must be reached between supporting an individual practitioner to make effective risk management decisions and the overall responsibility of the organisation to create a culture where there is a clear understanding of the complex issues surrounding risk. "It is recognised that in any organisation the principles should be 'what has happened' and 'how can we improve' rather than 'who made the error'"[27].

Clear arrangements, both regional and local, are required to ensure risk information is centralised and assimilated, as appropriate. Mental health and learning disability service providers should have robust clinical and social care governance systems in place that link in to the wider corporate risk management structure. This will ensure an integrated, organisation-wide response to tackling recurring risk issues.

HSC Trusts must tie in with established regional governance arrangements, and ensure that adverse incidents are consistently reported in accordance with DHSSPS and Regulation and Quality Improvement Authority Guidelines, and to comply with the Quality Standards for Health and Social Care.

25 The review should be conducted in accordance with Mental Health Commission guidance (April 2006)
[26] Morgan S. (2007)
[27] DHSSPS (2007a)

6.0 Improving the Quality of Risk Management

6.1 Collaborative Working

Mental health and learning disability service users often require access to a wide range of interventions offered by various professionals. It is vital that all members of the multidisciplinary team providing care for the service user work closely together. Each discipline will have different professional skills, expertise and experience which, combined, will result in more informed risk assessments and management plans, and the formulation of comprehensive and appropriate Care Plans.

It is only when there is a firm commitment to this kind of team-working that staff will feel comfortable to examine their own practice with colleagues and learn from one another to create better outcomes for service users.

"Change can start now if there is sufficient commitment and vision in individual mental health services to make it happen" (Mental Health Commission Ireland, 2006).

6.2 Standardised Documentation

The RQIA's review of local practice found that there was a lack of consistency in the documentation used to assess and record the management of risk in HSC Trusts. In order to improve the quality of risk assessment and management processes, standardised assessment tools have been developed for use throughout mental health and learning disability services regionally. This should create procedures which are transferable across Trust boundaries and result in a standard approach to care planning. These tools are at section 8.0. The addenda (at section 9.0) also give guidance on appropriate tools for these specialist services.

6.3 Standards and Benchmarking

"What gets measured gets done". Risk assessment and management processes must be subject to audit, both internal and external, to ensure that they are effective in creating better outcomes for the service user. Ongoing monitoring of service delivery is vital to ensure that there are continuous checks and balances in the system, which will hopefully flag up any areas for improvement before an adverse incident occurs.

As noted above, HSC Trusts are to act collaboratively to develop an audit tool to assess compliance with this guidance. Governance reviews will be carried out by the RQIA, during which application of the risk assessment and management principles of this guidance may be assessed.

6.4 Training

Staff training in the assessment and management of risk is essential for improving the quality of risk management, and should be carried out as part of regular mandatory training for all mental health and learning disability staff, appropriate to their level. Staff need to be able to apply risk assessment tools competently and to use them, as appropriate, to inform risk management and care planning. To inform this, a "Training Needs Analysis" should be carried out as part of the implementation of this guidance.

The induction process for mental health and learning disability staff must include an overview of the local risk assessment and management process. Awareness and training sessions should be provided to the full range of mental health and learning disability staff, and other relevant staff who will be referring service users in to mental health and learning disability services. Refresher training should also be carried out, as necessary, where identified as a need through supervision.

HSC Trusts should develop information systems to record details of attendance at training events and be able to demonstrate that all staff have received relevant training on a regular basis.

6.5 Staff Support and Supervision

Clinical supervision is fundamental to developing safe and effective practice. It provides the opportunity to positively challenge professional practice to improve the quality of care.

Mental health and learning disability professionals benefit by continually developing their knowledge, skills, competence and confidence to provide the best care for service users in a protected, supportive environment. Regular supervision can also provide emotional support for this group of staff who regularly deal with difficult and complicated circumstances as part of their daily work. For managers, supervision is an opportunity to ensure that policy is being followed and professional standards are being maintained.

All mental health and learning disability staff should have the opportunity to share learning and receive support through clinical supervision, either on an individual or group basis. By making sure that risk, its assessment and management, is a regular aspect of clinical supervision, a contribution will be made to ensuring higher standards of care in mental health and learning disability services.

The guidelines developed by the DHSSPS Nursing and Midwifery Advisory Group, *Clinical Supervision For Mental Health Nurses In Northern Ireland: Best Practice Guidelines* (DHSSPS, 2004b) should be followed and the recommendations implemented throughout mental health nursing.

In order to further support staff, HSC Trusts should, as good practice, endeavour to put in place some of the following initiatives:

- *Multidisciplinary professional fora;*
- *Mentoring programmes;*
- *Champions at ward/team levels to support staff; and*
- *Group work sessions.*

7.0 The Way Forward

7.1 Implementation

The Department recognises that risk assessment and management cannot be solved by a policy and procedural response alone. These are fundamental systematic issues, which must take into account the anxieties of professionals, service users and their families/carers in order to facilitate improvement. This will require action and commitment by professionals, management teams and organisations, building on current good practice and experience.

Trusts must now:

- *Develop the protocols and procedures required to support implementation of this guidance;*
- *Use the standardised documentation (including the recommended risk assessment tools);*
- *Ensure staff are appropriately trained with regard to the use of risk assessment tools/documentation;*
- *Work collaboratively to develop an audit tool to assess compliance with this guidance; and*
- *Report regularly to the HSC Board on compliance with the elements contained in this guidance.*

7.2 Audit

The Department will commission from the RQIA an audit of compliance with this guidance, through the RQIA's programme of reviews, in 2011.

RISK SCREENING TOOL

NAME		**DOB**		**DATE**		**TIME**	
Outpatient / community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED ON COMPLETING RISK HISTORY

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / probation services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE DETAILS UNDER EACH HEADING (HISTORICAL AND CURRENT)

SELF HARM / SUICIDAL BEHAVIOUR

Yes		**No**		**Unknown**	

ALCOHOL/SUBSTANCE MISUSE

Yes		**No**		**Unknown**	

If there is history of drug use, ever injected not under instruction of doctor **Yes** **No** **Unknown**

NEGLECT AND VULNERABILITY

Yes		**No**		**Unknown**	

CHILS CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for Children)

Yes		**No**		**Unknown**	

PHSYICAL IMPAIRMENT (e.g. medical/ sensory)						
	Yes		No		Unknown	

DISSOCIAL OFENDING BEHAVIOUR						
	Yes		No		Unknown	

VIOLENCE &AGGRESSION						
	Yes		No		Unknown	

POTENTIAL DISENGAGEMENT/LOSS OF CONTACT/NON-COMPLIANCE/ABSCONDING						
	Yes		No		Unknown	

AREAS IDENTIFIED FROM MENTALSTATE ASSESSMENT						
	Yes		No		Unknown	

OTHER INDICATORS OF RISK						
	Yes		No		Unknown	

COLLATERAL HISTORY / RELATIONSHIP TO SERVICE USER

SUMMARY OF ACTIVE RISK

SUMMARY OF PROTECTIVE FACTORS

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK ACTION	Name of Person(s) responsible	Signed:

CONTINGENCY ARRANGEMENTS

FURTHER ACTION NECESSARY **Discuss with Multidisciplinary Team** ☐

Comprehensive Risk Assessment ☐ **Specialised Risk Assessment** ☐

Keep under review ☐ **No further action required** ☐

DISTRIBUTION
Service user ☐ **Key Worker** ☐ **Other** ☐ **(specify)** _____

Service User's signature: _____ **Date:** _____ **Refused to sign** ☐

Where signature refused, indicate reason _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

On inpatient admission - to be completed jointly by the admitting Doctor and nurse in consultation with the Family/Carers and others (if in attendance at time of admission).

RISK SCREENING TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
PHYSICAL IMPAIRMENT • Medical • Sensory	**DISSOCIAL & OFFENDING BEHAVIOUR** • Criminal history, including exclusion orders, bail • Conviction for violent offences • Conviction for sexual offences • Previously been a diagnosis made of psychopathy / antisocial personality disorder • History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit • Dissocial behaviours
VIOLENCE AND AGGRESSION • Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public • Talking of or planning to harm others • Display high anger, hostility, threatening behaviour • Threats against a particular individual • History of owning, carrying, using weapons • History of property damage • Arson (deliberate fire setting) • Sexual assault (includes touching / exposure)	**POTENTIAL DISENGAGEMENT** • Previous history of poor concordance with treatment / medication • Does the person understand his/her illness? • Does the person actively attempt to mislead others with respect to concordance with treatment? • Severe side-effects of medication • Unplanned disengagement from services • History of compulsory admission
MENTAL STATE • Appearance and behaviour • Speech • Mood • Perception, command hallucinations • Cognition • Mini Mental State • Insight • Previous history of serious mental illness • Thought content (over-valued ideas / delusions) • Relapse signatures	**RELATIONSHIP WITH RELATIVE / CARER** • Known history of threat / violence towards the relative / carer • Current risk of threat / violence towards the relative / carer • Known history of abuse towards the client
OTHER INDICATORS OF RISK • Recent severe stress • Concern expressed by others • Recurrence of circumstances associated with risk • Impending stressors e.g. court appearance • Abuse / victimisation by others • Social isolation • Lack of social or carer support system • High levels of stress of carer / high carer burden • Volatile personal relationships	**PROTECTIVE FACTORS** ▪ Willingness to engage with mental health services ▪ Compliance with medication ▪ Abstinence from alcohol/ drugs ▪ Family/ social support networks ▪ Faith/ religion ▪ Financial security ▪ Support from employer ▪ Weapons removed ▪ Fear of physical injury/ disability after failed attempt

• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

THOSE CONTRIBUTING TO RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**

FOR EACH HEADING WHERE RISK IDENTIFIED THROUGH SCREENING, PLEASE PROVIDE DETAILS (HISTORICAL AND CURRENT) (expand/delete sections below as necessary)

SELF HARM / SUICIDAL BEHAVIOUR

ALCOHOL/SUBSTANCE MISUSE (including injecting drug use)

NEGLECT & VULNERABILITY

CHILD CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for care of any dependent children)

PHYSICAL IMPAIRMENT (e.g. medical/ sensory)

DISSOCIAL & OFFENDING BEHAVIOUR

VIOLENCE & AGGRESSION

POTENTIAL DISENGAGEMENT / LOSS OF CONTACT / NON COMPLIANCE / ABSCONDING

AREAS IDENTIFIED FROM MENTAL STATE ASSESSMENT

OTHER INDICATORS OF RISK

SUMMARY OF PROTECTIVE FACTORS

Overall Risk Summary		
Management Plan of Identified Risk Needs	**Intervention**	**Name of Person(s) responsible**
Contingency Plan Scenario (including Relapse Signatures)	**Intervention**	**Name of Person(s) responsible**

Service User's signature: _____ **Date:** _____ **Refused to sign** ☐

Where signature refused, indicate reason _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

COMPREHENSIVE RISK ASSESSMENT TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
PHYSICAL IMPAIRMENT • Medical • Sensory	**DISSOCIAL & OFFENDING BEHAVIOUR** • Criminal history, including exclusion orders, bail • Conviction for violent offences • Conviction for sexual offences • Previously been a diagnosis made of psychopathy / antisocial personality disorder • History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit • Dissocial behaviours
VIOLENCE AND AGGRESSION • Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public • Talking of or planning to harm others • Display high anger, hostility, threatening behaviour • Threats against a particular individual • History of owning, carrying, using weapons • History of property damage • Arson (deliberate fire setting) • Sexual assault (includes touching / exposure)	**POTENTIAL DISENGAGEMENT** • Previous history of poor concordance with treatment / medication • Does the person understand his/her illness? • Does the person actively attempt to mislead others with respect to concordance with treatment? • Severe side-effects of medication • Unplanned disengagement from services • History of compulsory admission
MENTAL STATE • Appearance and behaviour • Speech • Mood • Perception, command hallucinations • Cognition • Mini Mental State • Insight • Previous history of serious mental illness • Thought content (over-valued ideas / delusions) • Relapse signatures	**RELATIONSHIP WITH RELATIVE / CARER** • Known history of threat / violence towards the relative / carer • Current risk of threat / violence towards the relative / carer • Known history of abuse towards the client
OTHER INDICATORS OF RISK • Recent severe stress • Concern expressed by others • Recurrence of circumstances associated with risk • Impending stressors e.g. court appearance • Abuse / victimisation by others • Social isolation • Lack of social or carer support system • High levels of stress of carer / high carer burden • Volatile personal relationships	**PROTECTIVE FACTORS** ▪ Willingness to engage with mental health services ▪ Compliance with medication ▪ Abstinence from alcohol/ drugs ▪ Family/ social support networks ▪ Faith/ religion ▪ Financial security ▪ Support from employer ▪ Weapons removed ▪ Fear of physical injury/ disability after failed attempt

• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

Addendum on Child and Adolescent Mental Health Services (CAMHS)

Background

To complement the production of the main guidance, it was recognised that there was a need for guidance in relation to the legislation, policies and procedures which staff need to take account of in their day-to-day work with children and young people who have emotional, psychological or psychiatric disorder.

Generally, the main guidance applies equally to children. This addendum, however, identifies circumstances where there are noteworthy differences between practice in the adult and child and adolescent arenas.

This addendum should, therefore, be read in conjunction with the core good practice guidance.

Context

Good assessment and the management of risk is integral to the treatment and care of children and young people.

The State, in accordance with the principle of Parens Patriae, has additional duties to children and young people, which it and its agents, such as Health and Social Care Trusts, Education Services and other statutory providers, must discharge in a responsible manner.

The Children Order requires that children are *children first* regardless of disability or illness. For CAMHS, this means that children and young people with emotional, psychological and psychiatric disorders who are patients should be treated and cared for as *children first*. The value base of CAMHS is family-oriented: this enable families and carers to be partners in the treatment and care of their children and young people. In addition to providing treatment and care directly to children, a key objective of the service is to help parents/carers better understand, manage and care for their children when they have a mental health or psychological problem.

Practitioners working with children and young people are part of a wider network of support. This includes family and other professionals, tasked with providing care, treatment, or support to the child or young person and his or her carers. To achieve effective risk assessment and management requires staff to work within a multi-agency, multidisciplinary and family context.

To assist them to contribute effectively to the multidisciplinary and family support networks, it is important that CAMHS professionals are aware of the additional responsibilities for children placed on statutory agencies, such as the Trusts' Family and Childcare Services which have the lead responsibility for discharging the Trusts' child protection responsibilities.

Generally, children and young people referred to CAMHS are not suffering from a mental disorder requiring their detention and treatment under the Mental Health (Northern Ireland) Order 1986 (the Mental Health Order). The mental health care

of children is, therefore, usually provided under the general duty in Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972, to provide integrated Health Services which promotes the physical and mental health of the people of Northern Ireland.

Legislative Base

Of particular relevance to CAMHS professionals, is the legislative base set out in the Children (Northern Ireland) Order 1995 (the Children Order) to safeguard and promote the welfare of:

- children in need;
- children in need of protection; and
- looked after children.

Health and Social Care Trusts are responsible for discharging statutory functions, delegated to them by the Health and Social Care Board under Schemes for the Delegation of Statutory Functions. These functions are discharged on behalf of each Trust by its Family and Childcare Programme. The HSC Board monitors performance against the Schemes on an annual basis.

Children in Need

Article 18 of the Children Order places a general duty on each Trust to safeguard and promote the welfare of children who are in need: this includes children with emotional, psychological and psychiatric disorders.

Article 17 of the Children Order states that a child is in need if:

a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of personal social services;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Where children are assessed and identified as children in need under Article 17, Trusts are required under Article 18 to provide a range and level of personal social services appropriate to their needs. In so doing, the Trust discharges its general duty to safeguard and promote the welfare of children in need. A number of children in need will require the support of CAMHS professionals in addition to the Trusts' social care services.

Under the Children Order, there is no authority to admit or detain a competent child or young person in hospital against his or her wishes, or to prevent a child from leaving hospital because of mental health concerns. Such detentions can only be achieved through the provisions of the Mental Health legislation.

Children in Need of Protection

The Department's guidance *Co-Operating to Safeguard Children* (DHSSPS, 2003) and the Health and Social Services Boards' Area Child Protection Committees' Regional Child Protection Policy and Procedures, 2005 (ACPCs'

Policy and Procedures) set out the responsibilities of all agencies, professionals and services working with children to assist with the recognition of potential indicators of abuse and to be aware of their roles and responsibilities to assist with the protection of such children, including the requirement to share information with the Trusts' Family and Childcare Services. The sharing of information ensures that a comprehensive and holistic assessment can be made of the child's needs and circumstances to underpin the development of a Child Protection Plan to ensure the child's safeguarding needs are met.

Compulsory intervention in family life by a Trust is underpinned by its specific duties in Article 66 of the Children Order to safeguard and promote the welfare of children suffering or at risk of suffering harm. Article 50(3) of the Children Order sets out the criteria by which a judgement can be made whether the harm a child has suffered amounts to significant harm. In practice, however, mental health and other professionals' responsibilities are to consider whether there is reason to believe or suspect that a child has been abused, or is at risk of abuse.

Child abuse occurs when a child is neglected, harmed or not provided with proper care and may take the form of physical, emotional and/or sexual abuse, or neglect. CAMHS professionals should familiarise themselves with the ACPCs' Child Protection Policy and Procedures in relation to the definition of abuse (Paras 2.3 – 2.5). Guidance on significant harm is also available at Paras 2.6 – 2.14.

Each CAMHS staff member must be aware of his/her obligation to safeguard children in circumstances where harm or the likelihood of harm to the child is identified. In such cases, Departmental guidance and ACPCs' Policy and Procedures are clear that a referral must always be made to the Trust's Family and Childcare Services, through the relevant Gateway Team or Out-of-Hours Social Work Service. Each CAMHS professional must be aware of his/her obligation to safeguard children and to co-operate with the Trust's Family and Childcare Services, in circumstances where they identify abuse or the likelihood of abuse.

In some circumstances, the harm posed to a child may not come from a member of his or her family. This does not alter the duty to refer such children to the Trust's Family and Childcare Services for assessment.

Children who are in Need of Protection as a Result of Engaging in Risk-Taking Behaviours

In some situations, risks to children result not from the harm that may be caused to them by others, but rather from their own risk-taking behaviours. In these circumstances, the approach often taken is to offer support to the parents or care givers to ensure that they are better able to care for their children. Where risk-taking behaviours include self-harm and/or a risk of suicide, a thorough assessment of treatment and care needs and safety planning must be prioritised by CAMHS. This should be completed on a multidisciplinary and multi-agency basis. Where CAMHS professionals assess that the family situation is contributing to the risk-taking behaviours they should ensure that a referral is made to Trusts' Family and Childcare services to enable an assessment and support to be provided to the children and his/her family, as appropriate.

As a family-orientated service, CAMHS professionals recognise the importance of working with parents and carers. Young people in distress sometimes may, however, have mixed feelings about their parents/carers. This can place CAMHS professionals in a difficult position where risks are identified due to the young person's behaviours. Whilst seeking to preserve the rights of young people to confidentiality, CAMHS professionals should in the first instance work with children to gain their support for sharing information with their families in an effort to keep children safe. Ultimately, however, where the risks are significant, CAMHS professionals may have to breach confidentiality. In such instances, the young person should be advised that disclosures will be made either to parents/carers and/or social services.

No simple definition of a family exists. Sometimes children will be living in one parent families or families which have been reconstituted. When assessing children who are deemed to be in need or at risk, it is important to remember the role that is being played, or could be played, by the absent parent who may still retain parental responsibility for the child and be in a position to offer additional help and support.

Looked after Children

A child or young person is described as *looked after* when provided with accommodation for more than 24 hours by a Trust, either with his or her parents' consent, or through a Court Order placing the child in the care of a Trust. Each Trust has Corporate Parenting responsibilities to children whom it looks after. Like any other parent, the Trust has the duty to ensure the physical, social, emotional, educational and spiritual development of children or young person whom it looks after. The Trust's Family and Childcare social workers are responsible for fulfilling statutory functions on behalf of the Trust as a whole.

A significant number of the children and young people who are looked after have suffered loss, trauma or abuse. They are, therefore, a population with a disproportionate need for CAMHS support. CAMHS staff provide an important element of a wider range of support services which the Trust as a Corporate Parent will need to provide to children whom it looks after.

Article 174 (6) of the Children Order states that where a child or young person has been an inpatient in any hospital setting for more than 3 months, or the intention is that this will happen, then they are regarded as being accommodated. This means that where a child remains in hospital beyond the 3 months (or indeed for any period less than 3 months) for clinical reasons, i.e. is receiving medical care and treatment which cannot be provided in the child's home or in another community setting, the child is not accommodated within the meaning of Article 21 of the Children Order and Looked After Children (LAC) provisions do not apply.

However, where the child is in hospital for 3 months or is likely to be in for 3 months or more for clinical care and treatment, the Trust's community family support team, or the hospital based social worker, should be involved to assess the child and family needs as many families require support even in terms of the needs of other children in the family if they have to visit sick children for long periods. The Trust should, therefore, be asked to undertake an assessment of family needs at or before the conclusion of the 3 month period.

However, if a child's clinical care and treatment has been completed and he/she is fit to be discharged, but a lack of community resources are preventing that discharge, then the child becomes a looked after child and subject to all LAC provisions. The social worker is required to develop, with hospital colleagues, a plan which seeks to meet the child's basic developmental needs and at regular intervals to review and monitor that these needs continue to be met. This arrangement is regulatory in nature and parental responsibilities remain with the child's parents.

Risk Assessment Process

The process identified in the main document can be adopted by CAMHS staff for use with children and young people.

All incoming referrals should be screened in terms of clinical need and risk, to determine which element of CAMHS, or indeed any other service, is most appropriate to deal appropriately with the referral. It is important, therefore, that referrals contain all relevant details about any likely risks and their source.

CAMHS professionals should ensure that their generic assessment of risk is consistent with UNOCINI, the regional multidisciplinary assessment tool utilised within Family and Childcare Services. This will help to ensure a consistent approach for all professionals working within children's services. Further work is necessary for this to be realised.

Many children or young people who need emotional, psychological or psychiatric support can receive assistance from their General Practitioner, education or youth justice services, particularly if these services themselves are supported by an experienced CAMHS professional. Referrals to tier 2 services such as these should be the subject of risk screening.

All tiers 3 and 4 referrals to specialist CAMHS provision should be risk assessed. This includes a mental state assessment, which should address specifically the risk of self-harm or suicide.

CAMHS professionals should adopt the CAMHS FACE Risk Assessment Tool, which has equivalence to the comprehensive assessment as part of the main document. This is an evidence-based, multi-professional tool which has been developed over a 10-year period through collaboration of senior practitioners from around the United Kingdom.

The CAMHS FACE Risk Assessment Tool:

- is a systematic tool structured to enable safe clinical judgement, risk analysis and care formulation. The tool is supported by a validated scoring system designed to quantify both dynamic and static risk factors.
- assesses risk to self, risk to others and from others and places risk formulations in the context of the young persons history, taking full account of both family and social dynamics.
- promotes a "Strengths/Protective" factor based approach to risk management by proactively involving young people and their families in the identification and management of risks and needs.

- supports clinical supervision/governance arrangements through internal validation/clinical audit/outcome measures. The tool also supports the measurement of practitioner, team, and organisational 'risk-load.
- integrates with case management approaches.
- interfaces with the recording of serious incidents and near misses.
- includes specialist supplement in relation to forensic/substance misuse/dual diagnosis risk assessment
- is supported by in-depth training based on "training the trainer cascade methodology".
- A FACE risk profile should be completed by all tier 3 and 4 CAMHS services at point of contact with the child, young person and family system. This should be reviewed as part of overall care plan.

The model of initial, comprehensive and specific risk assessments is in keeping with the overall model advocated in the main part of this guidance for adult mental health.

Care Planning and Risk Management

The principles set out in the main guidance are applicable to Child and Adolescent Mental Health Services.

Risk assessments and management plans should always be incorporated into treatment and care plans and not be perceived as separate documents. There is a need to design such a document that could be used across the region.

Roles and Responsibilities of CAMHS Staff

CAMHS staff will fulfil the role of Key Worker or Care Co-ordinator.

Key Worker Role

For children and young people with complex or challenging needs, there are likely to be a number of agencies involved, some of which also will have identified staff as Key Worker. This is particularly the case for the Trusts' Family and Childcare staff, who in many instances will be discharging statutory duties. It is, therefore, important that there is clarity about the roles, responsibilities and powers ascribed to each Key Worker, where there is more than one.

The main guidance, setting out the roles and duties of a Key Worker, where the role is to organise and maintain the mental health services needed by the patient, is applicable also to CAMHS staff.

The Care Coordinator Role

The Care Co-ordinator role is new to CAMHS. The main guidance describes the role as supporting and facilitating the Key Worker and multi-disciplinary team in the delivery of agreed Care Plans, ensuring that appropriate services are available and coordinating deputies when Key Workers are not available. The Co-ordinator is also responsible for chairing multiagency reviews at intervals of 6 months, or more frequently if required, for each service user who is subject to

comprehensive risk assessment and risk management planning. Generally, these are individuals who are deemed to be at greatest risk to themselves or to others.

For CAMHS to introduce Care Co-ordination would require a review of all cases, to determine those which meet the *greatest risk* criterion. It will, however, take some time before such an approach is bedded in.

Where Care Co-ordination is deemed necessary and the Trust has, through its Family and Childcare Programme, other statutory duties to the child, then there should always be discussion to ensure that the these roles are clearly understood to avoid confusion or duplication and to ensure all statutory duties take precedence. Even with clarity regarding the distinct roles of Family and Childcare social workers, the use of Care Co-ordination will have resource implications for CAMHS.

Given that Care Co-ordination is used only in cases where the individual is deemed to be at *greatest risk to him/herself, or to others*, it is clear that the service needs to develop systems and processes to monitor and manage the care of individuals within this category. The concept of a Risk Register is not unanimously supported, albeit that it is recognised that some form of recording arrangements are necessary.
This is an issue which requires further discussion.

Confidentiality

The principles underpinning confidentiality set out in the main document are applicable to children and young people. The duty of care owed to children and young people is, however, in sharper focus given their increased vulnerability and dependence on adults. The ethos of a family-orientated service such as CAMHS should mean that every effort is taken by CAMHS professionals to ensure that parents are aware of the risks that their children's behaviour may pose.

Under the European Convention on Human Rights, children and young people have a right to confidentiality. A case by Gillick established the concept of increased competence to make decisions as children matured (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)). **Gillick competence** is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Further information for staff is available in the Consent Guidance issued by DHSSPS in 2003 (*Good Practice in Consent).*

A key determinant of any child or young person's right to confidentiality is his or her competency to make such a decision. The determination of competency is a decision taken by the clinical team. Where it is deemed that the child is not competent, there is no duty on the professional to adhere to the child's request for confidentiality. Best practice requires that sharing information without consent is fully discussed with the young person; provided it will not compromise the safety of others or a possible police investigation.

The main guidance sets out the circumstances in which practitioners may disregard the patient's right to confidentiality, even where the patient is deemed to be competent: that is, where it is believed that there is a significant risk of harm to that adult or a belief that the adult poses a significant risk to the wider public. This

guidance applies also to children and young people. Indeed, professionals are under an obligation to take all necessary steps to protect the child or young person or the wider society, and are not bound by the duty of confidentiality.

Transfer and Transitions

The main guidance is deemed to be appropriate to the transfer of children and young people's cases.

Disengagement from the Service

The main guidance covering the circumstances where patients are not keeping appointments or maintaining treatment plans is appropriate for children and adolescents.

Additionally, it is good practice to proactively obtain the individual's and family's consent to share relevant information with other agencies. Given the often multiagency nature of work with children and young people, this would allow the concerns of CAMHS staff about disengagement from the service to be shared with other services/professionals who are still in contact with the child or family, thus enabling them to be better informed and potentially more vigilant.

In every instance, decisions to discharge children and young people from CAMHS should be taken only after assessment, which should include an assessment of any risk factors. The concept of an automatic discharge based upon failure to keep appointments, as a procedural response, should cease.

Discharge Planning

In general terms, the main guidance is applicable to children and young people.

An assessment of risk is necessary in each instance where a young person is discharged.

Where a discharge of a child or young person is taking place contrary to medical advice, consideration should always be given as to whether it is appropriate to detain the patient under the Mental Health Order. Where the threshold for detention does not exist, but CAMHS professionals have concerns about the capacity of the parents to adequately protect and safeguard their child, then these cases should be referred to Social Services. Where a young person is reluctant to return home, this should always be treated as an issue of concern which requires closer investigation and discussions with Family and Childcare social work staff to ensure the child's concerns are appropriately addressed.

Addendum on Forensic Mental Health and Learning Disability Services

Introduction

Forensic Mental Health and Learning Disability Services (forensic services) deal with some of the most disturbed and difficult to manage patients in psychiatric practice. Such services focus on the assessment and treatment of individuals with mental disorder, whose behaviours may bring them into contact with the Criminal Justice System (CJS), either because of the seriousness of their offending behaviour or their potential dangerousness. Their work is carried out predominantly, but not exclusively, at the interface between the Criminal Justice System and Mental Health/Learning Disability Services at both community and inpatient level.

Risk assessment and management is a core activity of HSC organisations and this is particularly evident in the delivery of forensic services. The term 'risk assessment and management' can cover a wide range of activities, ranging across corporate risk, financial risk and clinical risk. This framework, however, deals specifically with the process of assessing 'clinical risk' i.e. the risk posed by an individual to themselves or others because of their behaviours, in those who have been referred to forensic services and to support the development of a robust management strategy that minimises such risks.

As the assessment and management of people who may present a risk is not exclusively the domain of forensic services, the principles outlined in this framework should be assimilated into other areas of service delivery. Applying the principles of this framework alongside the main guidance and the NIO (2009) Guidance on Public Protection Arrangements, Northern Ireland, will support consistency of approach across HSC services.

Risk Assessment and Forensic Services

'Risk assessment informs risk management planning, which in turn informs subsequent assessment and planning in a live and dynamic process that continues throughout the lifetime of the offender,' (Risk Management Authority, 2007).

A significant bulk of the risk assessment work undertaken by forensic services tends to focus around the topic of violence, whether that is purely physical acts of aggression or sexual violence. Various tools have been developed to facilitate this process of risk assessment and management and include, for example, the HCR20, SARA, RSVP, Risk Matrix 2000 and the Stable and Acute Dynamic Assessment (Hanson and Harris 2007). The first three are used predominantly within the Health sector and the last two used predominantly within the Criminal Justice sector. However, although agencies are using a range of risk assessment tools, it is important to note that the tools used have been validated for their specific purpose and can be used together to influence the detail of risk management plans.

Regardless of the tools used in forensic services, as in other services there is a need for sound risk assessment involving appropriate methods used by trained and experienced staff, with risk assessment clearly linked to a risk management plan, and effective inter-agency communication arrangements in place.

Key Principles of the Risk Assessment and Management Process

Risk assessment by forensic services will:

- Be a live, dynamic, proactive process;
- Be based on collaborative multi-agency/multidisciplinary working, with timely communication and responsible information sharing;
- Be undertaken by appropriately trained staff;
- Show evidence of a thorough review of the relevant available information;
- Show evidence of the application of structured professional judgement involving utilisation of evidence-based, validated assessment tools that are fit for purpose;
- Produce a formulation of the risk, to include the robust risk management strategies with contingency planning and regular timely review;
- Address victim issues as part of the process; and
- Show best endeavours to elicit the cooperation of the individual under assessment.

Key Processes

1. Collaborative Working Arrangements

In order to effectively plan and implement risk management strategies, forensic services must put in place robust multi-agency and multidisciplinary working arrangements. This facilitates the collation of the diverse range of views and expert opinion that contribute to improved shared risk management. A central tenet of these arrangements will be effective, timely communication and responsible information sharing. This may involve the Public Protection Arrangements Northern Ireland (PPANI) and will ensure compliance with child protection responsibilities.

2. Client Engagement

Forensic services will use their best endeavours to positively engage, where possible, with the individual being assessed throughout the risk assessment and management process. This has the potential to promote compliance and co-operation with the risk management strategies being developed and implemented.

3. Risk Assessment

Forensic services will carry out risk assessment, not as a static process, but as a dynamic and continuous process that responds to changes in the individual's circumstances, as they occur. Forensic services will also ensure that the frequency of risk assessment reviews is dependent on the situation in which the individual finds him/herself: for example, an individual detained within a secure setting is likely to require less frequent risk assessment reviews than someone in a community setting.

In order for forensic risk assessments to be effective, they will incorporate the following dynamics:

- Clear evidence that there has been a thorough review of the relevant and available information collected from case files, records and interview sessions;
- The information collected must be applied to an evidence-based, validated risk assessment tool that is fit for purpose;
- There should be evidence that structured professional judgement has been utilised to support the identification of relevant and critical risk and protective factors;
- There should be a formulation of the risk that includes the nature, severity, imminence, frequency and likelihood of re-offending.
- Clear working examples of possible future risk scenarios that risk management plans will seek to avert;
- The risk formulation will also include information on the likely impact of the offending behaviours and to whom the offender poses a risk of serious violent or sexual harm:
    - **i.** Relevant risk factors (static, stable dynamic, acute dynamic);
    - **ii.** Active protective factors; and
    - **iii.** Early warning signs that risks are escalating.

For risk management to be effective, the information must be analysed and contextualised as to its soundness and relevance. Agencies/organisations that request a risk assessment from forensic services do not want a catalogue of events drawn from records and presented in a report. They require the information to be set in the context of the individual's experiences and circumstances. Therefore, any risk assessment that does not go beyond the information collection and collation process has no validity and would not support the principle of defensible decision-making.

4. Risk Management Planning

Risk management is the natural progression from risk formulation. It is the process whereby the validated and analysed information is developed into a risk management plan. Forensic services must develop plans which evidence the link between the identified risk factors/active protective factors and the risk management strategies employed to manage the risk.

Robust risk management involves strategies that exert external controls (monitoring, supervision, interventions) whilst attempting to enhance or maintain the individual's internal controls (motivation, self-agency, personal control, self-determination).

The risk management strategies being employed in forensic services must be:

Sufficient to manage as effectively as possible the risk posed;
Appropriate to the individual and the individual's situation;
Relevant to the risk factors;
Evidence-based; and
The *least restrictive* necessary.

Although all risk management plans will undergo regular review, particularly in the earlier stages of implementation, it is important to identify a review date, ideally in the near future, but certainly no longer than three months from last review or the initial implementation to ensure that the principles of risk management, i.e. that the level of intervention is guided by the individual's level of risk, still applies. Adopting this approach promotes the principles of defensible decision-making, thus ensuring necessity, proportionality, non-arbitrary, evidence-based, transparent processes in the decision-making process.

Risk management is enhanced considerably if the individual is motivated to participate in establishing and attaining the goals of the risk management plan.

5. Roles, Responsibilities, Communication, Co-ordination

All risk management plans developed by forensic services will clearly identify the roles and responsibilities of the various agencies/personnel involved in the implementation of the plan. Lines of communication, including contact numbers and names, will be included. Contingency plans should describe the course of action to be taken should the risk scenario change. The risk management plan should also clearly identify the case coordinator who will carry overall responsibility for the implementation of the risk management plan, and be the single point of contact for others involved in the delivery of the plan.

Addendum on Addictions Services

Introduction

Most addiction treatments are delivered within a menu-led service. In this way, most people negotiate their own management plan within the first few appointments and most people referred to Addiction Services play an active part in their own risk reduction plan.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population.

Substitute Prescribing

Substitute Prescribing Services, in addition to the provision of substitute medication, give counselling and significant levels of psychosocial support to those attending for this service. In addition, they provide counselling and testing for the blood borne viruses: HIV; hepatitis B; and hepatitis C. They also provide vaccination against hepatitis B in people who have not developed antibodies, as well as onward referral and continued support to engage in treatment services for hepatitis C and HIV. This requires good liaison with Hepatology Services and the HIV Services for affected individuals. Such intensive, consistent client working as been shown to reduce the likelihood of continued illicit drug use and to reduce the medical and psychiatric morbidity associated with it. It has also been shown to significantly reduce associated criminal behaviours and to reduce the chaotic nature of the person’s lifestyle.

Outreach

Those who inject drugs (usually Opiates) are frequently reluctant to engage in mainstream service treatment because of the very intensive nature of this treatment, as described in the previous paragraph. Outreach Services may provide a means of encouraging such people to access the mainstream services. They can also encourage use of other forms of harm minimisation, such as education about the dangers of injecting, safer injection techniques and safe sex. They can also encourage attendance at the needle exchange facilities available through the community pharmacies.

Reinstatement Overdose

Services must be alert to the risks of reinstatement overdose and death in injecting drug users, following voluntary or enforced abstinence. (Education of patients in this area forms part of recognised good practice in harm minimisation work. It is particularly important in custodial settings such as Prisons and Custody Suites as well as in services which encourage abstinence from Opiate drugs).

Children Affected by Drug Use of Others

Children may be affected by the drug and alcohol use of parents, siblings, or others within their family. The presence of addiction in a family member can lead to faulty family communications, disruption of the family system and inappropriate role modelling. In extreme cases, there may be parental neglect or physical, mental or sexual abuse of children either as a direct result of parental or other family substance use or the chaotic lifestyle potentially associated with it.

Risk assessment in Addiction Services must take account of this issue and as part of every assessment procedure there should be an attempt to establish whether there are any children within the family or with significant exposure to influence from the person with an identified substance misuse problem. Trusts must have clear policies and procedures regarding referral to Child and Family Childcare Services of any identified risk.

There is increasing recognition that services should be provided for families of those with the more serious elements of addiction or existing inappropriate family functioning. Clear protocols and policies must be in place to ensure appropriate referral between agencies and acknowledgement of the different roles of the respective agencies. Liaison must also be encouraged at all levels of these processes.

Those with Co-existing Mental Illness

The co-occurrence of substance use problems and psychiatric illness is often referred to as “dual diagnosis”. Within this document, the more narrow definition of “dual diagnosis” has been adopted: that is, those with severe and enduring mental illness and a co-occurring substance use problem. The overlap between serious mental health problems and alcohol and drug use is significant. Half of all patients with Schizophrenia have substance missue disorder and 50 to 60% of people with Bipolar Disorder have substance use disorder. Such co-morbidity is

associated with heavy use of psychiatric inpatient care, poor treatment compliance, poor prognosis and high offending rates.

Patients' needs may be multiple rather than "dual" and may include medical and social care needs in addition to straightforward psychiatric and substance use services.

Good risk management includes identification of the relevant risks presenting to either service and good liaison between the relevant services involved to develop the most appropriate care plan for the individual. Such patients frequently present to Psychiatric or Substance Misuse Services in an "emergency", with acute psychiatric disturbance made significantly worse by the presence of substance intoxication. Joint service involvement is appropriate to develop "longitudinal" treatment plans in order to best enable substance misuse interventions to be delivered at a time when the mental health problem is stable.

Some substances, particularly alcohol, Cannabinoids, hallucinogens and stimulants can produce psychotic symptoms directly without the presence of mental illness and without apparent vulnerability to these. The psychotic state may be sufficiently severe to warrant input from the Psychiatric Services if it persists beyond the spell of simple substance intoxication. The management of florid symptoms may, at times, require management through the Mental Health (Northern Ireland) Order 1986, if they are not simply the result of intoxication.

Primary Care Management of Psychiatric Conditions Within Addiction

Chronic heavy use of any addictive substance, including alcohol, may lead to neurotic conditions, including minor levels of depression, anxiety and other neurotic illneses. These are conditions, which are normally managed properly within Primary Care and for which the individual would not be expected to come into contact with the Secondary Care Psychiatric Services.

Workers within Substance Misuse Services should be capable of assessing, correctly identifying and managing these disorders, in partnership with the General Practitioner, at community level. They should also be able to adequately screen and identify more serious levels of depressive illness or other psychiatric illness, which may need referral to the Secondary Care Psychiatric Services for management.

The converse of this is that those working within the generic mental health services should be able to screen, identify and deliver brief interventions on addiction issues to those presenting with substance use problems as a manifestation of a psychiatric disorder requiring treatment. There should be policies and guidelines regarding referral in each case and regarding the liaison and communication between service personnel, when appropriate.

Those Who Self-harm

This group of people is "vulnerable" in terms of the relative risk of further self-harm or completed suicide in the 10 years after an episode of self-harm. The behaviour is frequently associated with substance use, which in itself, may be viewed by the patient as a form of self-harm. All Addiction Services staff should be able to carry out a screening risk assessment and should be able to carry out an assessment of risk of self-harm in individuals who have such a history.

The act of carrying out the risk assessment will, in many cases, be a useful piece of addiction work as it may help the individual to identify potential harms resulting from continued substance use. This may serve a "motivational" purpose and will enable the individual to become meaningfully involved in the development of plans to reduce his risk in the future. There are 2 significant management issues in this subgroup of patients.

a. Identification of Major Psychiatric Illness

Any person presenting to Addiction Services with a history of self-harm should have a full diagnostic screen to exclude the presence of depressive illness or other significant psychiatric illness. Any identified illness should be managed within Primary Care, but with the ability to refer for psychiatric opinion and management, if considered necessary. The identification and treatment of mental illness will reduce the risk of completed suicide.

b. Attention and Management of the Substance Misuse Issue

The act of addressing and managing a substance misuse issue will, in itself, reduce the likelihood of further self-harm regardless of the existence of other mental illness. There are various reasons for this, including the reduction in the depressed mood associated with chronic substance use, the positive attitude engendered by "dealing with" or undertaking to deal with a lifestyle issue and the associated social enhancement inherent in many addiction treatments. It should also be acknowledged that much self-harm behaviour is carried out while under the influence of alcohol or drugs so that the natural inhibitions are reduced.

Containment or amelioration of the addiction problem may lessen the likelihood of this. It should be borne in mind, however, that addiction is a chronic, relapsing condition. While some individuals can gain significant improvements (including cessation of substance use per se) of their illness during a spell of treatment, the risk of future relapse to substance use is very high and the risk appears to remain on a lifetime basis. Even with intensive, supportive management, only about 50% of the people attending services can expect significant amelioration of their substance use problem.

Pregnant Drug and Alcohol Users

In the case of pregnant women, risks to the mother and risks to the foetus must both be considered.

Risks to the mother include the normal sequelae of excessive drug or alcohol use, the unavailability of some of the normal pharmacological treatments because of the danger of teratogenicity, the potential for a difficult pregnancy and a difficult labour, risks of poor pregnancy outcome and the possibility of having to raise a child with significant disability.

Risks to the foetus include teratogenic affects from the drugs of misuse, potential teratogenic affects of treatments and substitute offered or prescribed (effects generally seen in the first 10 to 12 weeks of pregnancy), potential developmental delay and difficulty in assessing foetal dates (effects seen from substance use throughout pregnancy), potential for premature delivery and for complicated

labour (during this last 12 weeks of pregnancy), the potential for withdrawal syndrome manifesting in the foetus in the neonatal period, risk of death at any time during pregnancy or the neonatal period and risks of severe developmental delay or organ malfunction during childhood.

Pregnant women who use substances should have easy access to services for drug and alcohol misuse. Access should be signposted from Primary Care, and from Maternity Services and Addiction Services should prioritise these cases so that they are assessed as soon as possible after referral.

A variety of agencies must be involved in every instance. These include the normal Maternity Services as well as the normal child health services available to all women. There should be protocols and policies in place across services to enable easy access across services and to enable consultation liaison interactions without barriers and without waiting lists. There should be protocols for full and open sharing of information between the Addictions Services, Obstetricians, Community Midwives and the Childcare Social Services, where appropriate.

As the majority of care during pregnancy takes place within Primary Care, it is essential that the General Practitioner and the Primary Care structures are similarly fully informed. This enables good planning during pregnancy by the individual services and enables early decisions about optimum timing of delivery and management of delivery. Good aftercare services are also essential for both mother and infant to ensure optimum outcome.

For most women, advice and information about substance use should be available within Primary Care and should be delivered at the point where pregnancy is considered or as soon as a pregnancy is identified. Primary Care Services will normally refer more complicated cases to Addiction Services if it is considered that dependence on a substance is present, if the mother shows significant resistance to drug reduction or if a complicated withdrawal is envisaged.

Multiple substance use would often also be referred to Addiction Services. A full assessment should be made of substance use of the mother and her goals and aims for the pregnancy. Her motivation should be assessed to manage her substance use and advice and motivational interviewing are appropriate at this point.

It is imperative that women with undisclosed pregnancies should be encouraged to access the Maternity Services in order to establish the maturity of the foetus as early as possible. All complicated cases should involve the multidisciplinary team and should have a full assessment of risk carried out on the various domains, which appear relevant. There will often be additional involvement of the criminal justice services and there may additionally be issues of domestic or partner violence.

Children's Addiction Services

Most children who take drugs do so in a limited way and most learn over time to control their drug use. There are 2 significant sub-groups who may be at risk of additional harm.

a. Those Who Have Significant Pre-existing Psychological Problems

These children will often use drugs or alcohol in larger quantities then their peers and may use in isolation to their peers. They may demonstrate other high-risk behaviour such as truancy, conduct disorder, self-harm or other psychiatric disorder.

These children should be identified and should properly be referred to the Child and Adolescent Mental Health Services for assessment and management. Such children should be identified through screening processes by specialist services dealing with substance misuse in children and young people. These must have clear internal protocols and policies and must have strong links with the Child and Adolescent Mental Health Services at local level. There should be clear protocols and clear referral pathways.

b. Children Who Develop Significant Substance Misuse Problems

Those under the age of 18 may develop physical or psychological addiction to a drug of misuse, including alcohol. The management of children with addiction or other serious substance use problems should take place within the context of "child-centred" treatment.

There should be a holistic model of management, which takes into account the child's developmental level, other physical or psychiatric problems and should operate within the family environment and setting. Treatment models will normally include systemic family therapy and attention to education and all of the child's needs. They should also include specialist addiction work input by competent, trained staff.

Trusts should have policies and procedures in place for referral of all such children and should ensure that there is access to service provision for this age group. Good liaison is essential across the family and childcare network to ensure good and appropriate communication between the various agencies, which may be involved. Such children should not be exposed to adult substance misuse populations because of the risk of initiation of more dangerous drug taking behaviours or sexual behaviours.

Screening and Assessment Tools

The risk screening tool is appropriate for addiction services.

Similarly, the comprehensive assessment tool is appropriate to use to identify the nature of risk in cases where the screening process identifies specific risk, and where this is applied in specific cases, with the decision to apply made on the key worker's considered decision. It would not, for example, be appropriate to use automatically in all cases as most addiction cases are dealt with by a single case worker. Involvement of the multidisciplinary team in every case would require a staff resource which would be impossible to meet.

These more detailed instruments would be used as appropriate to describe and manage risk in cases that have been opened by the addiction services and which will require intensive support. All identified risk should be shared with the referrer, but it cannot all be managed from these low intensity, high volume services. The

priority has to be to identify reversible risk, such as psychiatric disorder, and risks posed to children. Addiction services should identify (screening) and refer to appropriate services, where they exist, issues like personality disorder and self-harm.

Annex

Risks Associated with Substance Abuse

Accidents

Most morbidity and mortality associated with substance use is due directly to accidents associated with intoxication. Alcohol and drug use account for a high proportion of road traffic accidents and fatalities, domestic accidents and work-related accidents. Mortality is highest in young adults and naive substance users from direct intoxication. Accidental overdose is a further significant cause of morbidity and mortality in this group. Serious accidents of this sort frequently arise in those who are not addicted to substances and who do not present to Addiction Services. Public Health advice and opportunistic advice from Primary and Secondary Care staff is an important part of prevention of such untoward events.

High-risk Behaviours

Substance use is associated with high-risk behaviour such as joy-riding, sexual promiscuity and high-risk ingestion of substances such as cigarette smoking and intravenous injection of drugs. Those who use alcohol or drugs have higher rates of deliberate self-harm than the general population. Continued excessive substance use in itself may be regarded as a form of “self-harm” with significant mortality rates, particularly in the case of alcohol, and significant levels of physical, psychiatric, and social disability resulting directly from substance misuse. Social disability includes major domestic effects including domestic violence, employment loss and interaction with the criminal justice system.

Lifestyle Choice

Those who develop significant dependence on a substance may develop a chaotic lifestyle. This results directly from the addictive process as the person’s life becomes increasing focused around obtaining and taking the drug of choice. Commitments and responsibilities become increasingly neglected and there will be increased self-neglect. This includes neglect of nutrition, of sleep, of grooming and self-care and neglect of normal social interaction. The dependent person often becomes isolated as he or she seeks to avoid influences which might moderate use of the drug of choice. Interventions to decrease the risk include treatment of the addiction process or, in more severe cases, harm reduction as a means of reducing risk.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population. Outreach Services may help reduce risk in those unwilling to engage with mainstream services.

Addendum on Adult Learning Disability Services

Introduction and Context

Within learning disability services, an integral component of sound, robust and safe care delivery is the consideration of risk, and how that risk is effectively assessed and managed, in whatever context it arises. Learning disability services (statutory and non-statutory) work with a heterogeneous, diverse and often vulnerable service user group, and consequently, the concept of risk often presents in a range of different contexts

This addendum, specific to the adult learning disability population, is focused on identifying a small but significant number of individuals who, alongside their learning disability, may also have substantial additional psychiatric, personality, forensic and/or behavioural needs, and who consequently may present with significant risks to self and/or others. Such circumstances require processes of risk screening to be in place, to identify those presenting with the most significant risks and then, for robust, collaborative, and comprehensive risk assessment and management processes to be established, where appropriate, in order to minimise the risk and reduce the potential of harm to self and/or to others.

This addendum only applies to adults. Children with a learning disability should be considered in the context of the CAMHS addendum.

It should be noted that the future direction of service delivery will result in more people with a learning disability (mostly mild to borderline learning disability) receiving services from mainstream mental health, CAMHS and other specialist services such as forensics. In these circumstances, the service in question should use the risk assessment processes that are used routinely with other service users who use that particular service.

The Main Guidance

The principles, fundamentals and processes of risk assessment and management outlined in the main guidance are equally applicable within the field of learning disability. However, a number of key principles and issues that have particular relevance to the field of learning disability include the need to:

- ensure that professionals completing risk assessment and management plans utilise a human rights-based approach (see section below);

- consider proactive/preventative risk reduction measures in the formulation of risk management strategies, including protective factors and individual wishes and strengths;

- involve people with a learning disability and/or their carers in the process of risk assessment and management. Outcomes are likely to be more positive for all concerned if staff optimise the participation of service users and carers in the processes and the decisions made (see section below);

- ensure implementation of the processes and systems across and within other services and agencies (considering the impact on service commissioning and contracts) involved in care delivery to the learning disabled population to whom this addendum applies;

- ensure that risk assessment and management processes utilise positive risk-taking strategies, where appropriate. Overstating risks and being overly risk-averse carry human rights implications for the service user and resource implications for services, and can also lead to unnecessary exclusion from services and stigmatisation;

- ensure shared, multi-professional, and multi-agency collaboration and accountability, with individual practitioners feeling confident and competent to make risk management decisions within a supportive organisational structure;

- promote consistency and standardisation of process and documentation across all care settings in Northern Ireland; and

- consider the impact of these developments from a resource, training and supervision perspective across all involved agencies.

A Human Rights Based Approach

All of the human rights protected by the European Convention belong to and may be relevant for learning disabled people. There are a range of issues that need to be carefully considered in the risk assessment and management process for people with learning disabilities. For example, the individual's right to human rights such as freedom and choice may need to be balanced against the need to protect the individual and/or society's right to protection. Therefore, professionals completing risk assessment and management plans must consider the impact on an individual's human rights, particularly when they are considering interventions such as enhanced supervision, use of medication, or other restrictive practices such as physical restraint. In such circumstances, the least restrictive option needs to be carefully considered. In other circumstances, principles of choice and freedom (e.g. the right to have a sexual relationship) may override the need for protection, recognising that within the right circumstances, taking positive risks can be beneficial, yet still require to be carefully managed.

Consequently, the risk assessment and management process in this addendum places strong emphasis on a human rights-based approach, which means:

a) enabling meaningful involvement and participation of **all** key people, and, in particular, service users;
b) encouraging a positive and proactive approach to risk taking and risk management;
c) considering the least restrictive option(s); and
d) applying the principle of proportionality in all risk management strategies, whereby the management of the risk must match the gravity of potential harm.
(Mersey Care NHS Trust 2008)

Accessible information relating to Human Rights can be found on the Equality and Human Rights Commission website.

http://www.equalityhumanrights.com/pages/eocdrccre.aspx

Involving Service Users and Carers

One of the most fundamental components of any human rights-based approach is involvement of the person concerned and the people who care for him/her. Consequently, the principles stated within the main guidance (Sections 3.4 and 4.8) are fully applicable to the learning disability population.

It is particularly important that staff are open and honest about the purpose and process of risk assessment and management and facilitate service users' and family/carer participation in the process. Consequently, it is important that efforts are made to make the process and documentation amenable and accessible. For example, summary and easy-read versions of the decisions made may have to be developed for some service users.

Family members and carers know the service user best and will have first-hand information about his/her history, behaviours and situation. Involving all relevant stakeholders from the outset in gathering information, in generating ideas and solutions will ensure a positive risk-taking approach and will help in the understanding of risk from various perspectives. Most importantly, such an approach will clarify the responsibilities of each person involved in managing risks effectively.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user and or the family/carer will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement. In such circumstances, the key worker needs to ensure that consideration of consent guidance, mental health legislation and human rights law have been made to ensure that any agreements are within the appropriate and acceptable frameworks. It is essential to recognise the potential within services and family carers for risk aversion that leads to the significant limitation of the person's life experiences and personal development.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment.

Service users may also refuse permission for information to be shared with particular family members and relatives for a variety of reasons: such wishes should always be taken into account. Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Professionals will, of course, need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986.

The issue of consent needs to be very carefully considered within the learning disability arena. The DHSSPS provides informative guidance regarding consent in the document "Seeking consent: Working with people with learning disabilities" (DHSSPS, 2004). However, recognising and understanding the issues involved in informed consent is often challenging, specifically where the individual's judgement is at odds

with that of the professionals/carers involved. Care needs to be taken that incapacity is not assumed relating to decision-making for people with learning disabilities, and shared discussion and decision-making should guard against such incidents in each case.

Further clarification around confidentiality, disclosure and consent can be found in the Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf.

Risk Assessment and Management in Everyday Practice Within Learning Disability Services

The main guidance focuses on 4 distinct categories of risk:

- Risk of harm to self;
- Risk of harm to others;
- Risk of harm to children/vulnerable adults; and
- Risk of harm from others and individual vulnerability.

Considering the preference to have a common and shared framework/protocol across both mental health and learning disability services, these 4 categories will remain the predominant focus within the screening and comprehensive risk management processes.

Although the categories of risk will be universal across learning disability and mental health services, the specific sub-set of risks within each category will be different. An aide memoire (Appendix 1 to this addendum) has been developed to assist staff, users and carers to consider the nature of risk that may be relevant within each category. This aide memoire is however simply a guide to the processes of risk screening, and when completing the more comprehensive risk assessment and management plan. It does not provide a definitive or exhaustive list.

It is also known that people with learning disabilities are vulnerable to exploitation, coercion, harassment, abuse, intimidation and bullying. In this context, the risk assessment and management process will complement and support vulnerable adults' processes.

The Process of Risk Assessment and Management in Learning Disability Services

Considering that the majority of individuals with a learning disability who present to services will not require a risk assessment and management plan in this context, the process of risk assessment and management within learning disability services will follow a slightly different pathway from that outlined in Section 4 of the main guidance. Arrangements within learning disability services, will involve the following 4 stage process:

1. Routine initial assessment;
2. Risk Screen;
3. Comprehensive and/or Specialised Risk Assessment and Management Plan; and
4. Review.

Stage 1. Routine Initial Assessment

Routine initial assessment will take place as is currently the case for every individual who presents for community-based learning disability services. It is good practice for all types and levels of risk (where apparent) to be thoroughly explored at the initial assessment phase. Trusts should, therefore, satisfy themselves that the routine assessment processes utilised at various points of access to learning disability services will identify needs, in the context of additional behavioural, forensic, personality or psychiatric co-morbidity that may benefit from a risk screen.

It is anticipated that for the high majority of service users with a learning disability, there will be no need to move to the next stage of risk screening in the context of additional behavioural, forensic, personality or psychiatric needs.

Indicators of need to carry out a risk screen may include:

- A history of violence or harm to others;
- Involvement with the Criminal Justice System;
- Inappropriate sexualised behaviour;
- A history of being easily led/exploited by others;
- Any issues regarding access to children; and
- Behaviour change as a consequence of mental health deterioration.

NB. IN CIRCUMSTANCES OF ADMISSION TO HOSPITAL, THE RISK SCREEN SHOULD BE COMPLETED FOR ALL NEW ADMISSIONS.

Stage 2. Risk Screen

When it is decided to complete the risk screen (Appendix 2), this will be completed by the relevant named nurse and admitting doctor (hospital) or named/key worker (community). Clearly, other relevant members of the multi-disciplinary team will be involved in this process. As is stated within the main guidance, screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Depending on the risk factors identified in the risk screen, a decision will need to be taken whether or not to progress to completion of the comprehensive risk assessment and management plan (Appendix 3) or, indeed, a specialised risk assessment process (see below).

There is no definitive threshold for such decisions. Clinical judgement, rather than specific scoring/rating systems, should inform decision-making through the stages of risk assessment and management. These decisions will be made by the relevant multidisciplinary team members involved in the service user's care, the line manager, and will include the service user and relevant carer(s).

This process should identify those individuals who have additional forensic, personality, psychiatric, and/or behavioural needs, **and** who present with

significant risks to self and others, **and** who require a more comprehensive assessment and management plan to address the risks that present.

Although not a definitive or exhaustive list, possible triggers for completion of the comprehensive risk assessment and management plan will include a previous history of involvement by the service user in activity such as:

- Sexual assault (as victim or perpetrator)
- Arson
- Exploitation
- Violence
- Self-harm
- Concerns regarding access to children

At the routine assessment stage it may be immediately apparent that a comprehensive or specialised risk assessment will be required. However, in many circumstances, the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately. Therefore the risk screen will still need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

NB. The risk screen also prompts the assessor to identify risks relating to physical health, such as epilepsy, complex health needs, risk of aspiration etc. However, this tool is specifically designed to assess and manage risks related to additional forensic, personality, psychiatric and behavioural needs. Therefore, any physical health risks identified at screening should be addressed via alternative risk assessment and management pathways (e.g. manual handling risk assessment).

Stage 3. The Comprehensive Risk Assessment and Management Plan

If a decision is taken to complete the comprehensive (or specialised) risk assessment and management plan, a key worker and care coordinator (Section 4.5 of main guidance) should be identified.

The key worker should ensure that the process of risk assessment and the development of the risk management plan is completed within 28 days of the risk screen being completed.

From a community perspective, completion of the comprehensive risk assessment and management plan (Appendix 3) should be facilitated by the key/named worker, although it is essential that it is contributed to by relevant members of the multidisciplinary team. Within the hospital setting, a member of the hospital staff will be responsible for facilitating completion of the comprehensive assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this role. The service user and family members/carer(s) should (where possible and appropriate) be fully involved in the risk assessment and management process.

Accurate history-taking plays an important role in the process of risk assessment. Relevant information should be obtained from health records and referral letters, as well as by asking service users themselves, carers, and other family members. It is important to obtain past records from other hospitals, districts, or social services departments and a history of criminal offences (where applicable).

Sometimes it may not be possible to obtain sufficient information to conduct a thorough and accurate assessment: immediately, in which case, this should be recorded and arrangements made to seek relevant information at a later stage. Self-reliance on information provided by service users should always be considered in the context of other available information.

The subsequent risk management plan must be based on the outcome of the above assessment, whereby the multidisciplinary team share responsibility for ensuring that risk is minimised, as far as possible, and managed effectively. The management plan should ensure that there is an appropriate balance between protection and ensuring that the service users psychological, physical and social needs are addressed, and that human rights are not compromised.

Within the risk management plan the following areas should be considered:

a) Triggers and warning signs;
b) Proactive and preventative strategies;
c) Reactive and emergency strategies; and
d) Human rights considerations.

Within risk assessment and management, proactive and preventative strategies, rather than simply reactive approaches are more likely to have long term impact and are more consistent with a human rights based approach. Such proactive strategies may include:

- Putting in place a suitable social activities programme to reduce boredom and social isolation
- Provision of sex education
- Referral for psychological therapy
- Skills teaching such as anger/stress management
- Managing the environment e.g. reduction in noise or activity
- Education and training of staff in relation to behaviour management, communication, mental health needs etc.
- Referral to the relevant behaviour support team
- Increasing the availability of appropriate support (e.g. family, carers, professionals, community workers, advocates, accommodation needs, day care needs, Probation Service etc);

Reactive strategies are an immediate or emergency response to the specific risks identified, and may include:

- Increasing the frequency of home visits
- Increasing the level of observation
- The use of prescribed medication
- The use of prescribed physical intervention

- The use of legal processes such as the Mental Health (Northern Ireland) Order 1986 or calling the police

Where the risk management plan identifies needs that cannot be met, these must be recorded in the "unmet needs" section and immediately brought to the attention of the relevant line manager. Any dispute or disagreement should also be recorded in the relevant section and immediately brought to the attention of the relevant line manager.

When completed, the risk assessment and management plan should be signed by the service user and/or his/her principal carer. Should either be unable or unwilling to sign the reason(s) should be clearly recorded. The risk assessment and management plan should also be signed by the key worker/caseload holder, and all who contributed to its completion and should be signed by the care co-ordinator/line manager.

In finalising and agreeing the risk management plan it is good practice to consult with and involve those people who will be expected to deliver and monitor it. Consultation, therefore, should also take place with relevant service providers and other carers. Care delivery can take place in a range of different environments, including inpatient settings, day care, residential care, and in the person's home. The risk assessment and management plan should therefore be integrated with other support plans such as the person's Essential Lifestyle Plan or Service Plan as a process of best practice. This information should be recorded in the section "Communication and information sharing process"

Specialised Risk Assessment

Although it is anticipated that in most circumstances the generic risk assessment process will suffice, there will be some occasions when an adult with a learning disability presents risks in areas such as extreme violence and aggression, sexual violence, offending behaviour and suicide. In these circumstances, the following considerations should be helpful in ensuring a robust approach to specialised risk assessment and management tools/processes.

Most of the research and evidence base around specialised risk assessment tools has taken place within mental health settings. However, the literature on the use of specialised risk assessment tools in the learning disability population reflects increased recent interest in exploring the validity of tools developed within forensic or general mental health practice for this population.

Evidence is now growing that the following tools are useful and valid for the assessment of people with a mild/moderate learning disability who present with significant risks in areas such as violence, arson, sexual violence or other inappropriate sexual behaviour:

- HCR-20 - (Historical, Clinical, Risk management–20, Webster et al., 1997)
- PCL-SV - (Hare Psychopathy Checklist: Screening Version (PCL:SV), Hart et al., 2004);
- VRAG - (Violence Risk Appraisal Guide, Quinsey, 2003);
- RRASOR - (Rapid Risk Assessment of sexual offence recidivism, Hanson, 1997);

- Static-99 - (Hanson and Thornton, 1999);
- RAMAS - (Risk assessment, audit and management systems, O'Rourke and Hammond, 2004);
- RSVP - (The Risk for Sexual Violence Protocol, Hart et al., 2003);
- SARN – (Structured Assessment of Risk and Need, Thornton, 2002).

The development of new tools for specialised risk assessment with people with a learning disability has also progressed in recent years. Validation work continues on DRAMS (Dynamic Risk Assessment and Management Systems, Lindsay et al., 2004) a tool for the assessment of dynamic risk factors that is designed to be used collaboratively and specifically with service users with a learning disability. It shows evidence of effectiveness for both risk assessment and therapeutic purposes.

The ARMIDILLO (Assessment, Risk Management of Intellectual, Developmental or Learning Disabled Offenders, Boer et al., 2007) is also currently undergoing validation and shows a high level of face validity in its consideration of both internal and environmental risk factors.

These specialised risk assessments are likely to be undertaken by a relatively small number of clinicians and efforts should be made to ensure a degree of consistency across the region. Further clarification on the range of tools appropriate and available for use with those service users with a learning disability who present risks in these specific areas should be sought from the responsible medical officer, and/or local/regional forensic leads within the Learning Disability Service.

It should be noted that the need to utilise a specialised risk assessment process may become apparent having gone through all the stages of risk assessment. Equally, the need for specialised risk assessment may become apparent at the screening stage.

Stage 4. The Review Process

The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed. Section 4.3 of the main guidance provides clarity in respect of the review process, and similar approaches to review should take place within learning disability services.

At review, it is important that relevant information is brought to the table, including any incidents/near misses since previous review, any changes in unmet needs, any changes in personnel, and what worked and what didn't in managing the risk. A format to assist in the review process is provided in Appendix 4 of this addendum.

It is recognised that there may be regional variation in the use of routine assessment (stage 1) formats for individuals who present to learning disability services. However, the same processes and documentation formats for stages 2 and 3 should be used consistently across the region. The review process (Stage 4) and forms should also be used consistently across the region.

Hospital Admission and Discharge Planning

As outlined in the main guidance, the key to good risk assessment and management for service users admitted to any inpatient assessment and treatment facility is effective communication and liaison between community and hospital personnel. Most admissions of learning disability service users to hospital are as a consequence of risk to self/others, or significant vulnerability. Consequently, it is recommended that **all** new admissions to hospital have a risk screen carried out on admission (which may be a review of a previous risk screen that has already been completed). This is necessary to inform the decision regarding the need for further in depth comprehensive or specialised risk assessment.

As outlined earlier, there may be circumstances where it is immediately apparent that a comprehensive or specialised risk assessment will be required. Once again, in acknowledging that the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately, the risk screen will need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

As part of safe and effective care delivery and robust discharge planning, the multidisciplinary team (including hospital and community personnel), the service user and carer, should be involved in determining and agreeing whether the comprehensive or specialised risk assessment and management plan needs to be applied on discharge. This decision should be routinely documented as part of the discharge planning process. For further guidance on the process of discharge planning, please refer to Section 4.11 of the main guidance.
As already highlighted, a member of the hospital staff will be responsible for coordinating the comprehensive risk assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this coordinating role.

Interface arrangements

Service users who have a learning disability will encounter a range of other transitions and interface arrangements: e.g. between children and adult services; within generic health and mental health settings; and with other agencies (housing and employment). To effectively manage such circumstances and maintain continuity of risk management, the same principles as outlined in the main guidance (Sections 4.9 and 4.10) should be applied.

Protocols governing the interests of service users between and within services/agencies need to be developed by learning disability service providers to ensure clear guidance for staff in maintaining and reviewing risk management plans at such times.

Co-ordination Responsibilities

Considering the wide range of services and agencies that may be involved in the delivery of care and support to adults with a learning disability, critical to the success of effective risk assessment and management is a coordinated approach.

As outlined in the main guidance, statutory agencies will have lead and coordinating responsibility. Therefore, this responsibility will either be held by community learning disability teams for community-based service users, or by the learning disability hospital if an individual is admitted to that setting (see above). Without a designated lead/coordinating agency, there is the potential for confusion, duplication and disjointed application.

As stated above, many non-statutory and other agencies may be involved in the delivery of care and support to individuals, and to assure effective risk communication, the lead individual/service must ensure that information available is documented and communicated to all those who need to have access to it, in order to effectively care for the service user and protect him/her/others from the risks identified within the risk assessment (see Section 3.5 of the main guidance).

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Appendix1

AIDE MEMOIRE FOR LEARNING DISABILITY SERVICES

NB, THIS IS AN AIDE TO BOTH THE SCREENING AND THE COMPREHENSIVE RISK ASSESMENT PROCESSES AND IS NOT AN EXHAUSTIVE LIST

RISK OF HARM TO SELF • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Alcohol/ substance misuse. • History of self harm or self injurious behaviour. • Reckless behaviour. • Impulsive behaviour • Sexualised behaviour causing concern such as, promiscuity/exploitation	**RISK OF HARM TO OTHERS** • Previous violence, aggression or assault towards others including – other patients vulnerable people / staff / family / carers / general public • Actual or suspected criminal history. • History of violent/sexual offences or assaults • Previously been a diagnosis made of psychopathy / antisocial personality disorder • Talking of or threats to harm others • Display high anger, hostility, threatening behaviour • History of owning, carrying, using weapons • History of property damage or arson
RISK FROM OTHERS AND VULNERABILITY • Known history of abuse towards the individual (physical, financial, sexual). • History of being targeted/bullied • History of being easily led and exploited by others. • Previous history of poor engagement with services/ treatment / medication • Problems coping with severe stress (e.g. bereavement) • Current/previous history of severe self neglect, inadequate housing, poor nutrition, poor hygiene	**CHILDREN AND/OR VULNERABLE ADULTS AT RISK** • Previous concerns regarding access to children. • Service user has been linked to formal vulnerable adult processes. • Involvement of other services, eg, family and child care team, CAMHS, health visiting. • Threats of previous harm to, or preying on any child / children or other person. • Emotional abuse or neglect of children • History of family or domestic violence • History of volatile personal relationships
THE FOLLOWING AREAS SHOULD ALSO BE CONSIDERED TO INFORM THE SCREENING, RISK ASSESSMENT AND MANAGEMENT PLAN PROCESSES	
MENTAL STATE (IF APPLICABLE) • Previous history of mental illness and associated risk behaviour • Delusions and/or hallucinations (command) associated with risk behaviour. • History of emotional distress associated with risk behaviour • Relapse indicators. • Medication effects, side effects and concordance. • Previous involvement in therapy for anger management..	**ENVIRONMENTAL FACTORS** • Suitability of the living environment (e.g. in design, or proximity to potential victims, access to intoxicants) • Staffing levels • Staff skills , attitudes and competencies • Communication systems • Lack of purpose and structure to day to day life
OTHER POSSIBLE INDICATORS OF RISK • Recent severe stress/loss. • Concern expressed by others • Impending stressors e.g. court appearance • Lack of social or carer support system • Difficulties managing or coping with social and personal relationships • Nomadic lifestyle • Housing problems • Severe financial difficulties • History of compulsory admission • Social isolation.	**HUMAN RIGHTS CONSIDERATIONS** • Involving service users and carers (where appropriate) throughout the process. Consent process followed • Consider wishes of service user • Consider skills and strengths of the individual • Utilise the least restrictive option • Consider what is important “to” the service user • Consider communication needs • Facilitate understanding of the process • Provision of appropriate and accessible information • Consider advocacy arrangements • Proportionality should be considered • Emphasis on proactive and preventative strategies
POTENTIAL PROTECTIVE FACTORS • Willingness to engage with learning disability services • Compliance with medication • Abstinence from alcohol/ drugs • Effective family/ social support networks • Faith/ religion • Financial security • Having a job / constructive activity • Ability to communicate • Belief that change is possible • Previous approaches used successfully to manage risk • Positive risk taking	**ADDITIONAL RISKS (REQUIRING ALTERNATIVE PATHWAYS OF REFERRAL OR INTERVENTION)** • Complex physical health needs • Specific co-morbid conditions such as Epilepsy, Diabetes etc. and associated risks • At risk of accidental wandering / falls / harm inside or outside the home. • Risks associated with nutrition/swallowing/aspiration • Risks associated with daily living (e.g. road safety, fire safety etc)

Appendix 2

RISK SCREENING TOOL FOR LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		*Voluntary*		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED FOR COMPLETING RISK SCREEN

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / Probation Services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE BRIEF DETAILS UNDER EACH HEADING ***(in particular, you should consider the likelihood and consequences of the risk behaviour taking place)***

RISK OF HARM TO SELF	**Yes □ No □ Unknown □**
RISK OF HARM TO OTHERS	**Yes □ No □ Unknown □**
RISK FROM OTHERS AND VULNERABILITY	**Yes □ No □ Unknown □**

CHILDREN AND/OR VULNERABLE ADULTS AT RISK	**Yes** □ **No** □ **Unknown** □
ASSESSMENT OF MENTAL STATE (IF APPLICABLE)	
ENVIRONMENTAL FACTORS THAT MAY BE ENHANCING THE RISK	
OTHER INDICATORS OF RISK	
CURRENT PROTECTIVE FACTORS	
OTHER RISKS HIGHLIGHTED DURING SCREENING *(NB: This section may highlight other risks such as risks associated with epilepsy, or risk of falls which will indicate the need for alternative pathways of risk assessment such as epilepsy risk assessment or manual handling risk assessment).*	
COLLATERAL HISTORY (INCL. RELATIONSHIP TO SERVICE USER)	

SUMMARY OF CURRENT RISKS:

(NB. *Should any risk issues have been identified in the above section, and the decision is* ***not to*** *proceed with the full risk assessment and management documentation, please specify reasons here).*

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK

ACTION	LEAD RESPONSIBILTY	Signed/Date

Risk screen completed by:_____ Designation: _____

Date: _____

Contact Tel. No. _____

Signature of Medical Officer *(for inpatient admissions only)* _____

Designation: _____ Date: _____

Contact Tel. No. _____

Service user signature: _____ **Date:** _____

Unable/Refusal to sign ☐ Please explain:

Carer signature: _____ **Date:** _____

Unable/Refusal to sign ☐ Please explain:

Is a comprehensive risk assessment and management plan indicated? Yes ☐ No ☐

Is a specialised risk assessment and management plan indicated? Yes ☐ No ☐

IF NO, PLEASE OUTLINE ACTION TAKEN_____

Line Manager Signature: _____ **Designation:** _____

Date: _____

Contact Tel. No. _____

DISTRIBUTION
Service user ☐ Carer/Family member ☐ Key Worker ☐ Other ☐ (specify)

IF COMPLETING COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN:

KEY WORKER WIL BE: _____

CARE CO-ORDINATOR WILL BE: _____.

Appendix 3

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

THOSE CONTRIBUTING TO COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**
OTHER INFORMATION SOURCES		

STATEMENT OF CURRENT CAUSE FOR CONCERN (including brief pen picture, background information, and why there is a need for comprehensive risk assessment)

CHRONOLOGY OF SIGNIFICANT EVENTS

EVENT (include date of event, if known)	Source of Information	Time/Date/Signature

HISTORICAL FACTORS: *(Consider an analysis of the significant events above. Assessors should look for patterns or trends in the service users behaviour. Analyse their frequency and severity and the context in which they took place (e.g. for aggressive or violent behaviour: has this been targeted at other service users, staff, children). Consider how these were managed previously. Other contextual issues such as exposure to institutional care, involvement with the criminal justice system, any history of drug/alcohol abuse)*

CLINICAL FACTORS: *(Consider the degree of learning disability, associated conditions (e.g. autism, epilepsy), physical and mental health factors that may affect the risks posed by or to the service user, previous clinical psychological or behavioural interventions associated with potential risks. Also consider the service users interpersonal style (traits such as impulsivity, hostility, anger, ability to self control will all affect how risk is managed):*

SOCIAL FACTORS: *(Consider previous and current social factors that may affect the risk behaviour, such as early childhood experiences, relationship stability, ethnicity, bullying, social isolation, finance, environmental factors(such as layout of environment, access to weapons) that may enhance or contribute to risk behaviour)*

HUMAN RIGHTS CONSIDERATIONS: *(What are the key human rights issues to consider in the formulation of this risk management plan. Consider the strengths and wishes of the service user, the need for advocacy, proactive/preventative strategies, positive risk taking, proportionality and least restrictive option).*

RISK MANAGEMENT PLAN FOR .....

1. RISK OF HARM TO SELF

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour)*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

2. RISK OF HARM TO OTHERS

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential severity of consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

3. RISK FROM OTHERS AND VULNERABILITY

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

4. CHILDREN AND/OR VULNERABLE ADULTS AT RISK *(Specify arrangements for care of any dependent children)*

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

COMMUNICATION AND INFORMATION SHARING PROCESS: *(Specify who needs to receive a copy of this risk management plan, are there any confidentiality or consent issues in sharing information that need to be considered?)*

UNMET NEEDS IDENTIFIED: *(Please include any difficulties encountered in applying any of the preventative or control mechanisms to address the stated risks in any of the settings (including home) in which the individual receives care).*

Has this risk assessment and management plan been shared with the service user, and/or carers?

Service user: Yes ☐ No ☐ **Service user signature .....**

Refusal to sign ☐

Unable to sign ☐

Carer: Yes ☐ No ☐ **Carer signature .....**

Refusal to sign ☐

If not shared, please specify reasons.

Are there any disagreements with this risk assessment and management plan from the individual service user, main carers or relevant others? Yes ☐ No ☐

If yes, please specify nature of disagreement and outline action taken.

Signature of Key/Named Worker _____Date:_____

Signature of Line Manager/Care Coordinator: _____Date: _____

Signatures of all other professional/advocacy staff involved in the development of this comprehensive risk assessment and management plan

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Date of Review: _____

Appendix 4

Comprehensive Multidisciplinary Risk Assessment and Management Plan

Review Record

Service user name:_____

Attended By **(Identify each person's role in the review)**	**Person's consulted** **Persons not in attendance**

Date of initial risk assessment:_____ Date of last review: _____

Overview since previous risk assessment/management plan:(include any incidents/near misses, changes in unmet need or involved personnel, what worked and did not work, changes in service user's situation/understanding/co-operation levels/self management skills).

Action(s) required following this review

Key actions	Responsible person	Target date

Signature of service user _____Date _____

Signature of Key/Named Worker _____ Date: _____

Signature of Carer _____ Date _____

Signature of Line Manager _____ Date _____

Copies to: (please list all individuals/services who are provided with a copy of this form)

_____
_____
_____
_____
_____
_____

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Annex A

Assessment and Management of Risk Regional Steering Group Members

Ms Linda Brown (Chair)	DHSSPS
Mr Martin Bradley	DHSSPS
Ms Maura Briscoe	DHSSPS
Mr Hugh Connor	Eastern Health and Social Services Board
Ms Marie Crossin	CAUSE
Dr Oscar Daly	South Eastern Health and Social Care Trust
Mr Martin Daly	LAMP
Mr Oscar Donnelly	Northern Health and Social Care Trust
Ms Norma Evans	Northern Health and Social Care Trust
Mr Roy Keenan	DHSSPS
Dr Paula Kilbane	Eastern Health and Social Services Board
Mr Paul Martin	DHSSPS
Mr Brendan Mullen	Belfast Health and Social Care Trust
Professor Roy McClelland	Board for Mental Health and Learning Disability
Mr Paul McFall	LAMP
Mr Noel McKenna	Mental Health Commission (Northern Ireland)
Dr Ian McMaster	DHSSPS
Mr Colin McMinn	DHSSPS
Miss Gillian McMullan	DHSSPS
Ms Heather O'Neill	DHSSPS
Mr Jude O'Neill	Regulation and Quality Improvement Authority
Dr John Simpson	Southern Health and Social Care Trust
Mr Phelim Quinn	Regulation and Quality Improvement Authority

Annex B

Background

Context

In May 2006, both in response to serious adverse incidents reported to the Department and to the publication of the McCleery Independent Inquiry Report, DHSSPS established a multi-agency Regional Steering Group to address the issues raised in relation to the assessment and management of risk within adult mental health and learning disability services.

To do this, a key objective of the Group was to develop regional guidance to ensure that mental health provider organisations have robust risk assessment and management processes embedded in their practice to minimise, as far as possible, the occurrence of adverse incidents.

The Steering Group was informed in the development of this guidance by:

- *A review of current practice in HSC Trusts;*
- *A review of currently available information on adverse incidents in general mental health and learning disability services; and*
- *Regional stakeholder workshops to identify good practice and challenges in risk assessment and management by mental health services.*

The publication of the O'Neill Independent Inquiry Report in March 2008 significantly reinforced the need to urgently address these issues and highlighted recurring systematic failures, e.g. poor communication between professionals, lack of collaboration and ineffective interfaces between services, and a failure to adequately address the holistic needs of the service user and his/her families/carers.

Review of Current Practice

During the Autumn of 2007 the RQIA carried out the first dedicated Clinical and Social Care Governance Review of general adult mental health within each of the five HSC Trusts in Northern Ireland. The review was commissioned by the Steering Group to provide independent assurance that the Trusts have appropriate policies and standard operating procedures in place for the assessment and management of risk, which are in keeping with the McCleery Report recommendations and the 2004 Departmental Discharge Guidance.

Each Trust completed a 'Self Assessment Proforma' supported by evidentiary documents. Visits to validate the information were then completed by multidisciplinary review teams, comprising Health and Social Care professionals (Peer reviewers) and members of the public (Lay reviewers).

Key findings from these review visits have been incorporated into this guidance and an overview report was published by the RQIA in March 2008.

Review of Local Adverse Incidents

This work was informed by *'Supporting Safer Services'*, the second annual DHSSPS report promoting safety and learning arising from serious adverse incidents[28]. It found that between 1st January 2006 and 31st March 2007, 43% of all incidents notified to the Department came from mental health services. Whilst the report acknowledges that mental health service users are vulnerable to a number of potential risks such as self-harm, violence and aggression, which may be linked to their mental illness, much can still be done to reduce their risk of harm.

The report highlighted learning for mental health services categorised by three themes: assessment and management of risk; Trust internal reviews; and suicide and self-harm. Several areas for improvement in relation to the assessment and management of risk were suggested, including:

- *Prompt and proactive follow-up following discharge from inpatient care;*
- *Management of disengagement from services;*
- *Management of alcohol misuse, especially with dual diagnosis;*
- *Improving compliance with medication;*
- *Preventing absconding, especially detained patients;*
- *Increased staff awareness/training to encourage identification and management of specific well known risk factors;*
- *Improving assessment and management of risk, both to self and others, with particular focus on risk factors sometimes being identified but not managed prior to "inevitable" incident; and*
- *The need to establish consistency across HSC units on risk assessment and subsequent management.*

Regional Stakeholder Workshops

The Department held a series of workshops in each of the five HSC Trust areas across Northern Ireland between January and March 2008. These were extremely well attended, with representation from user and carer organisations, each of the different mental health professional groups in HSC Trusts, HSS Boards and from the voluntary sector. During the workshops, the outcomes of the RQIA review visits were reported and views taken on key issues and good practice examples regarding risk assessment and management. Feedback from the workshops has been incorporated into this guidance.

The views of service users, their families and carers must be central to any decisions affecting the future planning and delivery of mental health and learning disability services[29]. Voluntary sector organisations representing both service users and their families and carers through real-life experiences, have made a valuable contribution to the development of risk assessment and management processes.

[28] *An adverse incident is "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation" (DHSSPS 2007a, 7)*
[29] *DHSSPS (2007a)*

Similarly, as regards identifying examples of good practice and understanding the challenges of risk assessment and management, mental health staff are key. Collaboration with professionals working throughout the service in Northern Ireland is essential to explore the potential opportunities for improvement.

At the workshops, there was some apprehension about using the word 'risk' in mental health services, as it was thought it might stigmatise service users and act as a barrier to involving them in a collaborative process. Whilst this concern is recognised, for the purposes of this guidance "risk" is being used as it represents a commonly understood term within mental health and learning disability services.

It is important to reinforce that risk assessment is only one component of the overall comprehensive assessment of a service user's health and social care needs, which contribute to the development of an effective Care Plan. A balance must be maintained between the need of the service user to progress towards recovery and the responsibility of mental health professionals to ensure the safety of the service user and that of those around him/her.

Development of Guidance

On the basis of these strands of work, the Department prepared draft guidance and issued it for consultation over July and August 2008. This included hosting one further stakeholder consultation conference. The responses to this exercise informed the finalisation of this document for the Steering Group's approval.

Supporting Tools

In addition, to support the implementation of this guidance, the Steering Group oversaw the development of new regionally-agreed risk screening and risk assessment and management tools. These were piloted over a 12 week period in adult mental health services in each HSC Trust at the beginning of 2009, in order to test their viability in day-to-day practice and to enable them to be finalised.

Tools for use in learning disability services are being similarly piloted in those services within each Trust and will be issued when finalised. Tools for use in CAMHS are also being developed.

Specialist Addenda

Another element of the work has been to develop specialist addenda to the main guidance, on specialist mental health services (CAMHS, forensic mental health services and addiction services) and on learning disability services, to provide advice on any specific issues and procedures within these areas of provision. A stakeholder consultation exercise on draft versions of these addenda was conducted in the Spring of 2009, as a result of which, they have been finalised and incorporated into the guidance document.

Annex C

What Is Meant by 'Risk'?

Risk relates to the possibility that service users will cause harm to themselves or others, i.e. physical violence to self (self-harm/suicide/self neglect) or to others, and psychological harm.

When actively assessing risk, historical information should be considered according to[30,31,32]:

- ***Recency*** *– When was the last incident of harm to self or others?*
- ***Severity*** *– How serious have previous incidents been?*
- ***Frequency*** *– How frequently do incidents of harm to self or others occur?*
- ***Pattern*** *– Is there a common pattern to the type of incident or the context in which it occurs?*
- ***Likelihood*** *– How likely is it that the event will recur?*

Risk assessment involves working with a service user to determine each of these aspects of risk. The assessment requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change.

Risk factors are not static and can be increased or decreased.

Risk factors relate to issues both internal and external to the client. There can be significant impact from external factors, for example: staff factors (attitudes; knowledge; training etc.); and organisational factors (such as openness of communication systems; models of staff support deployed etc.).

Risk Factors – A Risk Factor is "a personal characteristic or circumstance that is linked to a negative event that either causes or facilitates the event to occur" (DH, 2007a, 13).

The assessment of risk requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change. It also requires professionals to make a judgement on the basis of the information available at the time. This is always difficult but it is a professionally-informed decision. Consider:

- *What are the factors which contribute to the risk for the individual service user?*
- *Is the risk factor stable (e.g. history of child abuse) or dynamic (e.g. drug and alcohol use, current mental state)?*
- *Is the risk specific (i.e. directed at an individual person) or general?*
- *How can risk factors be modified or managed?*

[30] *University Of Manchester (1996)*
[31] *DH (2007a)*
[32] *Royal College of Psychiatrists (1996)*

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Appleby L, Shaw J, Kapur N, Windfuhr K *et al.,* 2006) found risk factors for suicide to include: acute episodes of illness; recent hospital discharge; social factors such as living alone; and clinical features such as substance misuse and non-fatal self-harm.

Types of Risk Assessment

Risk assessment seeks to identify the specific risks in an individual service user. There are three main methods to predict risk outcomes.

The **unstructured clinical approach** is based on interviews with the service user and his/her family/carers. As it does not follow a structured format there is the potential that important risk factors will be missed (DH, 2007a). Also, the element of subjectivity in the approach makes it susceptible to bias on the part of the clinician (Ryan, 2006).

The **actuarial approach** measures levels of risk according to factors that have been shown as statistically associated with increased risk amongst a large population of people. An overall score is calculated as a predictor of future risk over a specified time period.

Actuarial tools have several weaknesses. They are only applicable and suitable for use with service users who come from the population for whom the tool was developed and they emphasise risk prediction rather than management (DH, 2007a). Also, they tend not to be sufficiently sensitive to the idiosyncrasies of every individual service user they are used to assess (Ryan, 2006).

- *Actuarial tools should only inform clinical judgement*
- *They are not a substitute for clinical judgement but an aid to it*

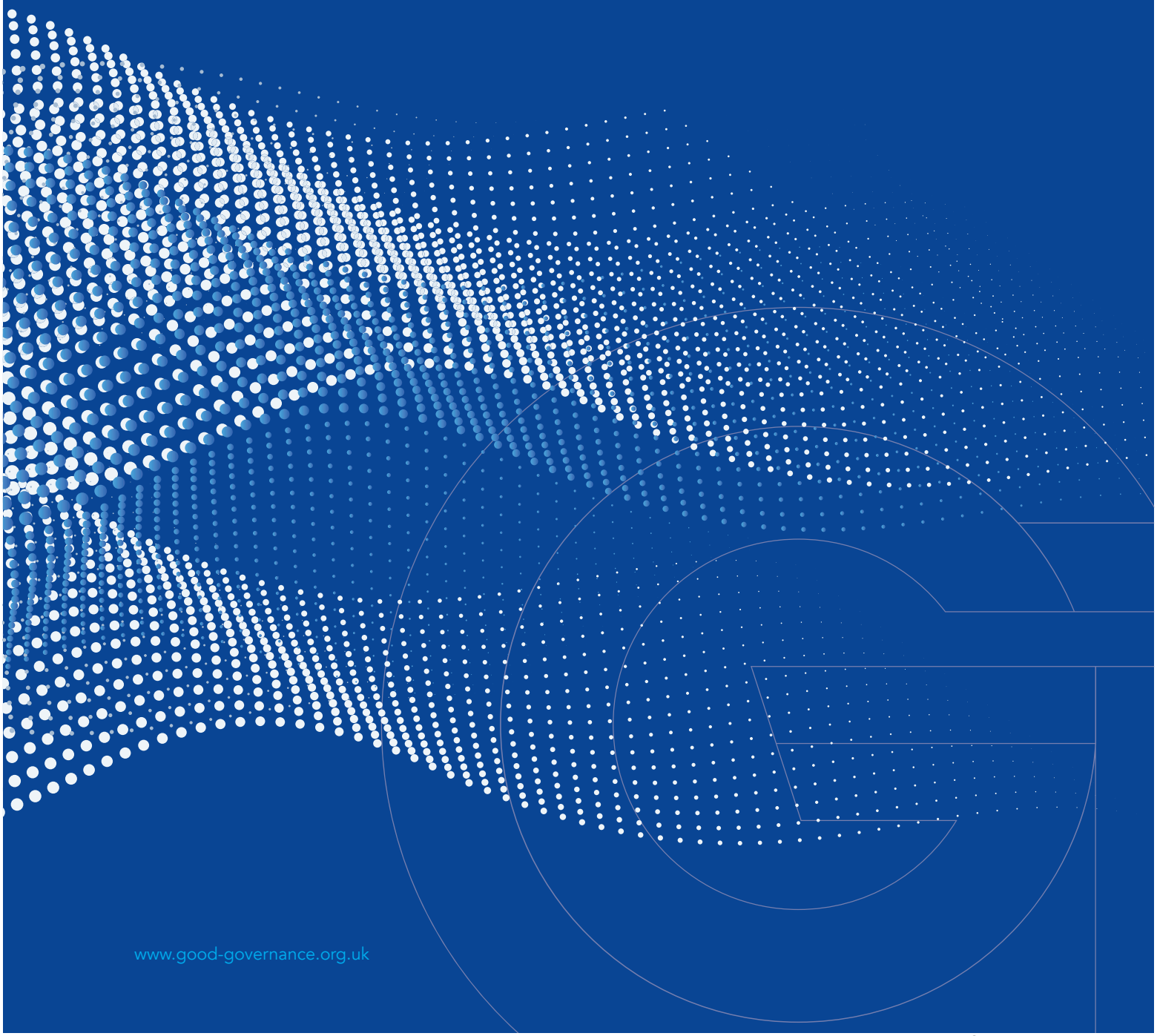
The structured clinical judgement approach combines the use of actuarial tools or evidence-based risk factors, clinical judgement and information from service users and their families/carers to assess risk. This is thought to be the best approach for risk assessment (Morgan J.F., 2007; Higgins *et al.,* 2005).

Good Governance Institute

Board guidance on risk appetite

Good Governance Institute (GGI)

May 2020



www.good-governance.org.uk

Board guidance on risk appetite

Risk appetite, defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take[1]' in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation's risk management strategy – and indeed its overarching strategy.

It is important that boards understand and apply risk appetite because:

- If they do not know what their organisation's collective appetite for risk is and the reasons for it, this may lead to erratic or inopportune risk-taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If they do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected
- It can serve as the basis for consistent and explicit communication at different levels, and to different stakeholders. Risk appetite will be influenced by a number of factors including personal experience, political factors and external events among others.

Risk can generate significant opportunities and therefore should be considered in terms of both opportunities and threats:

- When considering threats, the concept of risk appetite embraces the level of exposure which is considered tolerable and justifiable should it be realised
- When considering opportunities, the concept embraces consideration of how much one is prepared to actively put at risk in order to obtain the benefits of the opportunity
- It is important that boards understand that in order to achieve their strategic objectives they may have to adopt a more assertive risk appetite, recognising that risk appetite should be forward-looking.

Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board's strategy and risk appetite. It is the level of residual risk within which the board expects sub-committees to operate and management to manage. Breaching the tolerance requires escalation to the board for consideration of the impact on other objectives, competing resources, and timescales.

At least once a year, the board should set specific limits for the levels of risk the organisation is able to tolerate in the pursuit of its strategic objectives. The board should also review these limits during periods of increased uncertainty or adverse changes in the business environment.

In setting these risk appetite and tolerance levels, the board should consider risk factors in both the external and internal business environments. These levels could be measured quantitatively, qualitatively, or both, and should be specific to each of the relevant core activities and outcomes.

The board may also set limits regarding the enterprise's risk appetite, i.e. the risk limits that the board desires, or is willing to take.

The board should monitor and audit the management of significant risk undertaken by managers and clinical staff and satisfy itself that decisions balance performance within the defined appetite and tolerance limits. The board should ensure that it understands the implications of risks taken by management in pursuit of better outcomes, as well as the potential impact of risk-taking by, and on, local communities, partner organisations, strategic providers and other stakeholders.

This process is dynamic; risk probability and impact as well as risk appetite can change through circumstances and experience. The perception of the public to risk and confidence in the organisation's ability to identify and mitigate risk successfully can shift quickly in the light of publicity and risk failures often outside the direct control of the organisation. As such, risk awareness and communication play an important part in protecting the reputation of the organisation from such instances of outrage.

1. ISO 31000

ISBN: 978-1-907610-57-8

Published May 2020 by GGI Development and Research LLP, london

Good Governance Institute, (Company number 590301 Registered in the Republic of Ireland) Registered office: The Black Church St. Mary's Place Dublin 7 D07 P4AX Republic of Ireland; GGI Limited (Company number: 06836117 Registered in England and Wales) Registered Office: Old Horsmans, New Road, Sedlescombe, Battle, East Sussex, TN33 0RL UK; GGI Development and Research LLP (Company number C384196 registered in England and Wales) Registered Office: Old Horsmans, New Road, Sedlescombe, Battle, East Sussex, TN33 0RL, UK

GGI believes that it helps to identify different types of risk (including, but not limited to, finance, regulation, quality, reputation, and people) but it is important to always assess these in the round. To support this, we have developed the risk appetite matrix.

The matrix sets five levels of risk appetite for each of the risk types. There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, considering the risk appetite of others and the capacity for management to communicate and deliver.

Boards should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help the board to better manage its agenda and the level of routine reporting required.

Breaches of agreed appetite must be escalated with agility.

Strategic risks and the board assurance framework

A critical role of any board is to focus on the risks that may compromise the achievement of the organisation's strategic objectives. In order to be confident that the systems of internal control are robust, a board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them.

A good board assurance framework (BAF) is a live tool that helps boards to undertake this duty by providing a simple yet comprehensive means by which to effectively manage the principal risks to meeting the strategic objectives. The Audit Committee Handbook identifies the BAF as 'the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the board should use in discharging its overall responsibility for internal control'.[2]

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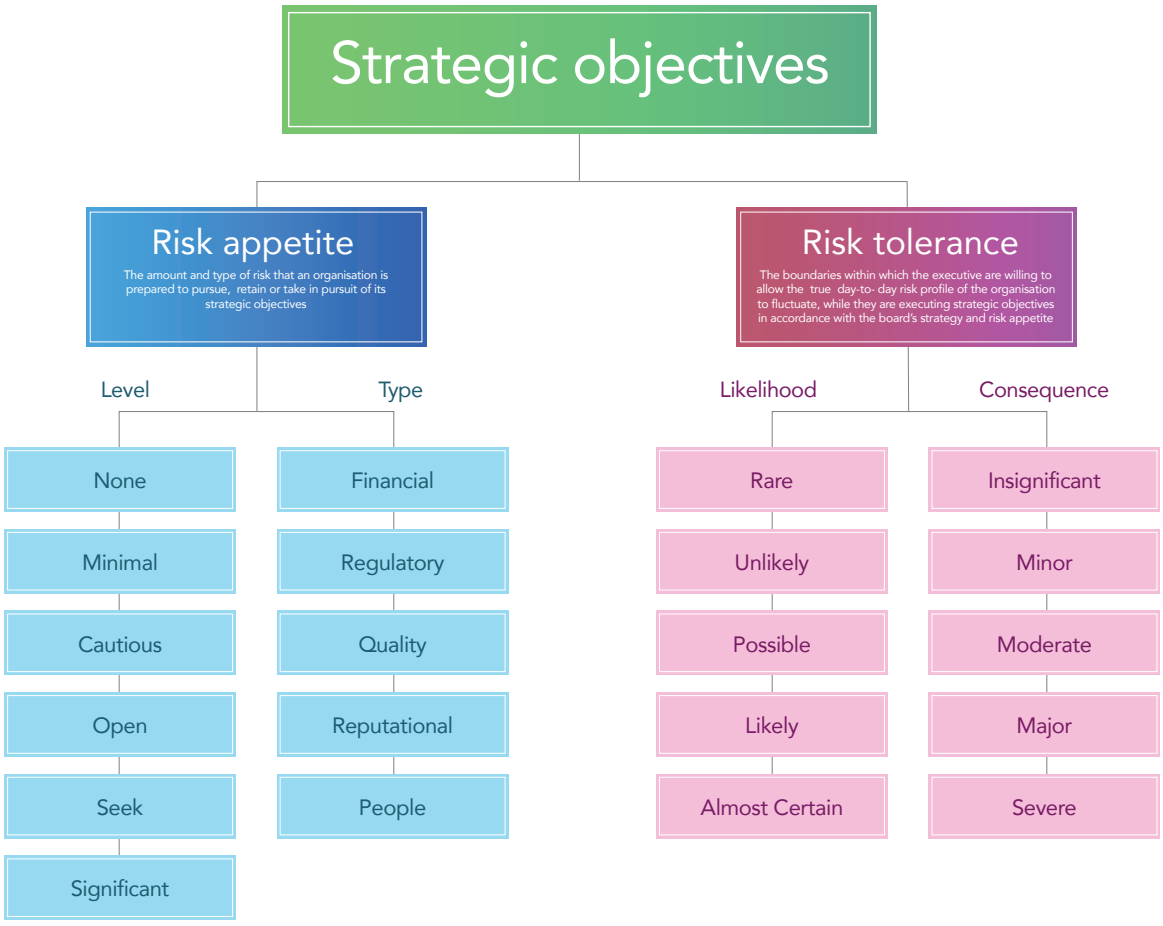
The BAF, therefore, is the key document that should be driving the board and committee agendas. It provides a structure that enables the board to focus on the significant risks, highlights any key controls (management actions to avoid or mitigate risks) that have been put in place to manage the risk, any areas requiring further action, sources of evidence or assurance, and any gaps.

The BAF is, in GGI's view, the original invest-to-save scheme for boards. Time spent on getting the various elements of the BAF right will help boards streamline assurance, locate where and how assurance is tested and develop proportionality in board reporting.

Key to this will be boards taking responsibility for identifying their risk appetite and risk tolerance for each strategic objective and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the risk appetite, the more controls should be put in place by management to avoid or mitigate the risk.



2. DH/HFMA, 2005, Gateway Ref 5706

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Applying risk appetite matrix

RISK TYPES \ RISK APPETITE LEVEL	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Good Governance Institute

Gatelog Reference 1054

Building the Assurance Framework: *A Practical Guide for NHS Boards*

March 2003

Contents

Introduction

More than ever before, as the NHS embraces a culture of decentralisation, increasing local autonomy and local accountability, Boards need to be confident that the systems, policies and people they have put in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. In support of that challenge, "Assurance: The Board Agenda" was issued in July 2002 and set out the principles for an assurance framework to give Boards the confidence they need.

The requirement for all NHS Chief Executive Officers to sign a Statement on Internal Control (SIC), as part of the statutory accounts and annual report, heightens the need for Boards to be able to demonstrate that they have been properly informed about the totality of their risks, both clinical and non clinical. To do this they need to be able to provide evidence that they have systematically identified their objectives and managed the principal risks to achieving them. The assurance framework fulfils this purpose.

The analysis of the 2001/2002 Statements on Internal Control confirm that, while organisations have made considerable progress, the approach is frequently fragmented with risk registers being incomplete and a lack of sound Board risk reporting in some organisations.

There has been considerable interest in receiving additional direction and advice on building an assurance framework and how to systematically bring together the existing fragmented risk management activity and make sure that the process is efficient, adds real benefits to the organisations and is highly focused. Accordingly, this guidance describes how to construct an assurance framework and is supported by worked examples. It also clarifies the relationship with performance management arrangements, the new clinical governance reporting framework, the core Controls Assurance Standards and other sources of assurance.

This does not introduce any new requirements on NHS organisations, but tries to provide practical assistance and clarity on what is currently required.

WHAT BOARD MUST DO

- Establish principal objectives (strategic & directorate).
- Identify the principal risks that may threaten the achievement of these objectives – typically in the range of 75-200 depending on the complexity of the organisation.
- Identify and evaluate the design of key controls intended to manage these principal risks, underpinned by core controls assurance standards.
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
- Evaluate the assurance across all areas of principal risk
- Identify positive assurances and areas where there are gaps in controls and / or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks
- Maintain dynamic risk management arrangements including, crucially, a well founded risk register

The Assurance Framework

The Assurance Framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Statement on Internal Control. This simplifies Board reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management.

Principal Objectives

The first step in preparing an assurance framework is for the Board to identify its organisation's objectives, clinical, financial and generic. It is necessary for Boards to focus on those that are crucial to the achievement of its overall goals and we have defined these as the ***principal objectives.*** These incorporate those at the strategic and directorate (or equivalent) level.

It may often be easier to identify specific risks at directorate rather than at the strategic objective level. However it is also necessary to take a strategic view to identify risks that affect all or many parts of the organisation to ensure that their total impact is assessed. What is important is the need to ensure that the linking of risk to objectives form an integrated part of the organisation's management activity and ensure this process brings real value and relevance and does not become a paper or 'tick box' exercise.

At the strategic level, objectives will include those linked to the NHS Plan, the Priorities and Planning Framework, national clinical quality improvement targets, and financial responsibilities, Public Service VFM agreements, compliance with governance and risk management standards, health improvement and partnerships. Appendix 1 provides some examples of principal strategic and directorate objectives identified by NHS bodies to show how they fit into the assurance framework. These are meant to be illustrative and Boards will need to consider their own priorities. Further examples will be available over time on the web at http://www.info.doh.gov.uk/doh/rm5.nsf/AdminDocs/Publications?OpenDocument and organisations are encouraged to contact the Department of Health to add to this list.

Directorate objectives are in turn supported by those of departments and individuals. Organisations may wish to record the linkages of these lower level objectives to their strategic objectives over time to provide assurances that the whole organisation is working together effectively to improve the quality of care.

Principal Risks

Principal risks are defined as those that threaten the achievement of the organisation's principal objectives. It is essential that boards understand that they need to manage potential principal risks, rather than reacting to the consequences of risk exposure.

Ideally, principal risks should be routinely identified from the risk management arrangements Boards have in place. However, we recognise that while many organisations have made good progress in identifying risks, many do not yet have comprehensive records that support full prioritisation of risks across all their main activities.

By focusing on risks to strategic and directorate objectives, organisations should be able to identify and manage in the range of 75 –200 principal risks. This is an appropriate number for the relevant assurance committee to consider, prioritise and regularly feed through around 6-12 current issues to the Board.

Boards may find it helpful to consider classifying their principal risks to match their organisation structure in order to simplify the mapping to objectives and arrangements for the management of risk. Examples of classification are shown at Appendix 1.

It would be wrong to try and consider principal risks in isolation because in practice they are derived from the prioritisation of risks fed up through the whole organisation. A sound assessment of the principal risks that the organisation actually faces can only be made once the risk management framework described below is fully in place. Where this is not the case, organisations should continue to refine their assessments as the risk management arrangements are implemented.

The key elements of a risk management system are:

- board and senior management commitment to risk management. A sense that risk management is integral to achieving objectives and being accountable, and not something that is done “on top of everything else we have to do”;

- a sense that risk taking can bring both rewards and penalties. Modernisation of the NHS cannot be achieved without risks being taken. But we must understand more fully the consequences of taking those risks. With such an understanding risks can be taken with greater confidence;

- a common framework for the analysis of all risks. For principal risks to be brought together in any meaningful sense for a Board there needs to be a common framework of analysis whether they be strategic or operational, clinical, financial or organisational risks. This calls not only for a common definition of risk and risk identification but also a common means of calibrating consequence and likelihood;

- a single point of coordination for the process. Once the Board has set the framework and the strategy there needs to be an appropriate infrastructure in terms of committee and individual responsibilities to carry through the agenda. A risk management or governance committee, constituted as a Board sub-committee, can be the forum to coordinate and filter the risk assessment processes that are being conducted throughout the organisation. The Audit Committee will review the overall operation of these arrangements, informed by the internal auditors, but will not have any executive role.

Key Controls

Organisations should ensure that they have ***key controls*** in place which are designed to manage their principal risks.

Controls should be documented and their design subject to scrutiny by independent reviewers, which include internal auditors, in conjunction with clinicians and other specialists where necessary, CHI and external audit. The key controls should be mapped to the principal risks. When assessments are made about controls, consideration must be given not only to the design but also the likelihood of them being effective in light of the governance and risk management framework within which they will operate - even the best controls can fail if staff are not adequately trained.

The relationship between a risk and control is not necessarily straightforward. One specific risk may be mitigated by a number of controls. Some of those controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk.

Assurances and coordination

One of the key challenges for Boards is to implement a system to gain assurances about the effectiveness of the operation of the controls they have in place to manage their principal risks. They not only need to ensure they have the right level of assurance (as described in the publication "Assurance – the Board Agenda") but they need to make use, wherever possible, of the work of the many external reviewers and ensure the whole process is efficient.

A system that provides good coordination and evaluation of the work of the auditors, inspectors and reviewers will bring increased benefits to both the organisation and the review bodies. It will help minimise the burden on the organisation by reducing overlap and allow potential gaps in assurance to be identified and addressed.

To ensure effective management and provide evidence to support the Statement on Internal Control (SIC), there will be a need to review the totality of assurance activity relating to the organisation's principal risks. In essence, this requires Boards to map their assurance needs and identify the potential sources for providing them.

The process for gaining assurance about the effectiveness of the key controls is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers which include CHI, internal and external audit and these are supplemented from non independent sources such as clinical audit, internal management representations, performance management and self assessment reports.

It is essential that Boards receive regular reports about the assurances on the management of their principal risks and are proactive in addressing issues that arise.
The Assurance Framework will form the key document for Boards in ensuring all principal risks are controlled, that the effectiveness of those key controls has been assured, and that there is sufficient evidence to support the SIC.

For each key control, risk or control system, the organisation should identify potential sources of assurance. It is important to acknowledge that many of the potential sources are reviewers who need primarily to satisfy their own legal or regulatory objectives, and the assurances that Boards may derive are a by-product of this process. Therefore, the issue is one of establishing whether there is an overlap between the work of a potential assurer and the organisation's own assurance needs.

Where the assurer's report is confirmed as relevant, the organisation must endeavour to confirm that sufficient work has been undertaken in the review to be able to place reliance on the conclusions drawn.

The organisation will need to assess whether a review provides:

- full assurance: there are sufficient, relevant, positive assurances to confirm the effectiveness of key controls and **the objectives are met**;
- gaps in control: there is a clear conclusion, based on sufficient and relevant work, that one or more of the key controls on which the organisation is relying are not effective;.
- gaps in assurance: there is a lack of assurance, either positive or negative, about the effectiveness of one or more of the key controls. This may be as a result of lack of relevant reviews, or concerns about the scope or depth of reviews that have taken place.

In the latter case, the Board may wish to consider how other assurances may be used, for example, its clinical governance reporting processes and the results of organisational self assessments to support the SIC. These should be seen as complementary rather than in place of assurances from Internal Audit or other independent assurers.

Board Reporting

The Assurance Framework provides a simple framework for reporting key information to Boards. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them. At the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. This allows Boards to determine where to make efficient use of their resources and address the issues identified in order to improve the quality and safety of care.

By focusing on around 75-200 principal risks, the Board's assurance committees can give priority to routinely reporting the current top 6-12 risk issues to the Board. This will ensure that risk management becomes firmly embedded as a Board responsibility.

The assurance committee will also need to prepare a summary report to the Board about the effectiveness of the organisation's system of internal control, covering all of the principal risks and providing details of:

- Positive assurances on principal risks where controls are effective and objectives are being met
- Organisation's achievement of its principal objectives are at risk through significant gaps in control
- Where there are gaps in assurances about the organisation's ability to achieve its principal objectives

Leading to

- Board action plan to improve its key controls to manage its principal risks and gain assurances where required.

In addition to providing opportunities to improve the effectiveness of management, this will provide the evidence to support the annual Statement on Internal Control.

Assessing the Assurance Framework

It is important for Boards to be able to evaluate the quality and robustness of their assurance framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements.

For example, if conflicts should appear between the organisation's actual performance in a particular area and the assessment from the assurance framework reports, then the reasons need to be investigated. It may be that the objectives themselves need to be revised, the risks reassessed or the assurance on the effectiveness of the controls reviewed. The Assurance Framework is a very effective management tool if used properly.

Relationship to Priorities and Planning Framework

The Planning & Priorities Framework for 2003/04 – 2005/06 (Improvement, Expansion & Reform, the next 3 years) set out those requirements, which the NHS must deliver over the next 3 years. It also introduced a new planning framework for the NHS based around fewer but more focussed outcome requirements. Part of this

framework is an intention to align existing performance monitoring systems to the Planning & Priorities Framework (PPF). Put simply the Department will in future base its monitoring requirements around targets set out in the PPF. Other existing monitoring requirements will be revisited and may in some cases by removed altogether, in other cases the frequency of collection will be reduced or may be moved into the assurance environment. In the case of the latter this is likely to reflect targets or process requirements that have already passed or should be being delivered by all organisations now. Rather than continue to monitor these centrally we will require that an assessment of compliance is made as part of local assurance work. Compliance may be tested as part of inspection regimes – as set out in the PPF.

It will also be important to ensure that Local Delivery Plans – and the achievement of outcomes set out in those plans – form an integral part of an organisation's objectives and risk management arrangements.

Clinical Governance Reporting Framework

All NHS organisations must fulfil their Clinical Governance responsibilities, which are underpinned by the statutory duty of quality introduced in the Health Act 1999. Clinical Governance requires Boards to be assured that the organisation has in place, systems and processes to support individual, team and corporate accountability for the delivery of patient centred, safe, high quality care, within a reporting and learning culture. NHS Boards must fully take into account Clinical Governance when signing their Statement on Internal Control and Clinical Governance arrangements must underpin Delivery Plans. For example, in Improvement, Expansion and Reform: The next 3 years Priorities and the Planning Framework 2003-2006 there is the statement: "At the same time every organisation needs to...ensure the safety of its patients and users and the quality of its services, including developing clinical governance arrangements."

A new Clinical Governance Reporting Framework has been introduced for 2003/4 and beyond, which all NHS organisations must comply with as part of their clinical governance responsibilities. This seeks to harmonise clinical governance reporting processes with other review and reporting processes, such as the current Commission for Health Improvement, the new planning framework and the arrangements for reporting to Strategic Health Authorities (StHAs). This is to avoid duplication of effort and by aligning reporting and planning timelines ensure that local delivery plans take account of plans to improve quality and safety of patient care.

Clinical governance development programmes and annual reports, together with sound governance systems and processes within the organisation will be key to Boards reaching an opinion on the systems of internal control operating in clinical areas.

Controls Assurance

The requirement for organisations to comply fully with the criteria of the three core controls assurance standards of governance, risk management and financial management remains unchanged and this is integral to the assurance framework. Achieving Level 1 of the Controls Assurance Maturity Matrix is no longer acceptable for any organisation in light of the requirements of the SIC, but the principles set out for levels 2 and 3 remain.

Compliance with the core standards should be subject to annual review by NHS internal audit and organisations should ensure that all of their principal activities are adequately considered under each criterion when making their assessments.

The core standards' criteria should form part of the assessment of whether controls are likely to be effective in the environment within which they operate. In addition, consideration should be given to performance against organisational controls assurance and other relevant standards as part of the overall management of risk.

NHS Internal Audit

NHS Internal Auditors are required to comply with the NHS Internal Audit Standards that are based closely on the Government Internal Audit Standards. This provides for consistency of audit across government bodies including the NHS. As part of their responsibilities NHS Internal Auditors are required to provide assurances about the effectiveness of controls in place across all of the organisation's activities. The NHS is highly complex and internal auditors will not necessarily have the full range of skills to provide all of the assurances needed by the Board. Therefore to fulfil their function they will review the overall arrangements the Board has in place for securing adequate assurances, and provide an opinion on those arrangements to support the SIC. This will entail reviewing the way in which the Board has identified objectives, risks, controls and sources of assurances on those controls and assessed the value of assurances obtained. In addition they will provide specific assurances about the areas covered in their audit plan, as approved by the Audit Committee, and will work alongside other professionals wherever possible to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the Board.

External Audit

External auditors are appointed by the Audit Commission and are required to undertake their audits in accordance with the Commission's Code of Audit Practice. The Code is approved by Parliament and expects auditors to comply with best

professional practice. This provides for consistency of audit across all Audit Commission appointments in both the NHS and local government.

The code requires external auditors to plan their audits on the basis of risk, focusing on three areas: the accounts; financial aspects of corporate governance; and performance management. Their work will entail considering the arrangements the body has put in place to, for example, manage risk, ensure value for money, and give appropriate assurances to directors and senior management.

Auditors report the results of their work through the report on the accounts (the audit opinion), the annual audit letter and ad hoc reports and memoranda on specific pieces of work. Close co-operation between the board and external auditors will help the auditor to produce high quality audit outputs which will, as a direct result, provide the board with an additional source of information in those areas where it is seeking to gain assurances.

Appendices

Appendix 1(a) provides examples of a number of illustrations of the link between strategic and directorate level objectives, which together form the organisation's ***principal objectives.***

Appendix 1(b) illustrates how the ***principal objectives*** are linked to the principal risks, the key controls, assurances and board reports which together form the ***assurance framework***. These are not intended to be comprehensive but to demonstrate the principles to be applied.

Appendix 1(c) expands the principles illustrated above to provide worked examples of the assurance framework based around two ***principal objectives.*** These will be supplemented with additional examples on the web at http://www.info.doh.gov.uk/doh/rm5.nsf/AdminDocs/Publications?OpenDocument
Appendix 2 provides a glossary of the terminology as used in this document

Appendix 3 provides a number of references to other relevant Department of Health and other guidance.

Appendix 1(a) **(Page 1 of 6)**

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
This may or may not sit within one directorate. It is recommended that the monitoring of delivery be coordinated by the relevant Assurance Committee	*This will relate to an overall goal of the organisation*	*This will relate to how the organisation translates an overall goal into deliverables*
Clinical Services	To ensure that clinical services are developed and maintained to meet the needs of patients effectively and in a timely way	To develop and communicate a shared strategic direction which reflects the population it serves currently and in the future
		To implement those aspects of the NSFs which are appropriate to the services the organisation delivers
		To review Clinical services, and where necessary redesign services so they meet the needs of patients in an effective and timely way
		To develop & implement a user/carer involvement strategy which allows users of clinical services to actively influence the development of those services
		To form clinical alliances and participate in clinical networks with other providers to ensure best care for patients
		To ensure that clinical services are provided in such a way that patients dignity is protected/preserved
		To ensure the Organisation meets the targets contained within the PPF, as appropriate to the services delivered by the organisation
		To ensure that prescribing costs and behaviour are effectively managed

Appendix 1(a) (Page 2 of 6)

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
Mental Health Services	To ensure the development of effective commissioning of hospital and specialist mental health services	To reduce the duration of untreated psychosis to a service median of less than 3 months (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004
		To offer 24 hour crisis resolution to all eligible clients by 2005
		To deliver assertive outreach to adult outpatients with severe mental illness and complex problems who regularly disengage from services by December 2003
		To increase breaks available to carers and strengthen care support and networks
		To continue to increase Child and Adolescent Mental Health Services (CAMHS) according to agreed local priorities
		To develop a comprehensive service within CAMHS to include mental health promotion and early intervention by 2008
Governance	To establish effective governance arrangements and ensure the organisation is run appropriately and in a way that inspires public confidence	To ensure the Organisation has in place the systems, resources and training to deliver services that are safe, transparent and clinically effective
		To develop and implement a risk identification, assessment, and treatment strategy & plan that assists in the delivery of the organisations principal objectives
		To develop & implement a service user involvement strategy which engages users in the evaluation & development of services
		To ensure that the Organisation responds to all external & internal audit findings as appropriate
		To complete, implement and update a clinical governance development plan, with particular focus on NSF and NHS Cancer Plan, and report on clinical governance in the Annual Report
		To implement the action plan agreed in response to a Commission for Health Improvement review or inspection

Appendix 1(a) **(Page 3 of 6)**

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
Workforce	To ensure that the Organisation recruits, retains & develops staff in order to provide high quality patient services	To develop and implement a recruitment & retention strategy which reflects available resources and predicts growth
		To increase the number of therapists and scientists employed by 2004, and plan for further increases by 2008
		To increase the number of health care assistants employed by 2005
		To Ensure the workforce is properly skilled
		To develop staff through the provision of training, education and development opportunities in order in order to improve the quality of services
		To work with staff to deliver efficient, effective, patient centred services through pursuing 7-day working
		To ensure that equitable & transparent employee rewards & benefit arrangements are in place
Access	To ensure that patients can receive treatment at a time that suits them in accordance with clinical need in line with the NHS Plan	To improve patient access to emergency care through implementing the recommendations contained in Reforming Emergency Care
		To achieve the standard of 75% of category A ambulance calls receiving a first response within eight minutes
		To improve emergency heart attack care in accordance with the PPF
		To achieve a maximum wait of 9 months for all inpatient waiters and reduce the number of 6-month inpatient waiters by 40% by March 2004
		To ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day and a GP within 2 working days by December 2004
		To increase the level of choice offered each year, offering routine choice of hospital provider at point of booking for all patients by December 2005 with 100% booking of day cases and two thirds of all first outpatient and inpatient elective admissions being pre-booked by March 2004

Appendix 1(a) **(Page 4 of 6)**

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
Education and Research & Development	To ensure the Organisation is a leading centre for Education and R&D	To develop and improve links with universities
		To ensure the organisation continues to strive to be a world class centre for R&D
		To ensure all staff have access to lifelong learning
		To ensure the organisation continues to strive to be a leading teaching institution
		To ensure the continued use of evidence based medicine
Patient Experience	To ensure that focus is centred on patient experience	To improve the 5 key dimensions of the patient experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the four star rating system.
		To agree, implement and jointly monitor local communities through improved engagements with them, as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in health, and annual publication of a prospectus covering local health issues
		To establish an active Patient Advisory and Liaison Service (PALS)
		To ensure there is a regular and systematic approach to obtaining, analysing and responding to local patient and public feedback about services
Partnership Working	To work with partners to improve the way health services and other services work together to improve health & health service provision	To work with providers of Primary Care and the Strategic Health Authority to agree areas of responsibility on an individual, joint and tripartite basis
		To develop a communications strategy for both internal & external stakeholders
		To develop & implement a user involvement strategy
		To ensure skills and competencies in partnership working are developed throughout the whole organisation
		To form clinical alliances and participate in clinical networks with other providers to ensure best care for patients
		To ensure effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective

Appendix 1(a) **(Page 5 of 6)**

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
Clinical Quality and Patient Safety	To ensure compliance with the statutory duty of quality and the delivery of safe, high quality patient care within a reporting and learning culture.	To ensure that at a team level systems and processes are in place to ensure the delivery of safe high quality care
		To ensure that arrangements are put in place for the purpose of monitoring care and evaluating the outcome of care.
		To work in partnership with others to improve the patient experience of care and to implement agreed service objectives
		Promote an open and learning culture where staff identify, report and learn from adverse events and near misses.
		To ensure the implementation of national quality imperatives eg NPSA reporting guidance and alerts, NICE guidance, national clinical audits and NSF standards
		To make clear, clinical leadership and team accountability arrangements
		Ensure that clinicians participate in National Confidential Enquiries, and relevant national and local clinical audits
		To develop service improvement programmes that reflect the priority needs of service users, define responsibilities for implementation, describe expected outcomes and indicate ways in which outcomes can be evidenced or measured
		To ensure national patient safety alerts and requirements are implemented promptly

Appendix 1(a) **(Page 6 of 6)**

Illustration of examples of Principal Objectives showing the link between Strategic & Directorate level objectives.

Area	Strategic Objective	Directorate Level (or Equivalent) Objective
IM & T	To ensure technology is developed to meet the needs of the NHS Plan and is supporting information strategy.	To meet the PPF target of all staff having access to e-mail, browsing and national applications
		To progress towards the PPF target of Level 3 Electronic Patient Records (EPR)
		To meet national targets in relation to progressing data quality
		To progress towards delivery of European Computer Driving License (ECDL) in conjunction with Personal Development Plans
		To ensure access to NHS Strategic Tracing servers (NSTS) for new NHS numbers
		To implement Electronic Booking by September 2005
		To ensure facilities for telemedicine are in place by 2005, allowing patients to connect with staff electronically for advice
Finance	To ensure that mandatory financial targets are met	To ensure that statutory financial duties are met
		To ensure the organisation achieves financial balance
		To ensure that the capital programme reflects the strategic direction of the organisation and is delivered within timescales and budget

Appendix 1(b) (Page 1 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To ensure the organisation achieves financial balance	**Unforeseen expenditure**	**Finance**	**Detailed policy & procedure in place for budget setting Robust system for budget profiling System for budget setting involves all relevant parties**	**External Audit Internal Audit Internal manager/peer review Etc.**		**Insufficient training given to new Budget Holders to support the budget setting process**	
	Uncertainty over income levels						
	Misforecasting nationally agreed pay awards						

Appendix 1(b). (Page 2 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the Organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To ensure there is effective monitoring and evaluation of the outcome of care.	**Poor investment in IT and inadequate provision/ availability of clinical information to clinical staff and teams**	**Direct patient care**	**Trust wide IT strategy Delegated management and team accountability**	**Directorate/team performance reporting and monitoring processes Board performance/ monitoring reports CHI Review Benchmarking Performance indicators and ratings. National clinical audits and National confidential enquiries**	**Performance indicators and ratings Progress against clinical governance development plans National clinical audits and National confidential enquiries**	**No regular review of performance or poor monitoring of outcome measures or inadequate upward reporting**	**No assurance of action to address exception reports**

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Appendix 1(b) (Page 3 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To ensure that prescribing costs and behaviour are effectively managed	**Failure to manage funding** *Failure to implement NICE guidance* *Inadequate training for nurses responsible for prescribing leading to adverse incidents*	**Clinical Services**	**Strategy for cost-effective prescribing Monitoring arrangements in place for in-year spends and prescribing activity Capacity Planning undertaken**	**Prescribing Pricing Authority** **Local Prescribing Advisory Group Drugs and Therapeutic Committee Etc.**			**No assurance gained on effectiveness of Capacity Planning**

Appendix 1(b) (Page 4 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To establish effective governance arrangements and ensure the organisation is run appropriately and in a way that inspires public confidence	**Failure to identify the risks to the organisations principal objectives** *Failure to prioritise risks across the organisation in a consistent manner* *Inability to deliver risk treatment/ action lans*	**Organisation wide**	**Principal objectives set and agreed at board level and communicated to staff** **Policy and Strategy in place regarding the identification and management of risks** **Framework in place to gain assurance on the management of risks and the delivery of objectives**	**CHI Review** **RPST Review** **Internal Audit** **Etc.**			**No assurance on the effectiveness of the overall assurance framework**

Appendix 1(b). (Page 5 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To ensure effective shared service arrangements are in place which provide reliable and accurate management information, and are cost effective	**Poor investment in IT, Finance & HR systems** *Breakdown in core business systems, controls and processes* *Business discontinuity*	**Partnership Working**	**SLA in place with shared service provider** **System in place to monitor performance of shared service provider against SLA** **Clear lines of accountability set out within provider and user organisations for shared service provision**	**External Audit** **Internal Audit** **Management reports from shared service host organisation** **Etc.**		**No performance monitoring against SLA taken place in current year**	

Appendix 1(b). (Page 6 of 6) Assurance Framework (extracts) for illustration only

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relate to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where are we failing to put controls/ systems in place. / Where are we failing in making them effective*	*Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
To ensure the workforce is properly skilled	**Lack of appropriate training** *Inability to recruit the right staff* *Failure to retain key skilled staff*	**Workforce**	**Trust-wide training needs analysis** **Trust-wide training strategy linked to individual staff appraisal** **System for monitoring the effectiveness of training strategy**	**CHI Review** **Royal Colleges** **Internal Audit** **Etc.**	**Full Assurance on nursing training**	**Gaps in linkage to staff appraisal for support staff**	**No assurance on effectiveness of training strategy**

Appendix 1(c). Example 1: Shared Services

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver.	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relates to.*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where we are failing to put controls/ systems in place. / Where we are failing in making them effective*	*Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
1. To develop effective shared service arrangements	1.1 Provision of unreliable management information and inaccurate data for accounts. 1.2 Breakdown in core business systems, controls and processes. 1.3 Business discontinuity. 1.4 Problems recruiting and retaining staff. 1.5 Poor investment in IT, finance and HR systems. 1.6 Failure to achieve statutory accounts targets.	Finance	Strategy in place to recruit staff. (1.4) Accountability arrangements defined. (1.2, 1.6) Data quality procedures in place. (1.1) Performance monitoring information available. (1.2, 1.6) Financial liabilities identified. (1.6) Agreements in place with all users. (all risks) Support in place for current systems. (1.2, 1.3) HR arrangements in place. (1.4, 1.5)	External Audit will independently report upon risk 1.6. Internal Audit have independently reviewed key controls relating to risks 1.1 and 1.2 Benchmarking of levels of investment has been undertaken by Finance (1.5) Reports from SS Management Board are reported to full Board. (1.2, 1.6) IT review of continuity (1.3)	Controls are deemed to be satisfactory and shown to be operating effectively in relation to risks: 1.1, 1.2, 1.3, 1.5	Key performance indicators have not been fully developed nor are they routinely reported. (all risks)	Timing of assurance in relation to the risk of failing to meet statutory accounts targets is too late. (1.6) No assurances have been received on the adequacy and effectiveness of staff recruitment and retention. (1.4)

Appendix 1(c). Example 2: Financial Management

Principal Objectives	Principal Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver.	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relates to.*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where we are failing to put controls/ systems in place. / Where we are failing in making them effective*	*Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective*
2. To ensure sound financial management, delivering in-year/recurrent financial balance as well as other financial duties.	2.1 Failure to achieve financial targets. 2.2 Inability to deliver services against PPF targets. 2.3 Inability to plan for future services across health economies. 2.4 Failure to deliver annual value for money targets. 2.5 Failures in probity and good governance. 2.6 The Board not fully engaged in financial planning.	Finance	Financial monitoring arrangements in place at Board level. (all risks) Financial strategy and associated risks formally endorsed by the Board. (2.6) Robust recovery plan agreed. (all risks) Financial performance strategy in place across health economy. (2.3) Budgetary control over allocations, provisions and reserves. (all risks) Regular reconciliation processes. (2.1, 2.5) Sound financial systems. (2.1, 2.5))	External audit Annual Letter will give assurance particularly controls relating to risk 2.1. StHa have reviewed robustness of recovery plan (all risks) Internal audit plan provides ongoing assurance on controls relating to financial systems, reconciliation processes and budgetary control. (all risks)	Controls are deemed to be satisfactory and shown to be operating effectively in relation to risks: 2.3, 2.5 and 2.6	Insufficient monitoring of PPF targets at Board level (2.2) Risk assumptions not debated in relation to vfm targets (2.4) Regular checks are not being undertaken into the adequacy of reserves. (2.1)	Timing of Annual Letter assurance is too late. (2.1) No third party assurances are being received in respect of financial services being delivered by other organisations (all risks)

APPENDIX 2

GLOSSARY

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved
Assurance Committee	A board level committee with overarching responsibility for ensuring appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance, or risk management committee
Assurance Framework	A structure within which boards identify the principal risks to the organisation meeting its principal objectives and map out both the key controls in place to manage them and also how they have gained sufficient assurance about their effectiveness
Board Assurance Action Plan	An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required
Board Assurance Reports	Key information reported to the board on the assurance framework, providing details of positive assurances and significant gaps in internal controls and assurances relating to principal risks. In addition to providing information leading to a board assurance action plan this will also provide evidence to support the annual Statement on Internal Control
Controls Assurance	A holistic concept based on best governance practice. It is a process designed to provide evidence that NHS organisations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds
Core Controls Assurance Standards	Three self assessment standards which underpin the annual Statement on Internal Control, these being: Governance Standard; Risk Management Standard; Financial Management Standard
Directorate Level Objective	How the organisation translates an overall goal into deliverables at directorate (or equivalent) level
Effective Control	A control that is properly designed, and delivers the intended objective

Term	Definition
External Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, Commission for Health Improvement or Royal Colleges for example
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
Head of Internal Audit Opinion	An annual opinion provided to inform the Board in completing their Statement on Internal Control. This provides opinions on (a) the overall assurance framework and (b) the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year
Independent Assurance	Assurances provided by (a) reviewers external to the organisation and (b) internal reviewers working to government standards, such as Internal Audit
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical Audit or management peer review
Internal Control	The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected
Key Control	A control to manage one or more principal risks
Mapping of Assurance	A process, providing a clear management trail, that links • principal objectives to principal risks • principal risks to key controls • key controls to assurances •
Organisational Controls Assurance Standards	Eighteen self assessment standards (excluding the core standards) which provide a framework to improve internal controls across a wide, but not all encompassing, range of organisational areas
Positive Assurance	Evidence that shows risks are being reasonably managed and objectives are being achieved

Term	Definition
Principal Objectives	Objectives set at strategic and directorate (or equivalent) level
Principal Risk	A risk which threatens the achievement of Principal Objectives
Prioritisation of Risk	A process by which risks are graded in order based on the likelihood of their occurrence and the impact of their consequences
Reasonable Best	A decision or course of action, agreed by the board, that is based on sufficient evidence
Risk	The possibility of suffering some form of loss or damage. The possibility that objectives will not be achieved
Risk Assessment	The identification and analysis of relevant risks to the achievement of objectives
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored
Sources of Assurance	The various reviewers, auditors and inspectors, both internal and external, who carry out work at NHS organisations (see Internal Assurance and External Assurance). Boards will have to determine which sources of assurance are relevant to principal risks and to what extent they are sufficient
Statement on Internal Control (SIC)	An annual statement signed by the Accountable Officer on behalf of the board that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organisation's system of internal control
Strategic Objective	An overall goal of the organisation
System of Internal Control	A system, maintained by the board, that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically

APPENDIX 3

Other Reading

Department of Health Guidance
Department of Health 2002. *Clinical Governance Reporting Processes.* Chief Executives bulletin 143
Department of Health 2002. *NHS Planning & Priorities Guidance 2003-2006*
Department of Health 2002. *Assurance: the Board Agenda*
Department of Health 2002: *Governance in the NHS: Statement on Internal Control for 2001/2002 and beyond*
Controls Assurance Core Standards 2002. *Governance Standard*
Controls Assurance Core Standards 2002. *Risk Management Standard*
Controls Assurance Core Standards 2002. *Financial Management Standard*
Department of Health (National Patient Safety Agency) 2001. *Doing Less Harm*
Department of Health 2001. *Building a safer NHS for Patients*
Department of Health 2001. *Governance in the new NHS: Controls Assurance Statements 2000/2001 and establishment of the controls assurance support unit.* HSC 2001/005
Department of Health 2001. *Primary Care Trust Corporate Governance Framework*
Department of Health 2001. *Audit Committee Handbook*
Department of Health 2000. *An Organisation with a Memory*
Department of Health 1999. *NHS Performance Assessment Framework*. HSC 1999/078
Department of Health 1999. *Clinical Governance: Quality in the new NHS.* HSC 1999/065
Department of Health 1999. *Governance in the new NHS controls assurance statements 1999/2000-risk management and organisational controls.* HSC 1999/123
Department of Health 1999. *A First Class Service: Quality in the new NHS.* HSC 1999/033
Department of Health 1997. *Corporate Governance in the NHS: Controls Assurance Statements*. HSG 97(17)
Department of Health 1994. *Code of Conduct and Accountability*
Other Guidance
National Audit Office 2000. *Supporting innovation: Managing risk in government departments.* HC 864
HM Treasury 2000. *Management of Risk a Strategic Overview*
Controls Assurance Support Unit (CASU) February 2003: *Developing an Assurance Framework in Primary Care Trusts*
Standards Australia 1999. *Risk Management Standard.* AS/NZS 4360

Establishing an Assurance Framework:
A Practical Guide for management boards of HPSS organisations

January 2006

Establishing an Assurance Framework:
A Practical Guide for management boards of HPSS organisations

Governance **-** *"the system by which an organisation directs and controls its functions and relates to its stakeholders"* ***HM Treasury***

Assurance **-** *"a statement or indication that inspires confidence"* ***Cambridge Dictionary***

Quality Assurance **-** *"the practice of managing the way goods are produced or services are provided to make sure they are kept at a high standard"* ***Oxford Dictionary***

Framework **-** *"a system of rules, ideas or beliefs that is used to plan or decide something"* ***Cambridge Dictionary***

Belfast Health and Social Care Trust
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Reference No: TP 91/14

Title:	**Risk Register Production and Management Guidance**		
Author(s)	Claire R Cairns, Co-Director Risk and Governance, Tel: [redacted] Gillian Moore, Administration and Datix Manager, Corporate Governance, Tel: [redacted]		
Ownership:	Dr Chris Hagan, Interim Medical Director		
Approval by:	Trust Policy Committee Executive Team Meeting	**Approval date:**	06 February 2020 12 February 2020
Operational Date:	February 2020	**Next Review:**	February 2025
Version No.	3	**Supercedes**	V2 – August 2016 – May 2019
Key words:	Risk management		
Links to other policies	BHSCT Risk Management Strategy (2019) TP 58/08 BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 BHSCT General Health and Safety Policy (2018) TP 50/08 BHSCT Board Assurance Framework BHSCT Risk Assessment Guidance		

Date	Version	Author	Comments
June 2014	1.0		Final version issued
June 2016	1.1	C McMullan G Moore	Corporate Governance review
August 2019	2		Final version issued
May 2019	2.1	G Moore	Corporate Governance Review

1.0 INTRODUCTION / PURPOSE OF GUIDANCE

1.1 Background

This document is intended to support the Trust Risk Management Strategy, providing operational guidance on the production and management of risk registers at all levels in the organisation.

1.2 Purpose

It is vital that staff with management responsibilities at all levels in the organisation have clear guidance on how to produce and maintain a risk register ensuring that identified risks are effectively monitored to provide assurance regarding their management, thus supporting the Trust to do its reasonable best to protect service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings.

This guidance document supports the Risk Management Strategy, and links with the Adverse Incident Policy and Procedures, the Board Assurance Framework and the General Health and Safety Policy and Risk Assessment Guidance.

1.3 Objectives

- Support staff in understanding the various sources for risk identification
- Provide clarification on how to apply the risk evaluation system to identified risks
- Provide clarification in relation to appropriate monitoring and review of risk registers at all levels of the organisation.
- Provide clarification for the management of escalation, de-escalation and acceptance of risk
- Assist staff in allocating risks to appropriate corporate objectives

2.0 SCOPE OF THE GUIDANCE

This guidance applies to all staff with management responsibilities for delivery of a service or services at all levels of the organisation.

3.0 ROLES/RESPONSIBILITIES

All clinicians, managers and co-directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produces and maintains risk registers and action plans, to address identified risks. The 'Datixweb for Risks' system is used to maintain risk registers. Areas not yet using Datixweb should contact Corporate Governance for access to the system and arrange appropriate training.

Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

Chief Executive

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The Chief Executive:

- will ensure that responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document is implemented; and

- has delegated responsibility for the strategic development and operation of clinical and social care governance and risk management arrangements to the Medical Director. However, in order to discharge the responsibilities of Accounting Officer the Chief Executive will ensure that risk management features regularly on the Trust's operational and Trust Board agendas and will discuss issues and progress with the Medical Director.

Directors

Directors require assurance of appropriate management of all identified risks within their Directorate; however the role of **'Overall Lead'** as described on the Datixweb risk form and in Section 4 below, can be delegated to Co-Directors, Committee chairs within the Assurance Framework or Service Managers depending on the evaluated risk level (see Appendix 1).
Any risk identified as Extreme (red) must be escalated to the relevant Director via Directorate processes and an immediate investigation instigated with an action plan agreed to eliminate/ reduce/control the risk. The Director will remain identified as Overall Lead for all Extreme risks within their Directorate.

All Extreme risks should be considered against the Corporate Risk criteria outlined in Section 4.0. Directors are responsible for confirming inclusion on the Corporate Risk Register via the Directorate Governance and Quality Service Manager

Committee Chairs within the Assurance Framework

On occasion risks can be identified via the committee structure within the Board Assurance framework. It may be appropriate that the chair of a key committee will be identified as Overall Lead. In such instances they will ensure an appropriate risk lead is identified and an investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Collective Leadership Team

Senior collective leadership teams are collectively accountable to the Director across all aspects of the corporate objectives in their Division.

Co-Directors

Co-Directors may be identified as **Overall Lead** for risks evaluated as High (amber) or below. As Overall Lead they will ensure a Risk Lead is identified and an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing and regular monitoring of the risk until such times as it is closed. Co-Directors may also be identified as the **Risk Lead** as described on the Datixweb risk form and in Section 4 below.

Depending on the nature of the risk and the criteria as described in section 4.0 the Co-Director may consider a risk evaluated as High (amber) requires inclusion on the corporate risk register. Inclusion must be approved by the Director.

Service Managers

Service Managers may be identified as Overall Lead for risks evaluated as Medium (yellow) or below. As Overall Lead they will ensure a Risk Lead is identified to ensure an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for liaising with Directorate staff in relation to population and maintenance of risk registers using the Datix risk management system and work closely with their Director to ensure appropriate approval of risks for inclusion on the corporate risk register. They will also act as a resource for expert advice.

4.0 KEY GUIDANCE PRINCIPLES

DEFINITIONS

4.1 Corporate Risk

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

1. Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control;
4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

Although described as 'corporate', ownership of the risk still lies with the appropriate Director.

Corporate risks will be monitored four times a year at Board level by the Assurance Committee. These may form part of the Assurance Framework Principal Risks and Control document.

Operational Risk

An operational risk will be below 25 (Catastrophic x Almost Certain) but can be of any grade including extreme (red), but has been deemed by the Director as being appropriately managed at operational level and therefore not required for inclusion on the corporate register.

These risks may be managed at Ward / Facility / Specialty / Service Area or Directorate level.

Operational risks evaluated as Extreme (red) or High (amber) must be closely monitored and reviewed no less than four times a year at Directorate level.

Overall Lead

Director / Co-Director / Manager with overall responsibility for the area within which the risk has been identified. They must ensure that an appropriate risk lead is identified.

Risk Lead

Manager with lead responsibility for the risk. They must ensure that an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk, and must oversee ongoing monitoring and management of the risk until such times as it is closed. This may be the same person as the overall lead.

Residual Risk

The level of risk that is likely to remain once all proposed actions have been implemented.

Risk Register
A risk management tool which acts as a central repository for all risks identified by the Directorate / Service Area / Specialty / Ward / Facility.

Risk Appetite
Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1 for detail).

Risk Tolerance/ Acceptance
The willingness to live with a risk, but with the confidence that it is being properly controlled. The risk must still be reviewed at least annually with the aim of reducing further risk.

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

4.2 Identifying a Risk

Managers and staff at all levels must proactively identify hazards and potential risks to meeting objectives. These may relate to patient and client safety and wellbeing, quality of service, staff wellbeing, financial resources, targets / standards and reputation.

Risk can be identified from a number of information sources and by using various tools and techniques.

Information sources include adverse incidents, complaints, claims, risk assessments, staff absenteeism records, concerns raised, team meetings / workshops, internal and external audits/ inspections.

Practical methods and tools for identifying risks include group workshops, individual interviews, observation and review of data / records. Risks may be identified and analysed by an individual, however a group or team approach is recommended in order to provide challenge and discussion leading to a well-defined and analysed risk.

4.3 Risk Description

The risk description should be clear and concise, whilst still providing enough detail for it to be clearly understood. Each risk issue should be kept separate. If the risk is not clearly defined, appropriate controls, current grading and actions may not be forthcoming.

If a problem has materialised such as not achieving standards or having enough resource to deliver a service, this has now happened (real and current), as the management team are already managing a live situation. This is not to say there is no risk associated with the situation, but it is important to identify and describe the risk accurately, i.e. non-compliance with a standard is not a risk, rather the impact of the non-compliance is a risk, and this impact is what must be described. In other words, the risk description should state both **cause** and **effect**.

4.4 Linking a Risk to a Corporate Theme / Objective

The organisation has identified five key themes as follows:

- Safety, Quality and Experience
- Service Delivery
- People and Culture
- Strategy and Partnerships
- Resources

There are a number of corporate objectives associated with each of these themes (see Appendix 2). These should be considered for each risk in terms of the impact of the risk on the themes and associated objectives. One or more themes should then be applied to the risk.

4.5 Allocating overall lead and risk lead – different roles

The risk grade will determine how the overall lead and risk lead are allocated (see Section 3.0 Role/Responsibilities and section 4.0 Definitions). Overall lead and risk lead can be the same person.

4.6 Identifying Current Controls

Controls are existing processes, policies, devices, practices or other actions which act to minimise risk.

Some controls are stronger than others. For example, physical measures and additional staffing are stronger controls than procedures and training. When identifying current controls, their strengths and weaknesses should also be considered and taken into account when scoring / grading the risk.

4.7 Analysing and evaluating the risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix at Appendix 1

The tables and matrix are used to score / grade both the current risk and the residual risk.

The risk should be scored / graded taking into account all the controls already in place.

4.8 Proposed actions

Proposed actions are those actions which will be implemented to eliminate, reduce or control the risk. Some actions, like controls, are stronger than others and this should be considered when identifying actions. They should be explicit, timebound and deliverable. Avoid actions such as 'remind staff', 'promote awareness' but if they have to be used, explain how this will be done.
All proposed actions should have an expected date of completion recorded against them.

See tables 4, 5 and 6 in Appendix 1 for who is responsible for remedial action and the associated timescales.

4.9 Use of action plans

Generally, use of the risk register module on Datixweb will allow monitoring and review of actions adequately. However certain complex risks may benefit from separate action plans. Review and update of action plans should take place alongside review of the risks themselves and can be attached to the risk on Datixweb.

4.10 Ensuring appropriate and regular review and update

All risks require ongoing monitoring and review to ensure effective management. This also applies if the risk is accepted, as such risks may become unacceptable over time or because circumstances change. It is therefore essential that all open risks are regularly reviewed.

Extreme (red) risks must be reviewed at least four times a year, high (amber) risks twice to four times a year, while medium (yellow), low (green) or accepted risks may be reviewed less frequently. See table 5 in Appendix 1 for guidance. The review date of risks should be checked regularly to ensure that dates have not passed.

Corporate risks will also be reviewed four times a year by the Risk Register Review Group.

Review of risks should include careful consideration of whether proposed actions have been implemented. If so, and where applicable, these actions should be considered current controls and transferred accordingly. The risk grading should then be reassessed.

4.11 When a risk needs upgraded or escalated to a Corporate Risk

The circumstances surrounding a risk may change, requiring it to be amended and re-scored. In accordance with Directorate processes, the Director / Co-Director / Quality and Governance Manager must be notified if a previously medium (yellow) or low (green) risk is amended to become high (amber) or extreme (red).

If circumstances surrounding the risk change so that any of the following criteria are met, the Director must be notified and approval sought for inclusion on the Corporate Risk Register:

1. Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

4.12 When a risk can be downgraded or de-escalated

Where actions have been implemented and controls improved, it is expected that risks will be amended and re-scored to a lower grade.

Where these actions and controls have resulted in a corporate risk no longer meeting the criteria outlined in section 4.10, the Director may approve de-escalation of a risk from corporate to operational. This should be managed via Directorate processes and noted on the risk record on Datixweb and also at the Risk Register Review Group.

4.13 Closing a risk

A risk should only be closed when all proposed actions have been implemented to good effect and the risk no longer exists. The date should be entered in the 'Closed date' field against the risk and a progress note recorded which outlines the reasons for closure. Closed risks should be excluded from risk register reports.

4.14 Accepting a risk

Where a risk has been accepted (i.e. it has been agreed to live with the risk as long as it is properly controlled) the risk should still be added to the risk register and reviewed as required, at least annually.

The exception to this may be where medium (yellow) or low (green) risks have been identified as the result of a general risk assessment. Having appropriate risk assessments which are reviewed in line with policy will be sufficient to manage these risks at departmental level.

These risks need only be added to the risk register if:

- there are further actions required to adequately control the risk and which need to be closely monitored to ensure timely progress, or
- the risk meets the criteria for inclusion on the Corporate Risk Register

4.15 Removing a Risk

Risks can only be removed from Datixweb by a system administrator. Staff should contact the Corporate Governance department if they require a risk to be removed. Corporate Governance will change the status of the risk to 'Rejected'. This retains the risk on the system however it is only viewable by Corporate Governance.

4.16 Training/Advice

Each Directorate has a Governance and Quality Manager, or equivalent, and a partnered Health and Safety Manager who are available as sources of expert advice.
Other related training courses include, for example, general risk assessment and adverse incident reporting. Datixweb for Risks training is also provided by the Corporate Governance Dept and must be completed by any member of staff registered as a full user.

4.17 Helpful reading

See Section 7.0

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Responsibility of Service Directorates

6.0 MONITORING

The effectiveness of this procedure will be monitored by liaison between Corporate Governance and Directorate Governance and Quality Senior

Managers. It will be formally reviewed every 5 years or in the event of changes in guidance.

7.0 EVIDENCE BASE / REFERENCES

- A Risk Matrix for Risk Managers Jan 2008 – National Patient Safety Agency
- BSI IS0 31000: 2018
- Making it Happen – A Guide for Risk Managers on How to Populate a Risk Register, Risk Register Working Group
- WHSCT Risk Management Strategy and Procedure for the Production of Risk Registers
- Escalation of risk within and between Health and Social Care Organisations, Nov 2011, DHSSPS
- BRAAT (Belfast Risk Audit and Assessment Tool)

8.0 CONSULTATION PROCESS

Circulated to Directorate Governance and Quality Senior Managers for consultation.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Analysing and Evaluating the Risk
Appendix 2 – Corporate Themes and Objectives

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The

guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ Date: 12 February 2020

Chris Hagan
Interim Medical Director

_____ Date: 12 February 2020

Cathy Jack
Chief Executive

Appendix 1

Analysing and Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

- **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the Corporate risk register by the relevant Director.**
- **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co-Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
- **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
- **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Appendix2

Objectives Summary for Belfast Trust Corporate Management Plan 2018-21

Our vision is to be one of the safest, most effective and compassionate health and social care organisations

Corporate Themes	Safety, Quality & Experience	Service Delivery	People & Culture	Strategy & Partnerships	Resources	Expected Outcomes
What this means	Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services.	Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors.	Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams.	Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors.	Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.	
Corporate Objectives	1. We will seek, listen and respond to service user and carer experience, including real-time feedback in order to inform and develop our services. 2. We will make our services safer and achieve agreed improvements across our safety improvement measures. 3. With our partners, we will encourage our population to play an active role in their own health and wellbeing. 4. We will support people with chronic and long term conditions to live at home, supported by carers, families and their communities. 5. We will optimise the opportunities for young adult care leavers through education, training and employment. 6. We will further develop safeguarding services in partnership with service users, parents, carers, communities and other agencies to enhance safety and welfare of vulnerable adults and children. 7. We will improve community support to enable more timely discharge for older people and those with chronic conditions. 8. We will deliver agreed improvements for our unscheduled care patients and develop services to avoid unnecessary admission. 9. We will deliver agreed elective care improvement each year, including acute, mental health and cancer services. 10. We will increase staff engagement in order to improve the delivery of safe, effective and compassionate care. 11. We will work with partners to innovate and to develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors. 12. We will build a sustainable workforce, deploy our resources in an effective and efficient manner, invest in infrastructure which is fit for service delivery and achieve financial balance.					Improved service user and carer experience Improved service safety & quality Improved access to community & social care services Improved access to unscheduled care Improved access to elective care Improved staff engagement Improved use of resources

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP091/14

Title:	Risk Register Production and Management Guidance			
Author(s)	C R Cairns- Co-Director Risk & Governance G Moore- Administration & Datix Manager , Corporate Governance			
Ownership:	Dr Cathy Jack, Medical Director			
Approval by:	Policy Committee Executive Team		**Approval date:**	03 August 2016 10 August 2016
Operational Date:	August 2016		**Next Review:**	May 2019
Version No.	V2	**Supercedes**	V1 – June 2014-2015	
Key words	Risk management			
Links to other policies	Risk Management Strategy, Board Assurance Framework, Adverse Incident Reporting and management Policy, General Health & Safety Policy and Risk Assessment Guidance			

Date	Version	Author	Comments
01/03/2013	0.1	CR Cairns	Initial Draft
01/05/2013	0.2	CR Cairns G Moore	Second draft
01/06/2013	0.3	CR Cairns G Moore	Third draft
26/6/2013	0.4	CR Cairns G Moore	Fourth draft
22/5/2014	0.5	CR Cairns G Moore	Fifth draft
June 2014	1.0		Final version issued
June 2016	1.1	C McMullan G Moore	First review

1.0 INTRODUCTION / PURPOSE OF GUIDANCE

1.1 Background

This document is intended to support the Trust Risk Management Strategy, providing operational guidance on the production and management of risk registers at all levels in the organisation.

1.2 Purpose

It is vital that staff with management responsibilities at all levels in the organisation have clear guidance on how to produce and maintain a risk register ensuring that identified risks are effectively monitored to provide assurance regarding their management, thus supporting the Trust to do its reasonable best to protect service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings.

This guidance document supports the Risk Management Strategy 2016 - 2019, and links with the Adverse Incident Policy and Procedures, the Board Assurance Framework and the General Health and Safety Policy and Risk Assessment Guidance .

1.3 Objectives

- Support staff in understanding the various sources for risk identification
- Provide clarification on how to apply the risk evaluation system to identified risks
- Provide clarification in relation to appropriate monitoring and review of risk registers at all levels of the organisation.
- Provide clarification for the management of escalation, de-escalation and acceptance of risk
- Assist staff in allocating risks to appropriate corporate objectives

2.0 SCOPE OF THE GUIDANCE

This guidance applies to all staff with management responsibilities for delivery of a service or services at all levels of the organisation.

3.0 ROLES/RESPONSIBILITIES

All clinicians, managers and co-directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produces and maintains risk registers and action plans, to address identified risks. The 'Datixweb for Risks' system is used to maintain risk registers. Areas not yet using Datixweb should contact Corporate Governance for access to the system and arrange appropriate training.

Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

Chief Executive

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The Chief Executive:

- will ensure that responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document is implemented; and

- has delegated responsibility for the strategic development and operation of clinical and social care governance and risk management arrangements to the Medical Director. However, in order to discharge the responsibilities of Accounting Officer the Chief Executive will ensure that risk management features regularly on the Trust's operational and Trust Board agendas and will discuss issues and progress with the Medical Director.

Directors

Directors require assurance of appropriate management of all identified risks within their Directorate; however the role of **'Overall Lead'** as described on the Datixweb risk form and in Section 4 below, can be delegated to Co-Directors, Committee chairs within the Assurance Framework or Service Managers depending on the evaluated risk level (see Appendix 1).
Any risk identified as Extreme (red) must be escalated to the relevant Director via Directorate processes and an immediate investigation instigated with an action plan agreed to eliminate/ reduce/control the risk. The Director will remain identified as Overall Lead for all Extreme risks within their Directorate.

All Extreme risks should be considered against the Corporate Risk criteria outlined in Section 4.0. Directors are responsible for confirming inclusion on the Corporate Risk Register via the Directorate Governance and Quality Service Manager

Committee Chairs within the Assurance Framework

On occasion risks can be identified via the committee structure within the Board Assurance framework. It may be appropriate that the chair of a key committee will be identified as Overall Lead. In such instances they will ensure an appropriate risk lead is identified and an investigation is instigated

with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Co-Directors

Co-Directors may be identified as **Overall Lead** for risks evaluated as High (amber) or below. As Overall Lead they will ensure a Risk Lead is identified and an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing and regular monitoring of the risk until such times as it is closed. Co-Directors may also be identified as the **Risk Lead** as described on the Datixweb risk form and in Section 4 below.

Depending on the nature of the risk and the criteria as described in section 4.0 the Co-Director may consider a risk evaluated as High (amber) requires inclusion on the corporate risk register. Inclusion must be approved by the Director.

Service Managers

Service Managers may be identified as Overall Lead for risks evaluated as Medium (yellow) or below. As Overall Lead they will ensure a Risk Lead is identified to ensure an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for liaising with Directorate staff in relation to population and maintenance of risk registers using the Datix risk management system and work closely with their Director to ensure appropriate approval of risks for inclusion on the corporate risk register. They will also act as a resource for expert advice.

4.0 KEY GUIDANCE PRINCIPLES

DEFINITIONS

4.1 Corporate Risk

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

1. Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control;

4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

Although described as 'corporate', ownership of the risk still lies with the appropriate Director.

Corporate risks will be monitored four times a year at Board level by the Assurance Committee. These may form part of the Assurance Framework Principal Risks and Control document.

Operational Risk
An operational risk will be below 25 (Catastrophic x Almost Certain) but can be of any grade including extreme (red), but has been deemed by the Director as being appropriately managed at operational level and therefore not required for inclusion on the corporate register.

These risks may be managed at Ward / Facility / Specialty / Service Area or Directorate level.

Operational risks evaluated as Extreme (red) or High (amber) must be closely monitored and reviewed no less than four times a year at Directorate level.

Overall Lead
Director / Co-Director / Manager with overall responsibility for the area within which the risk has been identified. They must ensure that an appropriate risk lead is identified.

Risk Lead
Manager with lead responsibility for the risk. They must ensure that an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk, and must oversee ongoing monitoring and management of the risk until such times as it is closed. This may be the same person as the overall lead.

Residual Risk
The level of risk that is likely to remain once all proposed actions have been implemented.

Risk Register
A risk management tool which acts as a central repository for all risks identified by the Directorate / Service Area / Specialty / Ward / Facility.

Risk Tolerance/ Acceptance
The willingness to live with a risk, but with the confidence that it is being properly controlled. The risk must still be reviewed at least annually with the aim of reducing further risk.
It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A

risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

4.2 Identifying a Risk

Managers & staff at all levels must proactively identify hazards and potential risks to meeting objectives. These may relate to patient and client safety and wellbeing, quality of service, staff wellbeing, financial resources, targets / standards and reputation.

Risk can be identified from a number of information sources and by using various tools and techniques.

Information sources include adverse incidents, complaints, claims, risk assessments, staff absenteeism records, concerns raised, team meetings / workshops, internal and external audits/ inspections.

Practical methods and tools for identifying risks include group workshops, individual interviews, observation and review of data / records. Risks may be identified and analysed by an individual, however a group or team approach is recommended in order to provide challenge and discussion leading to a well- defined and analysed risk.

4.3 Risk Description

The risk description should be clear and concise whilst still providing enough detail for it to be clearly understood. Each risk issue should be kept separate. If the risk is not clearly defined, appropriate controls, current grading and actions may not be forthcoming.

If a problem has materialised such as not achieving standards or having enough resource to deliver a service, this has now happened (real and current), as the management team are already managing a live situation. This is not to say there is no risk associated with the situation, but it is important to identify and describe the risk accurately, i.e. non-compliance with a standard is not a risk, rather the impact of the non-compliance is a risk, and this impact is what must be described. In other words, the risk description should state both cause and effect.

4.4 Linking a Risk to a Corporate Objective

The organisation has identified five key objectives as follows:

- A Culture of Safety and Excellence
- Continuous Improvement
- Partnerships
- Our People
- Resources

These should be considered for each risk in terms of the impact of the risk on the objectives. One or more objective/s should then be applied to the risk.

4.5 Allocating overall lead and risk lead – different roles

The risk grade will determine how the overall lead and risk lead are allocated (see Section 3.0 Role/Responsibilities and section 4.0 Definitions). Overall lead and risk lead can be the same person.

4.6 Identifying Current Controls

Controls are existing processes, policies, devices, practices or other actions which act to minimise risk.

Some controls are stronger than others. For example, physical measures and additional staffing are stronger controls than procedures and training. When identifying current controls, their strengths and weaknesses should also be considered and taken into account when scoring / grading the risk.

4.7 Analysing & evaluating the risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix at Appendix 1

The tables and matrix are used to score / grade both the current risk and the residual risk.

The risk should be scored / graded taking into account all the controls already in place.

4.8 Proposed actions

Proposed actions are those actions which will be implemented to eliminate, reduce or control the risk. Some actions, like controls, are stronger than others and this should be considered when identifying actions. They should be explicit, timebound and deliverable. Avoid actions such as ‘remind staff’, ‘promote awareness’ but if they have to be used, explain how this will be done.
All proposed actions should have an expected date of completion recorded against them.

See tables 4, 5 and 6 in Appendix 1 for who is responsible for remedial action and the associated timescales.

4.9 Use of action plans

Generally, use of the risk register module on Datixweb will allow monitoring and review of actions adequately. However certain complex risks may benefit from separate action plans. Review and update of action plans should take place alongside review of the risks themselves and can be attached to the risk on Datixweb.

4.10 Ensuring appropriate and regular review and update

All risks require ongoing monitoring and review to ensure effective management. This also applies if the risk is accepted, as such risks may become unacceptable over time or because circumstances change. It is therefore essential that all open risks are regularly reviewed.

Extreme (red) risks must be reviewed at least four times a year, high (amber) risks twice to four times a year, while medium (yellow), low (green) or accepted risks may be reviewed less frequently. See table 5 in Appendix 1 for guidance. The review date of risks should be checked regularly to ensure that dates have not passed.

Corporate risks will also be reviewed four times a year by the Risk Register Review Group.

Review of risks should include careful consideration of whether proposed actions have been implemented. If so, and where applicable, these actions should be considered current controls and transferred accordingly. The risk grading should then be reassessed.

4.11 When a risk needs escalated

The circumstances surrounding a risk may change, requiring it to be amended and re-scored. In accordance with Directorate processes, the Director / Co-Director / Quality & Governance Manager must be notified if a previously medium (yellow) or low (green) risk is amended to become high (amber) or extreme (red).

If circumstances surrounding the risk change so that any of the following criteria are met, the Director must be notified and approval sought for inclusion on the Corporate Risk Register:

1. Has been evaluated as ‘Almost certain’ x ‘Catastrophic’(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

4.12 When a risk can be de-escalated

Where actions have been implemented and controls improved, it is expected that risks will be amended and re-scored to a lower grade.

Where these actions and controls have resulted in a corporate risk no longer meeting the criteria outlined in section 4.10, the Director may approve de-escalation of a risk from corporate to operational. This should be managed via Directorate processes and will be noted at the Risk Register Review Group.

4.13 Closing a risk

A risk should only be closed when all proposed actions have been implemented to good effect and the risk no longer exists. The date should be entered in the 'Closed date' field against the risk and it may be excluded from risk register reports.

4.14 Accepting a risk

Where a risk has been accepted (i.e. it has been agreed to live with the risk as long as it is properly controlled) the risk should still be added to the risk register and reviewed as required, at least annually.

The exception to this may be where medium (yellow) or low (green) risks have been identified as the result of a general risk assessment. Having appropriate risk assessments which are reviewed in line with policy will be sufficient to manage these risks at departmental level.

These risks need only be added to the risk register if:

- there are further actions required to adequately control the risk and which need to be closely monitored to ensure timely progress, or
- the risk meets the criteria for inclusion on the Corporate Risk Register

4.15 Removing a Risk

Risks can only be removed from Datixweb by a system administrator. Staff should contact the Corporate Governance department if they require a risk to be removed.

4.16 Training/Advice

Each Directorate has a Governance and Quality Manager, or equivalent, who is available as a source of expert advice.
Other related training courses include, for example, general risk assessment and adverse incident reporting. Datixweb for Risks training is also provided by the Corporate Governance Dept and must be completed by any member of staff registered as a user.

4.17 Helpful reading

See Section 7.0

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Responsibility of Service Directorates

6.0 MONITORING

The effectiveness of this procedure will be monitored by liaison between Corporate Governance and Directorate Governance and Quality Senior

Managers. It will be formally reviewed alongside review of the Risk Management Strategy every 3 years or in the event of changes in guidance.

7.0 EVIDENCE BASE / REFERENCES

- A Risk Matrix for Risk Managers Jan 2008 – National Patient Safety Agency
- AS/NZS 4360:2004 Australian/New Zealand Standard Risk Management
- Making it Happen – A Guide for Risk Managers on How to Populate a Risk Register, Risk Register Working Group
- WHSCT Risk Management Strategy and Procedure for the Production of Risk Registers
- Escalation of risk within and between Health and Social Care Organisations, Nov 2011, DHSSPS

8.0 CONSULTATION PROCESS

Circulated to Directorate Governance and Quality Senior Managers for consultation.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Analysing and Evaluating the Risk
Appendix 2 – Sample Risk Register Action Plan

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Date: 10 August 2016

Name Dr Cathy Jack
Title Medical Director

Date: 10 August 2016

Name Dr Michael McBride
Title Chief Executive

Appendix 1

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

- **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the Corporate risk register by the relevant Director.**
- **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co-Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
- **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
- **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Belfast Health and Social Care Trust

Reference No: TP091/14

Title:	Risk Register Production and Management Guidance		
Author(s)	C R Cairns- Senior Manager Corporate Governance G Moore- Administration & Datix Manager , Corporate Governance		
Ownership:	Dr AB Stevens – Medical Directors Directorate		
Approval by:	Policy Committee Executive Team	**Approval date:**	30 June 2014 09 July 2014
Operational Date:	June 2014	**Next Review:**	June 2015
Version No.	1	**Supercedes**	N/A
Links to other policies	Risk Management Strategy, Board Assurance Framework, Adverse Incident Reporting and management Policy, General Health & Safety Policy and Risk Assessment Guidance		

Date	Version	Author	Comments
01/03/2013	0.1	CR Cairns	Initial Draft
01/05/2013	0.2	CR Cairns G Moore	Second draft
01/06/2013	0.3	CR Cairns G Moore	Third draft
26/6/2013	0.4	CR Cairns G Moore	Fourth draft
22/5/2014	0.5	CR Cairns G Moore	Fifth draft

Belfast Health and Social Care Trust

1.0 INTRODUCTION / PURPOSE OF GUIDANCE

1.1 Background

This procedure is intended to support the Trust Risk Management Strategy providing operational guidance on the production and management of risk registers at all levels in the organisation.

1.2 Purpose

It is vital that staff with management responsibilities at all levels in the organisation have clear guidance on how to produce and maintain a risk register ensuring that identified risks are effectively monitored to provide assurance regarding their management, thus supporting the Trust to do its reasonable best to protect service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings.

This guidance document supports the Risk Management Strategy 2013-2016, and links with the Adverse Incident Policy and Procedures, the Board Assurance Framework and the General Health and Safety Policy and Risk Assessment Guidance .

1.3 Objectives

- Support staff in understanding the various sources for risk identification
- Provide clarification on how to apply the risk evaluation system to identified risks
- Provide clarification in relation to appropriate monitoring and review of risk registers at all levels of the organisation.
- Provide clarification for the management of escalation, de-escalation and acceptance of risk
- Assist staff in allocating risks to appropriate corporate objectives

2.0 SCOPE OF THE GUIDANCE

This guidance applies to all staff with management responsibilities for delivery of a service or services at all levels of the organisation.

3.0 ROLES/RESPONSIBILITIES

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produces and maintains risk registers and action plans, to address identified risks. The 'Datixweb for Risks' system is used to maintain risk registers. Areas not yet using Datixweb can use the Risk Register Excel template and associated guidance notes which can be accessed via the Risk & Governance pages on the Hub.

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Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

Chief Executive

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The Chief Executive:

- will ensure that responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document is implemented; and

- has delegated responsibility for the strategic development and operation of clinical and social care governance and risk management arrangements to the Medical Director. However, in order to discharge the responsibilities of Accounting Officer the Chief Executive will ensure that risk management features regularly on the Trust's operational and Trust Board agendas and will discuss issues and progress with the Medical Director.

Directors

Directors require assurance of appropriate management of all identified risks within their Directorate; however the role of **'Overall Lead'** as described on the Datixweb risk form and in Section 4 below, can be delegated to Co Directors, Committee chairs within the Assurance Framework or Service Managers depending on the evaluated risk level (see Appendix 1).
Any risk identified as Extreme (red) must be escalated to the relevant Director via Directorate processes and an immediate investigation instigated with an action plan agreed to eliminate/ reduce/control the risk. The Director will remain identified as Overall Lead for all Extreme risks within their Directorate. Extreme risks will automatically be considered for inclusion within the Corporate Risk Register, the Director is responsible for confirming inclusion on the Corporate Risk Register via the Directorate Governance and Quality Service Manager and Senior Manager, Corporate Governance Services.

Belfast Health and Social Care Trust

Committee Chairs within the Assurance Framework

On occasion risks can be identified via the committee structure within the Board Assurance framework. It may be appropriate that the chair of a key committee will be identified as Overall Lead. In such instances they will ensure an appropriate risk lead is identified and an investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Co Directors

Co Directors may be identified as **Overall Lead** for risks evaluated as High (amber) or below. As Overall Lead they will ensure a Risk Lead is identified and an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing and regular monitoring of the risk until such times as it is closed. Co Directors may also be identified as the **Risk Lead** as described on the Datixweb risk form and in Section 4 below.

Depending on the nature of the risk and the criteria as described in section 4 the Co-Director may consider a risk evaluated as High (amber) requires inclusion on the corporate risk register. Inclusion must be approved by the Director.

Service Managers

Service Managers may be identified as Overall Lead for risks evaluated as Medium (yellow) or below. As Overall Lead they will ensure a Risk Lead is identified to ensure an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for liaising with Directorate staff in relation to population and maintenance of risk registers using the Datix risk management system and work closely with their Director to ensure appropriate approval of risks for inclusion on the corporate risk register. They will also act as a resource for expert advice.

Belfast Health and Social Care Trust

4.0 KEY GUIDANCE PRINCIPLES

DEFINITIONS

Corporate Risk
A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control;
- Existing standards and guidance ignore or contribute to the risk;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

Although described as 'corporate', ownership of the risk still lies with the appropriate Director.

Corporate risks will be monitored four times a year at Board level by the Assurance Committee.

Operational Risk
An operational risk will be below 25 but can be of any grade including extreme (red), but has been deemed by the Director as being appropriately managed at operational level and therefore not required for inclusion on the corporate register.

These risks may be managed at Ward / Facility / Specialty / Service Area or Directorate level.

Operational risks evaluated as Extreme (red) or High (amber) must be closely monitored and reviewed no less than four times a year at Directorate level.

Overall Lead
Director / Co-Director / Manager with overall responsibility for the area within which the risk has been identified. They must ensure that an appropriate risk lead is identified.

Risk Lead
Manager with lead responsibility for the risk. They must ensure that an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk, and must oversee ongoing monitoring and management of the risk until such times as it is closed. This may be the same person as the overall lead.

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Residual Risk
The level of risk that is likely to remain once all proposed actions have been implemented.

Risk Register
A risk management tool which acts as a central repository for all risks identified by the Directorate / Service Area / Specialty / Ward / Facility.

Risk Tolerance/ Acceptance
The willingness to live with a risk, but with the confidence that it is being properly controlled. The risk must still be reviewed with the aim of reducing further risk. It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing, is even greater.

4.1 Identifying a Risk

Managers & staff at all levels must proactively identify hazards and potential risks to meeting objectives. These may relate to patient and client safety and wellbeing, quality of service, staff wellbeing, financial resources, targets / standards and reputation.

Risk can be identified from a number of information sources and by using various tools and techniques.

Information sources include adverse incidents, complaints, claims, risk assessments, staff absenteeism records, team meetings / workshops, internal and external audits/ inspections.

Practical methods and tools for identifying risks include group workshops, individual interviews, observation and review of data / records. Risks may be identified and analysed by an individual, however a group or team approach is recommended in order to provide challenge and discussion leading to a well defined and analysed risk.

4.2 Risk Description

The risk description should be clear and concise whilst still providing enough detail for it to be clearly understood. Each risk issue should be kept separate. If the risk is not clearly defined, appropriate controls, current grading and actions may not be forthcoming.

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If a problem has materialised such as not achieving standards or having enough resource to deliver a service, this has now happened (real and current), as the management team are already managing a live situation. This is not to say there is no risk associated with the situation, but it is important to identify and describe the risk accurately, i.e. non-compliance with a standard is not a risk, rather the impact of the non-compliance is a risk, and this impact is what should be described.

4.3 Linking a Risk to a Corporate Objective

The organisation has identified five key objectives as follows:

- A Culture of Safety and Excellence
- Continuous Improvement
- Partnerships
- Our People
- Resources

These should be considered for each risk in terms of the impact of the risk on the objectives. One or more objective/s should then be applied to the risk.

4.4 Allocating overall lead and risk lead – different roles

The risk grade will determine how the overall lead and risk lead are allocated (see Section 3.0 Role/Responsibilities and section 4.0 Definitions). Overall lead and risk lead can be the same person.

4.5 Identifying Current Controls

Controls are existing processes, policies, devices, practices or other actions which act to minimise risk.

Some controls are stronger than others. For example, physical measures and additional staffing are stronger controls than procedures and training. When identifying current controls, their strengths and weaknesses should also be considered and taken into account when scoring / grading the risk.

4.6 Analysing & evaluating the risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix at Appendix 1

The tables and matrix are used to score / grade both the current risk and the residual risk.

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4.7 Proposed actions

Proposed actions are those actions which will be implemented to eliminate, reduce or control the risk. Some actions, like controls, are stronger than others and this should be considered when identifying actions. They should be explicit, timebound and deliverable. Avoid actions such as 'remind staff', 'promote awareness' but if they have to be used, explain how this will be done.
All proposed actions should have an expected date of completion recorded against them.
See tables 4, 5 and 6 in Appendix 1 for who is responsible for remedial action and the associated timescales.

4.8 Use of action plans

Generally, use of the risk register module on Datixweb will allow monitoring and review of actions adequately. However certain complex risks may benefit from separate action plans. Review and update of action plans should take place alongside review of the risks themselves and can be attached to the risk on Datixweb.

4.9 Ensuring appropriate and regular review and update

All risks require ongoing monitoring and review to ensure effective management. This also applies if the risk is accepted, as such risks may become unacceptable over time or because circumstances change. It is therefore essential that all open risks are regularly reviewed.

Extreme (red) risks must be reviewed at least four times a year, high (amber) risks twice to four times a year, while medium (yellow), low (green) or accepted risks may be reviewed less frequently. See table 5 in Appendix 1 for guidance. The review date of risks should be checked regularly to ensure that dates have not passed.

Corporate risks will also be reviewed four times a year by the Risk Register Review Group prior to tabling at Assurance Committee.

Review of risks should include careful consideration of whether proposed actions have been implemented. If so, and where applicable, these actions should be considered current controls and transferred accordingly. The risk grading should then be reassessed.

4.10 When a risk needs escalated

The circumstances surrounding a risk may change, requiring it to be amended and re-scored. In accordance with Directorate processes, the Director / Co-Director / Quality & Governance Manager must be notified if a previously medium (yellow) or low (green) risk is amended to become high (amber) or extreme (red).

Belfast Health and Social Care Trust

If circumstances surrounding the risk change so that any of the following criteria are met, the Director must be notified and approval sought for inclusion on the Corporate Risk Register:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
- Existing standards and guidance ignore or contribute to the risk;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

4.11 When a risk can be de-escalated

Where actions have been implemented and controls improved, it is expected that risks will be amended and re-scored to a lower grade.

Where these actions and controls have resulted in a corporate risk no longer meeting the criteria outlined in section 4.10, the Director may approve de-escalation of a risk from corporate to operational. This should be managed via Directorate processes and will be noted at the Risk Register Review Group.

4.12 Closing a risk

A risk should only be closed when all proposed actions have been implemented to good effect and the risk no longer exists. The date should be entered in the 'Closed date' field against the risk and it may be excluded from risk register reports.

4.13 Accepting a risk

Where a risk has been accepted (i.e. it has been agreed to live with the risk as long as it is properly controlled) the risk should still be added to the risk register and reviewed as required.

The exception to this may be where medium (yellow) or low (green) risks have been identified as the result of a general risk assessment. Having appropriate risk assessments which are reviewed in line with policy will be sufficient to manage these risks at departmental level.

These risks need only be added to the risk register if:

- there are further actions required to adequately control the risk and which need to be closely monitored to ensure timely progress, or
- the risk meets the criteria for inclusion on the Corporate Risk Register

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4.14 Training/Advice

Each Directorate has a Governance and Quality Manager, or equivalent, who is available as a source of expert advice.

Other related training courses include, for example, general risk assessment, adverse incident reporting, Datixweb for Risks. These can be accessed via HRPTS or TAS.

4.15 Helpful reading

See Section 7.0

5.0 IMPLEMENTATION OF POLICY

Dissemination
Responsibility of Service Directorates

6.0 MONITORING

The effectiveness of this procedure will be monitored by liaison between Corporate Governance and Directorate Governance and Quality Senior Managers. It will be formally reviewed alongside review of the Risk Management Strategy on an annual basis.

7.0 EVIDENCE BASE / REFERENCES

- A Risk Matrix for Risk Managers Jan 2008 – National Patient Safety Agency
- AS/NZS 4360:2004 Australian/New Zealand Standard Risk Management
- Making it Happen – A Guide for Risk Managers on How to Populate a Risk Register, Risk Register Working Group
- WHSCT Risk Management Strategy and Procedure for the Production of Risk Registers
- Escalation of risk within and between Health and Social Care Organisations, Nov 2011, DHSSPS

8.0 CONSULTATION PROCESS

Circulated to Directorate Governance and Quality Senior Managers for consultation.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Analysing and Evaluating the Risk
Appendix 2 – Sample Risk Register Action Plan

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10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. x☐

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

9 July 2014

_____ **Date:** _____

Name Tony Stevens
Title Medical Director

9 July 2014

_____ **Date:** _____

Name Martin Dillon
Title Interim Chief Executive

Belfast Health and Social Care Trust

Appendix 1

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that on Datixweb, step 3 above is automatically completed once the consequence and likelihood scores are entered.

The tables and matrix are used to score / grade both the current risk and the residual risk.

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Table 1

BHSCT Impact Table

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Medium-term harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term / permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

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DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Belfast Health and Social Care Trust

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Belfast Health and Social Care Trust

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

➢ **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the Corporate risk register by the relevant Director.**
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Belfast Health and Social Care Trust

Terms of Reference

Policy Committee

January 2008

Belfast Health and Social Care Trust

POLICY COMMITTEE

DRAFT TERMS OF REFERENCE

1. Constitution

1.1 The Assurance Committee, is a sub-committee of the Trust Board, has established a Policy Committee.

1.2 The Policy Committee will provide assurance there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust.

2. Membership

2.1 Membership of the Committee will comprise of:

Mr Paul Ryan	Chairman
Mrs Olive MacLeod	Nursing/Co-Chair, Standards & Guidelines Committee
Dr Julian Johnston	Co-Chair, Standards & Guidelines Committee
Mr John Growcott	Social Care
Mrs Joan Peden	Human Resources & Equality
Miss Mairead Mitchell	Mental Health and Learning Disability
Mr Brian Barry	Older People and Medicine Surgery
Mr Kevin Corr	Finance
Ms June Champion	Medical Director/Governance
Mrs Jackie Austin	Head and Skeletal
Mrs Teresa McGonagle	Clinical Services
Ms Christine Murphy	Quality & Audit Department
Ms Carol-Anne Murton	Specialist Services
Mrs Denise Lynn	Records Management

2.2 Quorum

A quorum will be 4.

3. Attendance At Meetings

The meetings will be serviced by administrative support within the Head of Office function. The Senior Manager in Quality and Audit Department will be the keeper of all Trust policies.

4. Frequency of Meetings

4.1 Year One

The Policy Committee will meet at least monthly due to the special circumstances in establishing a Trust.

5. Roles and Responsibilities

5.1 Committee

It is the role and responsibility of the Policy Committee to ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust. This role will include:

- Over-seeing the outcome of the harmonisation of legacy Trusts policies into a Belfast Health & Social Care Policy Inventory
- Robust procedure in place to manage the approval of new and revised Trust polices
- Robust procedures to ensure version control of revised policies

5.2 Directors

Directors are accountable for the policies within their specific area of professional corporate or functional area of responsibility.

They will comply with the Policy Procedure document to ensure that all policies presented to the Policy Committee have been ratified prior to submission. The Chief Executive through the Executive Team will ultimately approve all polices.

6. Authority

6.1 The Policy Committee is authorised by the Trust Assurance Committee to ensure there are effective and efficient mechanisms in place to manage the creation, adoption, version control and approval of Trust policies (new, existing and revised).

6.2 Policies endorsed by the *Policy Committee will be recognised as Trust policies* and forwarded to the Executive Management Team for approval.

7. Reporting

7.1 The Policy Committee is accountable and reports to the Assurance Committee established by the Trust Board.

7.2 The Policy Committee reports to the Executive Team of the Trust and the Assurance Committee.

7.3 The Policy Committee is part of and contributes to the Trust's assurance framework (corporate governance, information and record governance and legislative and regulatory requirements).

8. Objectives

8.1 The Policy Committee will ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health and Social Care Trust.

8.2 The Policy Committee will ensure that best practice is followed in accordance with the Controls Assurance Records Management Standard.

8.3 Key Priorities

8.3.1 Formally establish a Policy Committee, accountable to the Assurance Committee.

8.3.2 Agree the Terms of Reference and submit to Executive Team and Assurance Committee for approval.

8.3.3 Agree a Procedure for submission of new, existing and revised policies to the Policy Committee for consideration and approval.

8.3.4 All policies must be drafted using the Trust's Policy Template. Only policies (and procedures) ratified by the relevant Director (s) at service level may be submitted to the Policy Committee for approval.

8.3.5 Equality & Human Rights considerations - all policies (new, existing and revised) must include the equality and human rights screening template fully completed.

8.3.6 Only policies approved by the Policy Committee will be submitted to the Chief Executive and Executive Team for endorsement and signature.

8.3.7 The Head of Office function within the Trust will maintain an inventory of all Trust policies.

8.3.8 The Quality and Audit Department will draw up a procedure for the dissemination/ communication of approved policies ensuring communication with Directors. The inventory of policies will be available and accessible on the Intranet site.

9. Monitor and Review

The Terms of Reference of the Policy Committee will be reviewed annually to ensure effectiveness and fit for purpose.

Belfast Health and Social Care Trust

POLICY COMMITTEE

Chairman Mr Paul Ryan
Head of Office, Chief Executive's Office

Membership

Mrs Olive MacLeod, Nursing/Co-Chair, Standards & Guidelines Committee
Dr Julian Johnston, Co-Chair, Standards & Guidelines Committee
Mr John Growcott, Social Care
Mrs Joan Peden, Human Resources & Equality
Miss Mairead Mitchell, Mental Health and Learning Disability
Mr Brian Barry, Older People and Medicine Surgery
Ms Maureen Edwards, Finance
Ms June Champion, Medical Director/Governance
Ms Christine Murphy, Quality & Audit Department
Ms Carol-Anne Murton, Specialist Services

Terms of Reference

1. Constitution

The Assurance Committee, is a sub-committee of the Trust Board, has established a Policy Committee.

The Policy Committee will provide assurance there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust.

2.1 Quorum

A quorum will be 4.

3. Attendance At Meetings

The meetings will be serviced by administrative support within the Head of Office function. The Senior Manager in Quality and Audit Department will be the keeper of all Trust policies.

4. Frequency of Meetings

Year One - The Policy Committee will meet at least monthly due to the special circumstances in establishing a Trust.

5. Roles and Responsibilities

Committee

It is the role and responsibility of the Policy Committee to ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust. This role will include:

- Over-seeing the outcome of the harmonisation of legacy Trusts policies into a Belfast Health & Social Care Policy Inventory
- Robust procedure in place to manage the approval of new and revised Trust polices
- Robust procedures to ensure version control of revised policies

5.2 Directors

Directors are accountable for the policies within their specific area of professional corporate or functional area of responsibility.

They will comply with the Policy Procedure document to ensure that all policies presented to the Policy Committee have been ratified prior to submission. The Chief Executive through the Executive Team will ultimately approve all polices.

6. Authority

The Policy Committee is authorised by the Trust Assurance Committee to ensure there are effective and efficient mechanisms in place to manage the creation, adoption, version control and approval of Trust policies (new, existing and revised).

Policies endorsed by the Policy Committee will be recognised as Trust policies and forwarded to the Executive Management Team for approval.

7. Reporting

The Policy Committee is accountable and reports to the Assurance Committee established by the Trust Board.

The Policy Committee reports to the Executive Team of the Trust and the Assurance Committee.

The Policy Committee is part of and contributes to the Trust's assurance framework (corporate governance, information and record governance and legislative and regulatory requirements).

8. Objectives

The Policy Committee will ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health and Social Care Trust.

The Policy Committee will ensure that best practice is followed in accordance with the Controls Assurance Records Management Standard.

Key Priorities

Formally establish a Policy Committee, accountable to the Assurance Committee.

Agree the Terms of Reference and submit to Executive Team and Assurance Committee for approval.

Agree a Procedure for submission of new, existing and revised policies to the Policy Committee for consideration and approval.

All policies must be drafted using the Trust's Policy Template. Only policies (and procedures) ratified by the relevant Director (s) at service level may be submitted to the Policy Committee for approval.

Equality & Human Rights considerations - all policies (new, existing and revised) must include the equality and human rights screening template fully completed.

Only policies approved by the Policy Committee will be submitted to the Chief Executive and Executive Team for endorsement and signature.

The Head of Office function within the Trust will maintain an inventory of all Trust policies.

The Quality and Audit Department will draw up a procedure for the dissemination/ communication of approved policies ensuring communication with Directors. The inventory of policies will be available and accessible on the Intranet site.

9. Monitor and Review

The Terms of Reference of the Policy Committee will be reviewed annually to ensure effectiveness and fit for purpose.

Belfast Health and Social Care Trust

POLICY COMMITTEE

Chairman Ms June Champion
Head of Office (Acting), Chief Executive's Office & Medical Director's Group

Membership

Mrs Olive MacLeod, Nursing/Co-Chair, Standards & Guidelines Committee
Dr Julian Johnston, Co-Chair, Standards & Guidelines Committee
Mr John Growcott, Social Care
Mrs Joan Peden, Human Resources & Equality
Miss Mairead Mitchell, Mental Health and Learning Disability
Mr Brian Barry, Older People and integrated Services
Mrs Nicola Briggs Finance
Mr Conor Campbell, Quality & Audit Department
Ms Jacqui Austen, Specialist Services
Mrs A McAuley, Family & Childcare

Terms of Reference

1. Constitution

The Assurance Committee, is a sub-committee of the Trust Board, has established a Policy Committee.

The Policy Committee will provide assurance there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust.

2.1 Quorum

A quorum will be 4.

3. Attendance At Meetings

The meetings will be serviced by administrative support within the Head of Office function. The Senior Manager in Quality and Audit Department will be the keeper of all Trust policies.

4. Frequency of Meetings

The Policy Committee will meet on a monthly basis.

5. Roles and Responsibilities

Committee

It is the role and responsibility of the Policy Committee to ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health & Social Care Trust. This role will include:

- Over-seeing the outcome of the harmonisation of legacy Trusts policies into a Belfast Health & Social Care Policy Inventory
- Robust procedure in place to manage the approval of new and revised Trust polices
- Robust procedures to ensure version control of revised policies

5.2 Directors

Directors are accountable for the policies within their specific area of professional corporate or functional area of responsibility.

They will comply with the Policy Procedure document to ensure that all policies presented to the Policy Committee have been ratified prior to submission. The Chief Executive through the Executive Team will ultimately approve all polices.

6. Authority

The Policy Committee is authorised by the Trust Assurance Committee to ensure there are effective and efficient mechanisms in place to manage the creation, adoption, version control and approval of Trust policies (new, existing and revised).

Policies endorsed by the Policy Committee will be recognised as Trust policies and forwarded to the Executive Management Team for approval.

7. Reporting

The Policy Committee is accountable and reports to the Assurance Committee established by the Trust Board.

The Policy Committee reports to the Executive Team of the Trust and the Assurance Committee.

The Policy Committee is part of and contributes to the Trust's assurance framework (corporate governance, information and record governance and legislative and regulatory requirements).

8. Objectives

The Policy Committee will ensure there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health and Social Care Trust.

The Policy Committee will ensure that best practice is followed in accordance with the Controls Assurance Records Management Standard.

Key Priorities

Formally establish a Policy Committee, accountable to the Assurance Committee.

Agree the Terms of Reference and submit to Executive Team and Assurance Committee for approval.

Agree a Procedure for submission of new, existing and revised policies to the Policy Committee for consideration and approval.

All policies must be drafted using the Trust's Policy Template. Only policies (and procedures) ratified by the relevant Director (s) at service level may be submitted to the Policy Committee for approval.

Equality & Human Rights considerations - all policies (new, existing and revised) must include the equality and human rights screening template fully completed.

Only policies approved by the Policy Committee will be submitted to the Chief Executive and Executive Team for endorsement and signature.

The Head of Office function within the Trust will maintain an inventory of all Trust policies.

The Quality and Audit Department will draw up a procedure for the dissemination/ communication of approved policies ensuring communication with Directors. The inventory of policies will be available and accessible on the Intranet site.

9. Monitor and Review

The Terms of Reference of the Policy Committee will be reviewed annually to ensure effectiveness and fit for purpose.

Belfast Health and Social Care Trust

ASSURANCE FRAMEWORK
COMMITTEE TERMS OF REFERENCE

COMMITTEE	Policy
PURPOSE	The Policy Committee will ensure that there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health and Social Care Trust. The Policy Committee will ensure that best practice in policy development and management is followed in accordance with the Records Management Organisational Assurance.
MEMBERSHIP	**Chair:** Head of Office, Chief Executive's Office/ Co-Director, Risk and Governance **Membership:** Co-Chair/Nursing, Standards and Guidelines Committee Co-Chair/Clinical, Standards and Guidelines Committee **Directorate/Department Representatives**: • Adult Social and Primary Care • Finance • Human Resources • Patient and Client Services • Performance, Planning and Informatics • Social Care/Children's Community Services • Specialist Hospital + Women's Health • Surgery and Specialist Services • Unscheduled and Acute Care • Standards, Quality + Audit **In attendance:** Policy Authors, as required **Secretary:** Executive Assistant, Chief Executive's Office
DUTIES	It is the role and responsibility of the Policy Committee to ensure that there is a systematic and planned approach to the adoption and review of new, existing and revised Trust-wide corporate policies within the Belfast Health and Social Care Trust. This role will include: • Ensure compliance with procedures to maintain appropriate version control of revised policies • Ensure compliance with procedures for submission of new, existing and revised policies to the Policy Committee for consideration and approval. • Ensure all policies are drafted using the Trust's Policy Template. Only Trust-wide corporate policies (and procedures) ratified by the relevant directorate structures may be submitted to the Policy Committee for approval. • Ensure that any Equality and Human Rights issues are considered- all policies (new, existing and revised) must therefore have completed the equality and human rights screening template prior to submission of the policy for approval. • Regular review of outstanding policies and consideration of any escalation required to ensure completion.
AUTHORITY	Directors are accountable for the policies within their specific area of professional corporate or functional area of responsibility. They will comply with the Policy Procedure document to ensure that all policies presented to the Policy Committee have been ratified prior to submission. The Chief Executive through the Executive Team will ultimately approve all polices.

	The Policy Committee is authorised by the Trust Assurance Committee to ensure there are effective and efficient mechanisms in place to manage the creation, adoption, version control and approval of Trust policies (new, existing and revised). Policies endorsed by the *Policy Committee will be recognised as Trust policies* and forwarded to the Executive Management Team for approval.
MEETINGS	**Quorum** 50% of the committee's membership should be in attendance for each meeting at least 2 of whom must be Service area/ Directorate representatives **Frequency of Meetings** bi-monthly **Papers** Agenda and relevant papers will be issued from the Chief Executive's Office prior to the meeting. **Meeting Arrangements** Organised via the Chief Executive's Office **Withdrawal of individuals in attendance** On conclusion of relevant business those in attendance should withdraw from the meeting.
REPORTING	The Policy Committee is accountable and reports to the Assurance Committee established by the Trust Board. The Policy Committee reports to the Executive Team of the Trust and the Assurance Committee. The Policy Committee is part of and contributes to the Trust's assurance framework (corporate governance, information and records governance and legislative and regulatory requirements). Only policies approved by the Policy Committee will be submitted to the Chief Executive and Executive Team for endorsement and signature. The Head of Office function within the Trust will maintain an inventory of all Trust policies. The Standards, Quality and Audit department will support the implementation of the dissemination/communication of approved policies ensuring communication with Directors. The inventory of policies will be available and accessible on the Intranet site. All policies must be displayed in the Policy and Guidelines section on the HUB. Only those policies available on the HUB are recognised as Belfast HSC Trust policies.
CONFLICT/ DECLARATION OF INTEREST	Any conflicts of interest should be declared at the outset of meetings.
REVIEW	The Terms of Reference of the Policy Committee will be reviewed annually to ensure effectiveness and fitness for purpose.

Belfast Health and Social Care Trust

ASSURANCE FRAMEWORK
COMMITTEE TERMS OF REFERENCE

COMMITTEE	Policy Committee
PURPOSE	The Policy Committee will ensure that there is a systematic and planned approach to the adoption of new, existing and revised policies within the Belfast Health and Social Care Trust. The Policy Committee will ensure that best practice in policy development and management is followed in accordance with the Records Management Organisational Assurance.
MEMBERSHIP	**Chair:** Head of Office, Chief Executive's Office/ Co-Director, Risk and Governance **Membership:** Co-Chair/Nursing, Standards and Guidelines Committee Co-Chair/Clinical, Standards and Guidelines Committee **Directorate/Department Representatives**: • Adult Social and Primary Care • Finance • Human Resources • Patient and Client Services • Performance, Planning and Informatics • Social Care/Children's Community Services • Specialist Hospital & Women's Health • Surgery and Specialist Services • Unscheduled and Acute Care • Standards, Quality & Audit • Service Manager, Corporate Standards & Risk, Risk & Governance Department • Standards & Guidelines Manager, Risk & Governance Department **In attendance:** Policy Authors, as required **Secretary:** Executive Assistant, Chief Executive's Office
DUTIES	It is the role and responsibility of the Policy Committee to ensure that there is a systematic and planned approach to the adoption and review of new, existing and revised Trust-wide corporate policies within the Belfast Health and Social Care Trust. This role will include: • To hear presentations from policy authors about new or revised policies and provide scrutiny and critic to ensure the policy fulfils its purpose. • Ensure compliance with procedures to maintain appropriate version control of revised policies • Ensure compliance with procedures for submission of new, existing and revised policies to the Policy Committee for consideration and approval.

	• To ensure that all policies that have been through the approval process are published on the Trust Policies and Guidelines page on the Trust intranet hub site. • Ensure all policies are drafted using the Trust's Policy Template. Only Trust-wide corporate policies (and procedures) ratified by the relevant directorate structures may be submitted to the Policy Committee for approval. • Ensure that any Equality Human Rights and Rural Impact issues are considered- all policies (new, existing and revised) must therefore have completed the equality and human rights screening template prior to submission of the policy for approval. • Regular review of outstanding policies and consideration of any escalation required to ensure completion. Committee members/ Directorate representatives are responsible for sharing and escalating with their Director the reports on out of date policies/ Directorate specific policies and seeking an update on same. If these methods of escalation do not assist in receiving responses, initially the Co-Chairs will write out to policy authors to request the response. Following this Co-Chairs will write to the relevant Director.
AUTHORITY	Directors are accountable for the policies within their specific area of professional corporate or functional area of responsibility. They will comply with the Policy Procedure document to ensure that all policies presented to the Policy Committee have been ratified prior to submission. The Policy Committee is authorised by the Trust Assurance Committee to ensure there are effective and efficient mechanisms in place to manage the creation, adoption, version control and approval of Trust policies (new, existing and revised). The Policy Committee will then recommend policies to the Executive Team for approval.
MEETINGS	**Quorum** 50% of the committee's membership should be in attendance for each meeting at least 2 of whom must be Service area/ Directorate representatives **Frequency of Meetings:** Every 2 months **Papers** Agenda and relevant papers will be issued from the Chief Executive's Office 1 week prior to the meeting. **Meeting Arrangements** Organised via the Chief Executive's Office **Withdrawal of individuals in attendance** On conclusion of relevant business those in attendance should withdraw from the meeting.
REPORTING	The Policy Committee is accountable and reports to the Assurance Committee established by the Trust Board. The Policy Committee reports to the Executive Team of the Trust and the Assurance Committee. The Policy Committee is part of and contributes to the Trust's assurance framework (corporate governance, information and records governance

	and legislative and regulatory requirements). Only policies approved by the Policy Committee will be submitted to the Chief Executive and Executive Team for endorsement and signature. The Head of Office function within the Trust will maintain an inventory of all Trust policies. The Standards & Guidelines Department will support the dissemination/communication of approved policies ensuring communication with Directors. The inventory of policies will be available and accessible on the Intranet site. All policies must be displayed in the Policy and Guidelines section on the HUB. Only those policies available on the HUB are recognised *a*s Belfast HSC Trust policies.
CONFLICT/ DECLARATION OF INTEREST	Any conflicts of interest should be declared at the outset of meetings.
REVIEW	The Terms of Reference of the Policy Committee will be reviewed annually to ensure effectiveness and fitness for purpose.

Belfast Health and Social Care Trust

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Standards & Guidelines Committee
PURPOSE	The committee will track the receipt and implementation of external standards and guidelines relating to patient / client care. The committee will oversee the development and approval of internal policies, standards and guidelines for all aspects of the management of BHSCT patients / clients. It will provide BHSCT staff with readily accessible, up to date advice and guidance using evidence based sources and well defined, transparent processes. The S&G committee aims to provide support to those developing guidelines to ensure that the presentation of the evidence required to inform key decisions in clinical practice is presented in a format that is simple, accessible and flexible. The committee will act as a primary driver for dissemination, implementation and audit of BHSCT standards and guidelines. The provision of good quality, accurate information to underpin clinical decision making will improve the quality and safety of care provided.
MEMBERSHIP	**Chair:** Julian Johnston & Olive MacLeod **Membership:** Dowd, Audrey; Barron, Orla; Boydell, Leslie; Jack, Cathy; Murphy, Christine; Adams, David; Cleland, DrOonagh; Heelham, Eunice; Heyburn, Gary; McVeigh, Gary; mcdonald, GraemeH; Steen, Heather; Johnson, Janet; ShawODoherty, Jill; McClelland, Joe; Growcott, John; Johnston, Julian; Champion, June; Keatley, Karen; Corr, Kevin; Shum, Lin; MacLeod, Olive; Mitchell, Mairead; McElroy, MaryJ; Cahalan, Paula; Coyle, Peter; Hannon, Ray; Houston, Russell; Clarke, Ruth; ODonnell, Sharon; Atkinson, Susan; Irwin, Terry; McKernan, Therese **In attendance:** Authors of Policies/Guidelines under review are invited to attend for the meeting where their tables are tabled. **Secretary:** The management, administrative and secretarial support required to support the working of the committee will be provided in full by the Standards, Quality and Audit Department, Medical Director's office. **Senior Manager -** Christine Murphy **Member Appointments:** Membership of the S&G will need to fulfil its dual role as a representative committee for all the legacy components of the BHSCT and a committee that has clearly defined assurance mechanisms.

	Members should represent:
	
	• Co-Chairpersons
	  o Medical - appointed by Medical Director
	  o Nursing – Co-Director Governance, Patient Safety and Performance
	• Manager of the Standards, Quality and Audit Department.
	• Standards & Guidelines manager
	• Risk / Patient Safety / Infection control expertise
	• Allied Health Professional – Senior Manager
	• Regional Governance Pharmacist
	• Midwife
	• Chairmen of
	  o Resuscitation Committee
	  o Transfusion Committee
	• Health & Social Services Inequalities Manager
	• Medicine
	• Surgery
	• Service Grouping

DUTIES	**a) Scope** For the purpose of this document the term **Guideline** encompasses all of the above terms e.g. standards, guidelines, policies and protocols unless they are used in a specific section. Full descriptions of the terms are available in Appendix 1. Staff need simple, patient/ client specific, user friendly guidelines. This document sets out how this Committee envisages it will obtain, develop, manage, approve, disseminate, store, implement, audit, follow-up and review the policies, standards and guidelines that will impact significantly on the BHSCT. <u>Receipt and collection of external guidelines</u> • receive and track Guidelines from DHSSPSNI (e.g. NICE, NPSA, etc.). • Use horizon scanning of appropriate sources to support the production of other internal guidelines required. (Royal Colleges). <u>Translate Guidelines into a format suitable for implementation.</u> • support identified authors and teams from Service Groups in developing the required BHSCT guidelines to insure compliance with external guidelines received. <u>Harmonisation of Legacy Guidelines</u>

	• define and agree a work programme, with the Service Groups, to include a review, rationalisation, dissemination and implementation of 'Legacy' Guidelines. • guide a process of harmonisation of legacy Guidelines across the whole BHSCT – this will be viewed as a unifying process leading to one set of policies trust wide. <u>Complete a validation process for Guidelines: The committee will:</u> • work with other specialist corporate committees and service groups to insure that appropriate processes are in place for the approval of specialist and service group specific guidelines. • manage the approval of guidelines, identified for approval by the Standards & Guidelines Committee, through committee meetings. • act as a central point through which all guidelines approved by specialist / service groups committees are ratified at the S&G committee prior to dissemination. • resolve tensions between authors, appraisers and other interested parties. <u>Dissemination and implementation of Guidelines.</u> • make all approved guidelines available on the intranet. • provide regular updates on new and revised policies to Service Group directors for dissemination. • advise and promote the best methods of implementation of these Guidelines throughout thee BHSCT. • support Service Groups in identification of resources required to implement Guidelines. • advise the Policy Committee of implementation priorities. <u>Collate, act as repository and display of Guidelines.</u> • maintain a database on all DHSSPSNI guidelines coming into the BHSCT and a separate list of all internally produced guidelines. • archive material to satisfy the requirement to identify the temporal context for BHSCT policies, standards and guidelines when satisfying requests by the courts for information regarding compliance with these standards. • manage the presentation of Guidelines to all staff of the BHSCT in a format that is easily accessible. • promote and maintain an up to date Guideline Intranet Library (CGIL).

Advise on a programme of work for the Audit department.

review internal guidelines and work to ensure that audits to support the implementation of guidelines are prioritised in the relevant service areas.

Communication

The S&G will

- Liaise with the DHSSPSNI, Regional groups, other Trust committees, offices within the Medical and Nursing directorates (education, patient safety and risk), service governance groups and other relevant parties. .

b) Boundaries

1. Patient/ Client focus

The S&G committee will primarily focus on client and patient focused Policies, Standards and Guidelines.

2. Clinicial Responsibilities

It will remain the responsibility of the practicing health professionals to interpret their application of Guidelines taking into account local circumstances and the needs and wishes of individual patients. Applying guidelines to individual care is always likely to require judgment even when recommendations are properly linked to evidence.

3. DHSSPSNI / Regional advisory bodies

When guidance is issued from the DHSSPSNI and/or Regional groups the S&G will, generally, attempt to adopt such guidance without any changes. Where there are sections that cannot be implemented or where time frames cannot be met, the S&G will advise the Policy Committee of the reasons and timeframes.

c) Implementation.

The S&G will develop and maintain an *Implementation Strategy* for Guidelines. This will be an integral component of the committee's decision making processes.

This will involve consideration of the following:-

1. Resource requirements – Service/Staff/Drugs/Equipment
2. Dissemination methods
3. Educational / Training requirements
4. Carepathways.

d) Desired Outcomes/Outputs

	The committees outcomes will be audited through looking at two main areas: 1. The process used for writing and reviewing guidelines, the engagement of service staff and the numbers of guidelines completed. The implementation success of said guidelines evidenced through audit. **e) Audit** The reports outlined in section h. will highlight the progress of specific external guidance, including compliance results.
AUTHORITY	The committee operates under the authority of the Medical and Nursing Directors.
MEETINGS	**Quorum** - A quorum is the minimum number of members of a committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as a majority of the committee i.e. half the membership plus one member. Documents for approval will be circulated electronically in advance of the meeting. In the event that a member cannot attend, they can advise of their comments / issues by communication with the author or committee administration in advance of the meeting. **Frequency of Meetings -** The Committee will meet every 6 to 8 weeks. **Papers** - Minutes will be circulated to committee members within 21 days after the meetings and will detail action points and responsibilities. Agendas for meeting will be produced in time for members to prepare for meetings. Guidelines for approval will be circulated at least 14 days in advance of the committee meeting date. (This may be less in the event where a revised document is being circulated for approval). Minutes will be circulated to all members and submitting authors. They will also be available on request. All documentation will comply with the Trust's Information policy. **Withdrawal of individuals in attendance** Not reported
REPORTING	The S&G manger will prepare a six weekly status report using agreed standard formats detailing: **7.1** Report on internal guidelines – including detail on author, approval dates or stage of development. **7.2** Report on compliance / progress with external DHSSPSNI

	guidelines These will be sent to the Policy Committee chairman and the Medical and Nursing Directors. The manger will submit these reports along with a committee workplan to the Assurance Group every 4 months. (Annual report to be submitted annually)
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
REVIEW	**Version 3:** Due to be reviewed November 2010. Revised version will be sent to the Patient & Client Safety Steering Group.

Belfast Health and Social Care Trust

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Standards & Guidelines Committee
PURPOSE	The committee will track the receipt and implementation of external standards and guidelines relating to patient / client care (e.g. DHSS Learning Letters / Safety Alerts; NICE Clinical Guidelines and Technology Appraisals). The committee will oversee the development and approval of internal policies, standards and guidelines for all aspects of the management of BHSCT patients / clients. It will provide BHSCT staff with readily accessible, up to date advice and guidance using evidence based sources and well defined, transparent processes. The S&G committee aims to provide support to those developing guidelines to ensure that the presentation of the evidence required to inform key decisions in clinical practice is presented in a format that is simple, accessible and flexible. The committee will act as a primary driver for dissemination, implementation and audit of BHSCT standards and guidelines. The provision of good quality, accurate information to underpin clinical decision making will improve the quality and safety of care provided.
MEMBERSHIP	**Chair:** Julian Johnston & David Robinson **Membership:** Chairs of Transfusion Committee Chair of Resuscitation Committee Standards & Guidelines Manager / Standards, Quality & Audit Manager **Directorate / Service representation from the following:** Community Nursing Acute Nursing Infection Control AHPs Pharmacy / Medicines Management Acute Services Unscheduled Care Paediatric - RBHSC Maternity Social Care Older People Orthopaedics

	Mental Health Learning Disability **In attendance:** Authors of Policies/Guidelines under review are invited to attend for the meeting where their tables are tabled. **Secretary:** The management, administrative and secretarial support required to support the working of the committee will be provided in full by the Standards, Quality and Audit Department, Medical Director's office. **Senior Manager -** Christine Murphy **Member Appointments:** Membership of the S&G will need to fulfil its dual role as a representative committee for all the legacy components of the BHSCT and a committee that has clearly defined assurance mechanisms.
DUTIES	**a) Scope** For the purpose of this document the term **Guideline** encompasses all of the above terms e.g. standards, guidelines, policies and protocols unless they are used in a specific section. Full descriptions of the terms are available in Appendix 1. Staff need simple, patient/ client specific, user friendly guidelines. This document sets out how this Committee envisages it will obtain, develop, manage, approve, disseminate, store, implement, audit, follow-up and review the policies, standards and guidelines that will impact significantly on the BHSCT. <u>Receipt of external guidelines and assurance on implementation</u> • receive and track Guidelines from DHSSPSNI (e.g. NICE, NPSA, etc.). • Issue to appropriate Director as per agreed Trust process and report by Exception to the Medical Director on a regular basis. • Use horizon scanning of appropriate sources to support the production of other internal guidelines required. (e.g Royal Colleges). <u>Translate Guidelines into a format suitable for implementation.</u> • support identified authors and teams from Service Groups in developing the required BHSCT guidelines to insure compliance with external guidelines received. <u>Harmonisation of Legacy Guidelines</u>

- define and agree a work programme, with the Service Groups, to include a review, rationalisation, dissemination and implementation of 'Legacy' Guidelines.
- guide a process of harmonisation of legacy Guidelines across the whole BHSCT – this will be viewed as a unifying process leading to one set of policies trust wide.

<u>Complete a validation process for Guidelines: The committee will:</u>

- work with other specialist corporate committees and service groups to insure that appropriate processes are in place for the approval of specialist and service group specific guidelines.
- manage the approval of guidelines, identified for approval by the Standards & Guidelines Committee, through committee meetings.
- act as a central point through which all guidelines approved by specialist / service groups committees are ratified at the S&G committee prior to dissemination.
- resolve tensions between authors, appraisers and other interested parties.

<u>Dissemination and implementation of Guidelines.</u>

- make all approved guidelines available on the intranet.
- provide regular updates on new and revised policies to directors for dissemination.
- advise and promote the best methods of implementation of these Guidelines throughout thee BHSCT.
- support Service Groups in identification of resources required to implement Guidelines.
- advise the Policy Committee of implementation priorities.

<u>Collate, act as repository and display of Guidelines.</u>

- maintain a database on all DHSSPSNI guidelines coming into the BHSCT and a separate list of all internally produced guidelines.
- archive material to satisfy the requirement to identify the temporal context for BHSCT policies, standards and guidelines when satisfying requests by the courts for information regarding compliance with these standards.
- manage the presentation of Guidelines to all staff of the BHSCT in a format that is easily accessible.
- promote and maintain an up to date Guideline Intranet Library (CGIL).

<u>Advise on a programme of work for the Audit department.</u>
review internal guidelines and work to ensure that audits to support the implementation of guidelines are prioritised in the

relevant service areas.

Communication

The S&G will

- Liaise with the DHSSPSNI, Regional groups, other Trust committees, offices within the Medical and Nursing directorates (education, patient safety and risk), service governance groups and other relevant parties. .

b) Boundaries

1. Patient/ Client focus

The S&G committee will primarily focus on client and patient focused Policies, Standards and Guidelines.

2. Clinicial Responsibilities

It will remain the responsibility of the practicing health professionals to interpret their application of Guidelines taking into account local circumstances and the needs and wishes of individual patients. Applying guidelines to individual care is always likely to require judgment even when recommendations are properly linked to evidence.

3. DHSSPSNI / Regional advisory bodies

When guidance is issued from the DHSSPSNI and/or Regional groups the S&G will, generally, attempt to adopt such guidance without any changes. Where there are sections that cannot be implemented or where time frames cannot be met, the S&G will advise the Policy Committee of the reasons and timeframes.

c) Implementation.

The S&G will develop and maintain an *Implementation Strategy* for Guidelines. This will be an integral component of the committee's decision making processes.

This will involve consideration of the following:-

1. Resource requirements – Service/Staff/Drugs/Equipment
2. Dissemination methods
3. Educational / Training requirements
4. Carepathways.

d) Desired Outcomes/Outputs

The committees outcomes will be audited through looking at two main

	areas: 1. The process used for writing and reviewing guidelines, the engagement of service staff and the numbers of guidelines completed. The implementation success of said guidelines evidenced through audit. **e) Audit** The reports outlined in section h. will highlight the progress of specific external guidance, including compliance results.
AUTHORITY	The committee operates under the authority of the Medical and Nursing Directors.
MEETINGS	**Quorum** - A quorum is the minimum number of members of a committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as a majority of the committee i.e. half the membership plus one member. Documents for approval will be circulated electronically in advance of the meeting. In the event that a member cannot attend, they can advise of their comments / issues by communication with the author or committee administration in advance of the meeting. **Frequency of Meetings -** The Committee will meet every 6 to 8 weeks. **Papers** - Minutes will be circulated to committee members within 21 days after the meetings and will detail action points and responsibilities. Agendas for meeting will be produced in time for members to prepare for meetings. Guidelines for approval will be circulated at least 14 days in advance of the committee meeting date. (This may be less in the event where a revised document is being circulated for approval). Minutes will be circulated to all members and submitting authors. They will also be available on request. All documentation will comply with the Trust's Information policy. **Withdrawal of individuals in attendance** Not reported
REPORTING	External exception reports will be circulated to the Medical Director, Governance Leads, Policy Committee Chairman and Nursing Director and HSCB

	The manager will submit these reports along with a committee workplan to the Assurance Group every 4 months. (Annual report to be submitted annually)
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
REVIEW	**Version 5.** Due to be reviewed **April 2016**

Belfast Health and Social Care Trust
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ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Standards & Guidelines Committee
PURPOSE	The committee will track the receipt and dissemination of external standards and guidelines relating to patient / client care. The committee will oversee the development and approval of internal policies, standards and guidelines for all aspects of the management of BHSCT patients / clients. It will provide BHSCT staff with readily accessible, up to date advice and guidance using evidence based sources and well defined, transparent processes. The S&G committee aims to provide support to those developing guidelines to ensure that the presentation of the evidence required to inform key decisions in clinical practice is presented in a format that is simple, accessible and flexible. The committee will act as a primary driver for dissemination of BHSCT standards and guidelines. The provision of good quality, accurate information to underpin clinical decision making will improve the quality and safety of care provided.

MEMBERSHIP	**Chair:** Deputy Medical Director & Deputy Director of Nursing for Safety , Quality and Patient Experience
	
	Membership:
	• Co-Chairpersons
	  ○ Medical - appointed by Medical Director
	  ○ Nursing – Co-Director Governance, Patient Safety and Performance
	• Manager of the Standards, Quality and Audit Department.
	• Standards & Guidelines manager
	• Risk / Patient Safety / Infection control expertise
	• Allied Health Professional – Senior Manager
	• Medicines Governance Pharmacist
	• RJMH representative
	• RBHSC representative
	• Equality Manager
	• Directorate representatives
	
	In attendance: Authors of New or Reviewed Policies/Guidelines are invited to attend the meeting where appropriate.
	
	Secretary: The management, administrative and secretarial support required to support the working of the committee will be provided in full by Standards and Guidelines Staff, Medical Director's office.

DUTIES	a) Scope

For the purpose of this document the term **Guideline** encompasses all of the above terms e.g. standards, guidelines and policies unless they are used in a specific section.

Staff need simple, user friendly guidelines. This document sets out how this Committee envisages it will obtain, develop, manage, approve, disseminate, store, follow-up and review the policies, standards and guidelines that will impact significantly on the BHSCT.

Receipt and dissemination of external guidelines

- receive and track Guidelines from DOH (e.g. NICE)
- Identify authors and teams from Directorates to develop the required BHSCT guidelines to insure compliance with external guidelines received.

Complete a validation process for Guidelines: The committee will:

- manage the approval of guidelines, identified for approval by the Standards & Guidelines Committee, through committee meetings.
- act as a central point through which all guidelines approved by specialist / service groups committees are ratified at the S&G committee prior to dissemination.

Dissemination of Guidelines.

- make all approved guidelines available on the intranet.
- provide regular updates on new and revised policies to directors for dissemination.

Collate, act as repository and display of Guidelines.

- maintain a database on all DOH guidelines coming into the BHSCT and a separate list of all internally produced guidelines.
- archive material to satisfy the requirement to identify the temporal context for BHSCT policies, standards and guidelines when satisfying requests by the courts for information regarding compliance with these standards.
- manage the presentation of Guidelines to all staff of the BHSCT in a format that is easily accessible.
- promote and maintain an up to date Guideline Intranet Library (CGIL).

Communication

- Liaise with the DOH, Regional groups, other Trust committees, offices within the Medical and Nursing and User Experience directorates (education, patient safety and risk), service governance groups and other relevant parties. .

	b) Boundaries 1. <u>Clinical Responsibilities</u> It will remain the responsibility of the practicing health professionals to interpret their application of Guidelines taking into account local circumstances and the needs and wishes of individual patients. Applying guidelines to individual care is always likely to require judgment even when recommendations are properly linked to evidence. 2. <u>DOH / Regional advisory bodies</u> When guidance is issued from the DOH and/or Regional groups the S&G will, generally, attempt to adopt such guidance without any changes. Where there are sections that cannot be implemented or where time frames cannot be met, the S&G will advise the Policy Committee of the reasons and timeframes.
AUTHORITY	The committee operates under the authority of the Medical and Nursing Directors.
MEETINGS	**Quorum** - A quorum is the minimum number of members of a committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as 6 members of the committee i.e. Documents for approval will be circulated electronically in advance of the meeting. In the event that a member cannot attend, they can advise of their comments / issues by communication with the author or committee administration in advance of the meeting. **Frequency of Meetings -** The Committee will meet every 6 weeks. **Papers** - Minutes will be circulated to committee members within 21 days after the meetings and will detail action points and responsibilities. Agendas for meeting will be produced in time for members to prepare for meetings. Guidelines for approval will be circulated at least 14 days in advance of the committee meeting date. (This may be less in the event where a revised document is being circulated for approval). Minutes will be circulated to all members and submitting authors. They will also be available on request. All documentation will comply with the Trust's Information policy. **Withdrawal of individuals in attendance** Not reported
REPORTING	A report to highlight policies due for review will be presented at S+G Committee meeting every 4 months. The report will be presented to the Trust Policy Committee and circulated to the Directors for action. The manager will submit a workplan to the Assurance Group every 4 months, who will feed up to the Assurance Committee (Annual report to be submitted annually)

CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
REVIEW	**Version 6 -** Due to be reviewed 2022 (5 years)

Belfast Health and Social Care Trust
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TERMS OF REFERENCE

NAME	Standards and Guidelines Committee
PURPOSE	**Trust Vision** **"To be one of the safest, most effective and compassionate health and social care organisations'**  The main purpose of the Standards and Guidelines (S&G) Committee is approve/note all new or approved ***Clinical Trust Wide*** policies and note all new or updated ***Directorate Specific*** policies and will monitor the progress and implementation of all external guidance (including NICE guidance).
DUTIES	The S&G Committee will work to support the Trust Assurance Framework Agenda. The S&G Committee duties are as follows – **<u>Policies</u>** To hear presentations from policy authors about new or revised clinical policies and provide scrutiny and critic to ensure the policy fulfils its purpose Ensure all policies which have been through the Trust approved approval process are published on the Policies and Guidelines page on the Trust intranet and advertised on the Trust intranet. Approve all new and updated ***Clinical Trust Wide*** policies, including those produced externally, and ensure all ***Clinical Trust Wide*** policies developed are in line with the Trust Policy Development and Approval Process policy. Monitor all out of date ***Clinical Trust Wide*** policies. Committee Members / Directorate reps are responsible for sharing and escalating with their Director and Governance Manager the out of date ***Clinical Trust Wide*** Policies Report and the out of date ***Directorate Specific*** Polices Report within their Directorate Governance Arrangements and seeking an update on same. Provide advice to the Directorate Rep / Director when a new ***Clinical Trust Wide*** policy requires to be developed or existing guidance requires updated in cases where learning is required e.g. from Serious Adverse Incidents, Coroner's cases, Litigation cases etc.

	Interventional Procedures Approve all new Interventional Procedures. **Care Pathways** Ensure all future Care pathways are approved at a Directorate level meeting and then added to the S&G Committee meetings to be noted. Ensure all Integrated Care Pathways developed are in line with the Trust Developing and Implementing a Care Pathway policy and are published on the Policies and Guidelines page on the Trust intranet. **External Guidance** Monitor progress made with the implementation of external guidance and the implementation of planning processes for each guideline. Ensure audits of NICE guidance rated as 'Green' are undertaken and seek feedback on outcomes to ensure compliance is assured and hold to account where necessary. Monitor the action and implementation (if applicable) of Safety Quality Alerts (external guidance). Approve a report detailing NICE Positive Assurance for the HSCB. Approve an S&G annual report.
AUTHORITY	The S&G Committee operates under the authority of the Medical Director and the Director of Nursing and User Experience.
REPORTING	A quarterly report which will detail out of date policies will be tabled at the S&G Committee. The approved report will then be presented to the Executive Team and then to the Assurance Committee within the Assurance Framework. A quarterly report which will detail external guidance (including NICE guidance) will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework. A quarterly report which will detail NICE guidelines received and any responses outstanding will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework. A 6 monthly report which will detail NICE guidance rated as 'Green' will be tabled at the S&G Committee and shared with the Chairs of Division to include as part of their clinical audit programme

	An annual report detailing NICE Positive Assurance for the HSCB will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework. An S&G annual report will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework.	
LEAD RESPONSIBILITY	Medical Director	
MEMBERSHIP	**Chair:**	The S&G Committee shall have two Chairs: - Deputy Medical Director
	Deputy Chair:	Deputy Director of Nursing for Safety, Governance and Patient Experience
	Membership:	Standards and Guidelines Manager Senior Manager for Corporate Risk and Standards Senior Manager for Nursing, Governance and Experience Governance Representative from ASPC Out of Hours Community Nursing Team Manager Learning Disability Divisional Nurse Children's Community Governance Manager Lead Nurse for Nursing Management Interim Lead Nurse for IPC Consultant Midwife Quality Co-ordinator, RBHSC Medicines Governance Pharmacist Divisional Nurse for Surgery/ Divisional Nurse for Cancer and Specialist Medicine Cardiology Clinical Coordinator Service Manager for Decontamination and Endoscopy Allied Health Professional Representative Chair of Division for Imaging and Neurosciences Senior Nurse, Accident and Emergency Service Interim Head of the Regional Medical Physics Service Chair of the Drugs and Therapeutics Committee Chair of the Hospitals Transfusion Committee Chair of the Resuscitation Committee Chair of the Medical Devices Committee
	In attendance:	Policy Authors will be required to attend meetings to present a new or updated ***Clinical Trust Wide*** policy in person to outline why the policy was developed or updated, who was involved, clarify any issues and answer questions raised by the Committee.
	Secretary:	The management, administrative and secretarial support required to support the working of the

	S&G Committee will be provided in full by the S&G Facilitator and the S&G Department.
	Member appointments Other members (either Trust staff, or external to the organisation) from time to time may be required to attend.
MEETINGS	**Quorum** A quorum is the minimum number of members of a Committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as 6 members from across the Directorates of the Committee. **Frequency of Meetings** The S&G Committee will meet every 8 weeks. **Secretarial Support** The formal minutes will include: The names of all present at the meeting. A record of the decisions made and any dissent. Details of how the Committee was assured and the evidence on which this was based. Details on any issues to be escalated. Declarations of interest of members and participants. **Papers** Minutes and an Action Plan from the previous meetings detailing action points and responsibilities will be circulated to S&G Committee members 1 week before the next meeting. An Agenda for the meeting will be produced in time for members to prepare for the meeting. Guidelines for approval will be circulated at least 7 days in advance of the S&G Committee meeting date (this may be less in the event where a revised document is being circulated for approval). All documentation will comply with Trust policy. **Withdrawal of individuals in attendance** From time to time depending on what is for discussion this may need to happen. If so a brief outline of this should be included and how this will be documented in the minutes.
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for S&G Committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of S&G Committee when making decisions.
REVIEW	Terms of Reference of the S&G Committee will be updated on an annual basis. **Annual review** Due to be updated October 2021.

OUTPUT	An S&G Annual Report will be approved for reporting through to the Governance Steering Group within the Assurance Framework.
Version	V7

Belfast Health and Social Care Trust
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TERMS OF REFERENCE

NAME	Standards and Guidelines Committee
PURPOSE	**Trust Vision** **"To be one of the safest, most effective and compassionate health and social care organisations'**  The main purpose of the Standards and Guidelines (S&G) Committee is approve/note all new or approved ***Clinical Trust Wide*** policies and note all new or updated ***Directorate Specific*** policies and will monitor the progress and implementation of all external guidance (including NICE guidance).
DUTIES	The S&G Committee will work to support the Trust Assurance Framework Agenda. Committee members are expected to participate fully in progressing the duties of the Committee and providing feedback during meetings. The S&G Committee duties are as follows – **<u>Policies</u>** To hear presentations from policy authors about new or revised clinical policies and provide active scrutiny and critic to ensure the policy fulfils its purpose Ensure all policies which have been through the Trust approved approval process are published on the Policies and Guidelines page on the Trust intranet and advertised on the Trust intranet. Approve all new and updated ***Clinical Trust Wide*** policies, including those produced externally, and ensure all ***Clinical Trust Wide*** policies developed are in line with the Trust Policy Development and Approval Process policy. Monitor all out of date ***Clinical Trust Wide*** policies. Committee Members / Directorate reps are responsible for sharing and escalating with their Director and Governance Manager the out of date ***Clinical Trust Wide*** Policies Report and the out of date ***Directorate Specific*** Polices Report within their Directorate Governance Arrangements and seeking an update on same.

	Provide advice to the Directorate Rep / Director when a new ***Clinical Trust Wide*** policy requires to be developed or existing guidance requires updated in cases where learning is required e.g. from Serious Adverse Incidents, Coroner's cases, Litigation cases etc. **Interventional Procedures** Approve all new Interventional Procedures. **Care Pathways** Ensure all future Care pathways are approved at a Directorate level meeting and then added to the S&G Committee meetings to be noted. Ensure all Integrated Care Pathways developed are in line with the Trust Developing and Implementing a Care Pathway policy and are published on the Policies and Guidelines page on the Trust intranet. **External Guidance** Monitor progress made with the implementation of external guidance and the implementation of planning processes for each guideline. Ensure audits of NICE guidance rated as 'Green' are undertaken and seek feedback on outcomes to ensure compliance is assured and hold to account where necessary. Monitor the action and implementation (if applicable) of Safety Quality Alerts (external guidance). Approve a report detailing NICE Positive Assurance for the HSCB. Approve an S&G annual report.
AUTHORITY	The S&G Committee operates under the authority of the Medical Director and the Director of Nursing and User Experience.
REPORTING	A quarterly report which will detail out of date policies will be tabled at the S&G Committee. The approved report will then be presented to the Executive Team and then to the Assurance Committee within the Assurance Framework. A quarterly report which will detail external guidance (including NICE guidance) will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework. A quarterly report which will detail NICE guidelines received and any responses outstanding will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework.

	A 6 monthly report which will detail NICE guidance rated as 'Green' will be tabled at the S&G Committee and shared with the Chairs of Division to include as part of their clinical audit programme If these methods of escalation do not assist in receiving responses, Initially, the co-chairs will write out to staff to request the response. Following this, the co-chairs will write to the relevant Director for a response. An annual report detailing NICE Positive Assurance for the HSCB will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework. An S&G annual report will be tabled at the S&G Committee. The approved report will then be presented to the Governance Steering Group and then to the Assurance Committee within the Assurance Framework.
LEAD RESPONSIBILITY	Medical Director
MEMBERSHIP	**Chair:** The S&G Committee shall have two Chairs: - Deputy Medical Director **Deputy Chair:** Deputy Director of Nursing for Safety, Governance and Patient Experience **Membership:** Standards and Guidelines Manager Senior Manager for Corporate Risk and Standards Senior Manager for Nursing, Governance and Experience Governance Representative from ASPC Out of Hours Community Nursing Team Manager Learning Disability Divisional Nurse Children's Community Governance Manager Lead Nurse for Nursing Management Interim Lead Nurse for IPC Consultant Midwife Quality Co-ordinator, RBHSC Medicines Governance Pharmacist Divisional Nurse for Surgery/ Divisional Nurse for Cancer and Specialist Medicine Cardiology Clinical Coordinator Service Manager for Decontamination and Endoscopy Allied Health Professional Representative Chair of Division for Imaging and Neurosciences Senior Nurse, Accident and Emergency Service Interim Head of the Regional Medical Physics Service Chair of the Drugs and Therapeutics Committee Chair of the Hospitals Transfusion Committee Chair of the Resuscitation Committee Chair of the Medical Devices Committee **In attendance:**

	Secretary:	Policy Authors will be required to attend meetings to present a new or updated ***Clinical Trust Wide*** policy in person to outline why the policy was developed or updated, who was involved, clarify any issues and answer questions raised by the Committee. The management, administrative and secretarial support required to support the working of the S&G Committee will be provided in full by the S&G Facilitator and the S&G Department.
	Member appointments Other members (either Trust staff, or external to the organisation) from time to time may be required to attend.	
MEETINGS	**Quorum** A quorum is the minimum number of members of a Committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as 6 members from across the Directorates of the Committee. **Frequency of Meetings** The S&G Committee will meet every 8 weeks. **Secretarial Support** The formal minutes will include: The names of all present at the meeting. A record of the decisions made and any dissent. Details of how the Committee was assured and the evidence on which this was based. Details on any issues to be escalated. Declarations of interest of members and participants. **Papers** Minutes and an Action Plan from the previous meetings detailing action points and responsibilities will be circulated to S&G Committee members 1 week before the next meeting. An Agenda for the meeting will be produced in time for members to prepare for the meeting. Guidelines for approval will be circulated at least 7 days in advance of the S&G Committee meeting date (this may be less in the event where a revised document is being circulated for approval). All documentation will comply with Trust policy. **Withdrawal of individuals in attendance** From time to time depending on what is for discussion this may need to happen. If so a brief outline of this should be included and how this will be documented in the minutes.	
CONFLICT/	Under the responsibilities will come a requirement for S&G Committee members, co-opted members and members of working	

DECLARATION OF INTEREST	groups to declare personal or commercial interests that may conflict with the impartial working of S&G Committee when making decisions.
REVIEW	Terms of Reference of the S&G Committee will be updated on an annual basis. **Annual review** Due to be updated October 2021.
OUTPUT	An S&G Annual Report will be approved for reporting through to the Governance Steering Group within the Assurance Framework.
Version	V7

Belfast Health and Social Care Trust
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TERMS OF REFERENCE

NAME	**Standards & Guidelines Committee**
PURPOSE	Trust Vision 'To be one of the safest, most effective and compassionate HSC organisations'  The primary purpose of the Standards and Guidelines Committee is to review and approve / note all Clinical Trustwide and Directorate/Division-specific policies, Care Pathways, and seek assurance of the dissemination, progression and implementation of Clinical External Guidance (e.g., Safety & Quality Alerts/Reminders, Learning Letters, NICE Guidance). The Standards and Guidelines Committee will work to support the Trust Assurance Framework agenda. Committee members are expected to participate fully in progressing the duties of the committee and have been nominated to utilize their skills and experience to support the work of the committee. Members are responsible for ensuring that all decisions taken are in the best interests of patients and their families, service users and staff and that those decisions are in accordance with the Trust's Corporate Plan and other strategies. Members should read and review papers in advance of each meeting and, where they are unable to attend, should arrange for a deputy to attend in their absence and provide comments as required.
DUTIES	The committee duties are as follows: • To develop and review the processes associated with the review, dissemination, implementation and monitoring of External Guidance received by the Trust, and incorporation in Trust policies or guidance as required. • To seek assurance on the review, dissemination, implementation of External Guidance received by the Trust. • To review and approve clinical policies, guidance and care pathways (at Trust, Directorate or Division level) in line with the Trust Policy Development and Approval Process. • To provide assurance that all policies, guidance and care pathways within the Trust are up to date and that any expired policies, guidance and care pathways are highlighted for review and updating by the relevant service in line with current evidence-based clinical standards. • To highlight to relevant internal stakeholders when new or existing clinical policies, guidance and care pathways (at Trust, Directorate or Division level) require review, development or update to include identified learning arising from recommendations of internal or external reports e.g., Serious Adverse Incidents, Coroner's cases, Litigation cases, or from external bodies (e.g., NPSA, NICE etc). • To publish all approved policies, guidance and care pathways on the Trust Intranet and publicised as appropriate. • To receive reports from the following committees: o Drugs and Therapeutics Committee o Hospital Transfusion Committee o Resuscitation Committee

	o Medical Devices Committee
AUTHORITY	The committee is accountable to the Governance Steering Group.
REPORTING	The committee will produce the following reports: **1.** External Guidance Quarterly Report detailing all outstanding External Guidance **2.** Quarterly Expired Clinical Policy Report at Directorate and Trust for presentation to the Trust Executive Team for noting. **3.** Standards & Guidelines Annual Report with presentation to the Governance Steering Group. **4.** Committee Assurance Update Report presented at each Governance Steering Group.
LEAD RESPONSIBILITY	Medical Director
MEMBERSHIP	**Chair:** The committee shall have Co-Chairs: Deputy Medical Director, Risk & Governance Deputy Director of Nursing for Safety, Governance & Patient Experience **Membership:** Service Manager, Corporate Standards & Risk Standards and Guidelines Manager Governance & Quality Governance Manager, ASPC LD Governance & Quality Governance Manager, ASPC MH Governance & Quality Governance Manager, ASPC ACOPS Governance & Quality Governance Manager, SHWH Governance Manager, CCS Governance Manager, UAC ???? Medication Safety Pharmacist Senior Manager, Nursing, Governance & Experience Lead Nurse for Nursing Management Lead Nurse for IPC Divisional Nurse x 1-2 Chair of Division x 1-2 Senior Nurse, Accident and Emergency Service Senior Midwife / Divisional Midwife Allied Health Professional Lead (or Deputy) Cardiology Clinical Co-ordinator Quality Co-ordinator, RBHSC Head of the Regional Medical Physics Service Service Manager for Decontamination and Endoscopy Chair of the Drugs and Therapeutics Committee Chair of the Hospital Transfusion Committee Chair of the Resuscitation Committee Chair of the Medical Devices Committee **In attendance:** Authors of Policies and Interventional Procedures should attend meetings to present a new or updated Clinical Trust wide policy to outline policy developments and/ or updates, consultation, and to clarify any issues. **Secretary**: Standards & Guidelines Facilitator

MEETINGS	**Quorum** The quorum will be defined as 60% and representation from all Service Directorates.
	Frequency of Meetings The committee will meet bi-monthly (every 8 weeks). **Secretarial Support** The formal minutes will include: • The names of all present at the meeting. • A record of the decisions made and any dissent. • Details of how the committee was assured and the evidence on which this was based. • Details on any issues to be escalated. • Declarations of interest of members and participants. **Papers** Minutes and Action Plan detailing action points and responsibilities will be circulated to committee members approximately one week before the next meeting. **Withdrawal of individuals in attendance** From time to time depending on what is for discussion this may need to happen. If so a brief outline of this should be included and how this will be documented in the minutes.
CONFLICT/ DECLARATION OF INTEREST	Committee members must complete an annual declaration of interests. Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
REVIEW	Terms of Reference will be reviewed on an annual basis.
OUTPUT	The Standards & Guidelines Committee produces an Assurance Update to the Governance Steering Group three times annually and an Annual Report.

Belfast Health and Social Care Trust

TITLE	How to write and manage a policy or guideline.

Summary	Processes to be followed for writing a policy or guideline.
Purpose	To establish a clear, uniform and comprehensive approach to writing and maintaining a policy or guideline.
Operational date	December 2007
Review date	December 2008
Version Number	V2
Supersedes previous	NA
Director Responsible	Medical Director
Lead Author	Christine Murphy, Standards, Quality and Audit Manager
Lead Author, Position	Standards, Quality and Audit Manager
Additional Author(s)	Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,
Department / Service Group	Standards, Quality and Audit Unit (SQAU)
Contact details	Jill Shaw-O'Doherty. Standards & Guidelines Manager Ext 6383(Royal site) [redacted]

Reference Number	
Supercedes	

Date	Version	Author	Comments
12/02/2007	1.0	JR Johnston	Initial Draft
12/12/2007	1.1	JR Johnston	BHSCT draft
6/01/2008	1.2	JR Johnston	BHCST minor changes

Policy Record

23/01/2008	1.3	JR Johnston	Final BHSCT Draft
25/01/2008	1.4	C Murphy	Final BHSCT

		Date	Version
Author (s)	Approval		
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Local Approval Process s

	Approval		

Dissemination

Areas	

Summary

Reference No:

Title:

How to write and manage a policy or guideline.

Purpose:
This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT).
(For a detailed set of definitions refer to appendix 2.)

Objectives:
This document ensures a

- standard style of policies or guidelines throughout the BHSCT .
- clear, uniform, comprehensive and consistent approach to writing and maintaining a policy or guideline.

This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

Policy Statement(s):

1. All policies and guidelines must follow the format of this guideline. (Appendix 1)
2. Policies and guidelines should be sent to the Trust Policy or Standards and Guidelines Committees for approval dissemination, implementation and review.
   Local policies – (those which relate to one service group) will be approved at local service group meetings (see appendix 3)
   The lead author must identify areas to which the policy/guideline should be disseminated.
3. The staff responsible for a particular subject area (usually a Standard Review Group [SRG]) will be responsible for producing the policies and guidelines and carrying out any implementation/impact assessment(s).
4. Any amendments requested will be the responsibility of the SRG lead.
5. Future review of a policy / guideline will be the responsibility of the Trust Policy or Standard and Guidelines Committee.

Chief Executive/Director	**Author**
Date:	**Date:**

Full Description

Reference No:

1. **Title:**
   How to write and manage a policy or guideline.

2. **Introduction:**
   This document details how to write and set out a policy or guideline for the BHSCT.

3. **Each policy must include the following:**
   - 2 cover sheets - identifying document control features.
     - identification of where the policy / guideline originated
     - a title
     - Primary identification table
     - Policy / Guideline reference number table
     - Version table
     - Authorisation Record table(s)
   - a description of the policy / guideline which
     - may include an executive summary to include the purpose, objectives and policy statement(s).
     - must include the full description of the policy or guideline.
   - signature of the Chief Executive/Director and date
   - signature of the principal author and date

4. **Type of Document**
   This section below the BHSCT logo identifies where the policy / guideline originates.

5. **The title**
   This must reflect the policy or guideline.

6. **Primary identification table**
   This table will be used for document control purposes and includes details of
     - Summary
     - Purpose
     - Operational date
     - Review date
     - Version Number
     - Supersedes previous
     - Director Responsible
     - Lead Author
     - Lead Author Position
     - Additional Author (s)
     - Department / Service Group
     - Contact details

7. **Reference number table**
   Office use only: for document control purposes.
   Identifies policy or guideline on Trust Policy or Standards and Guidelines Database.
   Contains Reference Number which will be allocated by TP or S&GC.

8. **Version table**
   Office use only: for document control purposes.
   This helps to identify where changes have been made to a document and ensure that everyone is using the most recent version.
   The first draft should be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0. Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
   If major changes are made to the document then it will be issued as version 2.0.
   See Guidance on version control of documents

9. **Authorisation record table(s)**
   Office use only: for document control purposes.
   Identifies approval, endorsement or authorisation position for guideline.

   BHSCT policies or guidelines are not valid until they receive Executive Team authorisation and are 'signed'. They will then be entered onto the Intranet.

10. **Policy / Guideline description – Summary**
    An executive summary may be inserted particularly if the overall document is long or complex. It should include the purpose, objectives and policy statement(s) and be signed and dated.

11. **The purpose.**
    This gives the underlying reason and justification for the policy or guideline in summary form. It could include a definition if required.

12. **The scope**
    A definition of the target audience and where or for whom the policy or guideline will apply.

    If appropriate, a common understanding of what, who or where is excluded from the guideline should be included here.

13. **The objectives.**
    This gives the purpose, goal and aim(s) for the policy or guideline – why it is necessary.

14. **Roles and Responsibilities**
    This section should identify the roles and responsibilities of all stakeholders involved with or affected by the policy / guideline. This can include personnel from the Trust (Board of Directors, Executive Team, Chief Executive, Directors, Managers, to all staff), individuals and committees, external individuals and agencies to include patients, relatives and members of the public.

15. **The definition and background of the policy or guideline.**
    This gives a definition(s) and clear outline of the parameters of the policy

or guideline identifying its boundaries.

This section will give the background and, if necessary, a context – historical, clinical or otherwise.

16. **The policy or guideline.**
Describe the policy or guideline itself, preferably in summary form or in short bullet points.

One method of writing this section of a BHSCT policy or guideline is to refer to, and if appropriate include as an appendix (pdf. format), a standard document from an outside agency or organisation e.g. NICE clinical guideline, NPSA document. Then, this section would only require the variations, exceptions or non-compliance with that standard document's recommendations to be outlined here in detail.

These exceptions would require a work plan and time scale for correction or alignment with the standard.

17. **Policy Statement(s)**
The policy or guideline may give rise to policy statement(s) and these should be indicated at this point. These are statements of the standard of service that is to be provided. They should be repeated in the executive summary.

Short bullet points are preferable.

Does not include operation procedures – these should be written separately.

18. **Implementation**
Each policy or guideline will ordinarily require an Implementation Report. This document is to outline:

i. The method for implementation.
ii. The evidence of implementation.
iii. The magnitude of the change in practice required.
iv. The expected benefits from implementing the change.
v. The specialties / departments affected by the change.
vi. The resource impacts of the implementation.
    - Clinical impact.
    - Financial impact.
    - Training/educational impact.

19. **Source(s) / Evidence Base**
This section should include a brief summary of the information sources for this policy / guideline. This may be from Government and/or the DHSSPSNI and should include such items as legislative requirements, regulations and material from regulatory bodies.

20. **The references including relevant external guidelines.**
Provide reference material wherever possible. This is a primary source of the evidence base. This should include references in journals, relevant documentation (e.g. NICE, NPSA, SIGN documentation).

Include a reference list at the end of the policy or guideline. This will identify the source(s) of the information as well as assisting the user to review the topic if more information is required.

Important documents can be appended – only in Word or PDF format.

Try not to append hyperlinks as these may cease to function in the future and may become obsolete.

21. **Consultation Process**
Indicate in this section the
- Internal external, professional / staff side representatives who were consulted in the development of this policy / guideline.
- name the internal/external individuals, committees, bodies and agencies that were involved.

22. **Equality screening**
Each policy or guideline will require an initial equality screening exercise to ascertain if the guideline should be subject to a full equality impact assessment and, if suitable, a statement included, such as:-

In line with its duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting social need Initiative and the Human Rights Act 1998 the BHSCT has carried out an initial equality screening exercise to ascertain if this policy should be subject to a full equality impact assessment.

23. **Procedure(s)**
The policy or guideline may give rise to procedural statement(s). This is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and to ensure efficiency, consistency and safety.

Short bullet points are preferable.

24. **Signature of Chief Executive/Medical Director**
Policies belong to the Trust, not the individual author and are therefore signed off by the Chief Executive/Director once approved by Executive Team.

All Trust policies or guidelines must be dated and signed.

APPENDIX 1

1. All documents must be in Word format.
2. All documents must follow the Belfast Trust -A5 written style guide 77.

   http://141.97.4.180/bchweb/Launcher.aspx?AttachmentID=3011
3. All points should be numbered for ease of referencing and editing.
4. All documents should have page numbering also with the total number indicated.
5. Each page should identify the parent committee issuing the policy or guideline, a running title, the version number and the date of production.

Appendix 2

Definitions (adopted from the United States National Library of Medicine)

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition that generally have been approved by a recognized standards organization or is accepted as a de facto standard. They are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research, and health services. A guideline is something you should do i.e. a recommendation, that may be ignored in particular circumstances but the full implications must be understood and therefore, practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical guidelines are systematically developed recommendations which assist healthcare professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help healthcare professionals in their work, but they do not replace their knowledge and skills.

A **policy** is a statement of the standard of service that is to be provided or the means by which a strategy is to be delivered. It is a statement of **what** must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures – these should be written separately.

A **procedure** is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and ensure efficiency, consistency and safety. It is a statement of **how** to do something. They may be specific to a particular work area or group of people but would be aligned with an overarching policy statement belonging to the parent organisation.

A **protocol** is a clear decision making process. It is in the form of explicit step by step instructions, on a specific aspect, giving a precise and detailed plan that should be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is that only one course of action(s) is considered appropriate – it is not discretionary. The terms 'procedure' and 'protocol' are often interchangeable.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 3

Local Approval Process –(A policy which will be used by one service group)

Specialist Services – Signed off by a 'named Medicine/Nursing lead and tabled at the Service Area Governance meeting

Mental Health & Learning Disability – Tabled at the Service group policy meeting, issued for consultation, when finalised the Senior Management Team will ratify prior to presentation at the Governance meeting

Paediatrics – Tabled at the Child Health Integrated Governance committee meeting

Older People Medicine & Surgery – Signed off by Mrs Valerie Jackson – Director

Appendix 4

Guidance on Version Control of Documents

Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee etc.

The content of a document under version control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this document will assist in the application of Version Control of all documents, for example policies, procedures etc. To assist in the application of Version Control, an example flow diagram has been developed (See Appendix 1).

Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0.1'. Subsequent versions of the initial document shall be described as 'Version 0.2', 'Version 0.3' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

First Approval of a Document

When a document is formally approved for the first time by the organisation, it shall be issued as 'Version 1.0'.

Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1.0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1.0.1'. Subsequent changes during the review of document 'Version 1.0', will be versioned as 'Version 1.0.2', 'Version 1.0.3' etc.

How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1.0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1.1'; or

- If the changes are considered to be **major** e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2.0'.

Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

If further changes are to be made to document 'Version 2.0', the draft version will be described as 'Version 2.0.1, 'Version 2.0.2', 'Version 2.0.3' etc.

The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:

- The version number;
- The date the version number was assigned;
- The author of the changes; and
- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions. An example of a Change Log is contained in Appendix 2.

Appendix 1

Example Flow Diagram on the application of Version Control

First draft of 'Version Control of Documents Guidance' produced.	Document is issued as: **Version 0.1**
Version 0.1 reviewed by the Project Team and amendments made to document.	Document is issued as: **Version 0.2**
Version 0.2 reviewed by the Project Assurance Team and amendments made to document.	Document is issued as: **Version 0.3**
Version 0.3 reviewed by Project Team and Information Services Department and amendments made to document.	Document is issued as: **Version 0.4**
Version 0.4 reviewed by Project Assurance Team and final amendments made to document.	Document is issued as: **Version 0.5**
Version 0.5 'Version Control of Documents Guidance' formally approved by the Senior Management Team.	Document is issued as: **Version 1.0**
Version 1.0 reviewed by Project Manager and **minor** amendments made.	Document is issued as: **Version 1.0 .1**
Version 1.0.1 formally approved by the Senior Management Team	Document is issued as: **Version 1.1**

Appendix 2

The Change Log

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

2 029

Belfast Health and Social Care Trust

TITLE	**Writing and approval of trust documents**

Summary	Processes to be followed for writing a trust policy or guideline.
Purpose	To establish a clear, uniform and comprehensive approach to the writing and approval of trust policies and guidelines
Operational date	December 2007
Review date	June 2014
Version Number	V4
Supersedes previous	V3.
Linked policy	Policy Template
Director Responsible	Medical Director
Lead Author	Christine Murphy, Standards, Quality and Audit Manager
Lead Author, Position	Standards, Quality and Audit Manager
Additional Author(s)	Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,
Department / Service Group	Standards, Quality and Audit Unit (SQA)
Contact details	Jill Shaw-O'Doherty. Standards & Guidelines Manager Ext [redacted] (Royal site) [redacted]

Reference Number	
Supercedes	V3

Date	Version	Author	Comments
12/02/2007	1.0	JR Johnston	Initial Draft
12/12/2007	1.1	JR Johnston	BHSCT draft
6/01/2008	1.2	JR Johnston	BHCST minor changes
23/01/2008	1.3	JR Johnston	Final BHSCT Draft
25/01/2008	1.4	C Murphy	Final BHSCT
02/04/2009	1.5	C Murphy	Draft review
23/04/09	2	C Murphy	Final version
01/07/2009	3	C Murphy	Changes to reflect service grp level approval processes
3/11/2009	3.1	J Shaw O'Doherty	Changes 4.15 - authors
25/11/2009	3.2	JR Johnston	Reinforce Evidence-based policies 4.3
14/02/2010	3.3	C Murphy	Review – update committee details in appendix 1.
06/04/2011	3.4	J Shaw-O'Doherty	Appendix 1 local service group arrangements updated & linked policy description added
07/06/2011	3.5	C Murphy	Update to Appendix 2 – Local approval of documents

Policy Record

		Date	Version
Author (s)	Approval	07/06/2011	V3.5
Director Responsible	Approval	08/06/2011	V3.5

Approval Process – Trust Policies

Standards and Guidelines Committee	Approval	21/04/2011	V3.4
Policy Committee	Approval	20/06/2011	V3.5
Executive Team	Authorise	27/06/2011	V3.5
Chief Executive	Sign Off	29/06/2011	V3.5

Writing and approval of trust documents

1.0 Purpose:
This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT). It also outlines the approval processes to be followed and contact details for key committees.

2.0 Objectives:

2.1 This document ensures a

- standard style of policies or guidelines throughout the BHSCT
- clear, uniform, comprehensive and consistent approach to writing and approving a policy or guideline.

2.2 This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

3.0 Scope
This policy applies to all policies, protocols, guidelines etc. developed for implementation within the Trust.

4.0 Policy Statement(s):

WRITING A TRUST DOCUMENT

4.1 Where a policy or guideline potentially applies to more than one service group, it must be written for all areas in the Trust.

Consultation should take place across the relevant service groups and approval from the Trust wide committees sought. *(See Appendix 1)*

4.2 Where a policy or guideline is specific to one Service Area or group, then they can be authorised through agreed service level governance arrangements.*(See Appendix 2)*

4.3 The lead author is responsible for identifying key areas for consultation prior to seeking approval of a policy / guideline.

The author(s) should primarily use regional and national policy as the basis to formulate policy. They will be expected to seek out this and other external guidance. Certain bodies hold primacy e.g. NICE, NPSA. This evidence base should be included in the section on consultation and referenced. Where the policy deviates or is at variance from such external guidance it should be highlighted.

4.4 Where a policy / guideline or protocol mentions medicines or refers to the process of managing medicines, the document should be reviewed by a pharmacist, where there is no pharmacist for the particular service area, the pharmacy services manager should be contacted in the first instance.

4.5 The lead author / group must identify areas to which the policy / guideline should be disseminated and include this in the document.

4.6 The lead author / group must identify what actions are needed for implementation and include these in the policies as so they can be reviewed by approving committees.

If there are implications for training of staff this should be clearly indicated; which staff, at what grade(s) and who will provide the training. If the policy needs to be discussed at appraisal, this should be indicated here.

4.7 All documents must use the Trust template which can be downloaded from the Policies and Guidelines page on the Belfast Trust Intranet. It is important that all new documents created use the template, and are not an overwrite of an existing document. A guide for completing the template, including definitions of various fields is provided in *Appendix 3.*

4.8 All points should be numbered for ease of referencing and editing.

4.9 All documents should have page numbering also with the total number indicated.

4.10 Documents should be titled appropriately. The title should be reflective of the content and include the appropriate definition as to the type of document that it is. *Appendix 4 provides a detailed set of definitions.*

4.11 Version control should be used for the writing and approval of documents. *Appendix 5 provides guidance on version control.*

4.12 Each page should identify the parent committee or service area issuing the policy or guideline, a running title, the version number and the date of production.

4.13 Where a document is endorsement of external guidance that is in an appropriate format for dissemination – then the cover pages of the trust template should be used, outlining the BHSCT reviewer, service area etc.

4.14 The lead author will be responsible for carrying out an equality impact screening process to identify if a full equality impact assessment is required.

4.15 Any amendments requested during consultation / committee approval will be the responsibility of the lead author.

Authors should acknowledge comments from staff who review policies especially if they are not going to take the comments into account

4.16 The Standards, Quality & Audit Department will contact the lead author at review date time to instigate a review.

4.17 APPROVAL

The Author should be invited, by the Chair, to committee meetings where the policy is on the agenda for approval

5. Appendices

Appendix 1 – Approval of Trust documents
Appendiix 2 – Approval of documents relevant to only one service area / group
Appendix 3 – Policy Template
Appendix 4 – Definitions of documents, Policies, Protocols etc.
Appendix 5 – Version Control of documents.

Director Dr A Stevens
Date: July 2011

Author C Murphy
Date: July 2011

Appendix 1

Approval of Trust Documents. (i.e. those which apply to more than one service group)

The Trust Standards & Guidelines Committee and Trust Policy Committee are responsible the review and approval of trust documents.

Their remits are:

(i) Trust Policy Committee

Approval of all trust policy documents which relate to the operation of corporate functions e.g. HR, IT. This committee is chaired by June Champion, Head of Office.

(ii) Standards & Guidelines Committee

Approval of all documents relating to the management of patients and clients in the Belfast Trust. This committee is co-chaired by Dr Julian Johnston, Consultant Anaesthetist, and the Co-Director of Nursing.

(iii) Specialist Committees

Where a document pertains to one of these specialities, it should be sent to the specialist committee for approval and it will then be ratified by the Trust Standards & Guidelines prior to being authorised by the Exec team. This follows through the process of accountability as outlined in the Trust Assurance Framework.

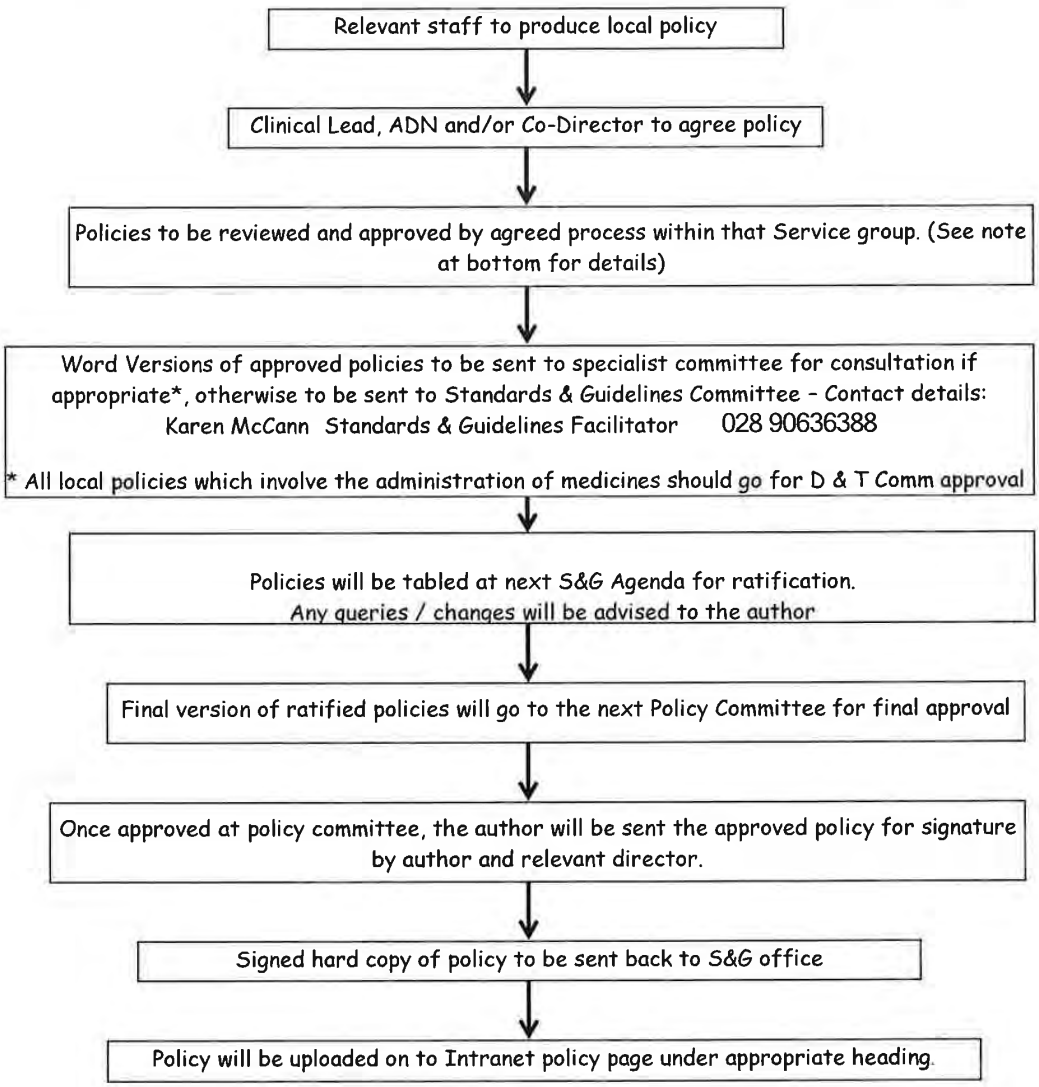
Committee	Chair
Drugs & Theraputics Committee All documents relating to the use of medicines. (for details refer to section 4.4 of this policy).	Prof Gary McVeigh [redacted]
Transfusion Committee All documents relating to transfusion processes.	Dr Helen Gililand Trust e-mail
Resuscitation Committee. All documents relating to resuscitation.	Joanna McCormick Trust e-mail
Medical Devices Committee	Ms Karen Brookes

Contact Details:

For all inquiries regarding the writing, approval or availability of policies / guidelines please contact the Standards, Quality & Audit Department:

Jill Shaw O'Doherty	Standards & Guidelines Manager	[redacted]
Karen McCann	Standards & Guidelines Facilitator	[redacted]

Approval of documents which pertain only to specific service areas. Appendix 2.



Approval of Local Policies within Service Groups

Social & Primary Care Services Tabled at the Service group policy meeting, issued for consultation. When finalised the Senior Management Team will ratify.

Social Care – Tabled at the Social Care Professionals meetings.

Specialist Hospitals, Women & Childrens Health Services

Paediatrics – Tabled at the Child Health Integrated Governance committee meeting

Womens – Tabled at the Obstetrics & Gynae Governance meetings.

Cancer & Specialist Services –

Signed off by the relevant 'named Medicine/Nursing lead' and tabled at the Senior Management Team meeting. If you have any queries, contact the relevant Service Manager in the first instance.

Acute Services – To be confirmed

Appendix 3 Guide for completing the trust template.

1. **Title:**
   How to write and manage a policy or guideline.

2. **Introduction:**
   This document details how to write and set out a policy or guideline for the BHSCT.

3. **Each policy must include the following:**
   - 2 cover sheets - identifying document control features.
     - identification of where the policy / guideline originated
     - a title
     - Primary identification table
     - Policy / Guideline reference number table
     - Version table
     - Authorisation Record table(s)
   - a description of the policy / guideline which
     - may include an executive summary to include the purpose, objectives and policy statement(s).
     - must include the full description of the policy or guideline.
   - signature of the Chief Executive/Director and date
   - signature of the principal author and date

4. **Type of Document**
   This section below the BHSCT logo identifies where the policy / guideline originates.

5. **The title**
   This must reflect the policy or guideline.

6. **Primary identification table**
   This table will be used for document control purposes and includes details of
   - Summary
   - Purpose
   - Operational date
   - Review date
   - Version Number
   - Supersedes previous
   - Linked policy – identifies the linked policy (if either policy is amended the other must also be amended.
   - Director Responsible
   - Lead Author
   - Lead Author Position
   - Additional Author (s)
   - Department / Service Group
   - Contact details

7. **Reference number table**
   Office use only: for document control purposes.

Identifies policy or guideline on Trust Policy or Standards and Guidelines Database.
Contains Reference Number which will be allocated by TP or S&GC.

8. **Version table**
Office use only: for document control purposes.
This helps to identify where changes have been made to a document and ensure that everyone is using the most recent version.
The first draft should be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0. Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
If major changes are made to the document then it will be issued as version 2.0.
See Guidance in Appendix 5 on version control of documents

9. **Authorisation record table(s)**
Identifies approval, endorsement or authorisation position for guideline.

BHSCT policies or guidelines are not valid until they receive Executive Team authorisation and are 'signed'. They will then be entered onto the Intranet.

10. **Policy / Guideline description – Summary**
An executive summary may be inserted particularly if the overall document is long or complex. It should include the purpose, objectives and policy statement(s) and be signed and dated.

11. **The purpose.**
This gives the underlying reason and justification for the policy or guideline in summary form. It could include a definition if required.

12. **The scope**
A definition of the target audience and where or for whom the policy or guideline will apply.

If appropriate, a common understanding of what, who or where is excluded from the guideline should be included here.

13. **The objectives.**
This gives the purpose, goal and aim(s) for the policy or guideline – why it is necessary.

14. **Roles and Responsibilities**
This section should identify the roles and responsibilities of all stakeholders involved with or affected by the policy / guideline. This can include personnel from the Trust (Board of Directors, Executive Team, Chief Executive, Directors, Managers, to all staff), individuals and committees, external individuals and agencies to include patients, relatives and members of the public.

15. **The definition and background of the policy or guideline.**
This gives a definition(s) and clear outline of the parameters of the policy or guideline identifying its boundaries.

This section will give the background and, if necessary, a context – historical, clinical or otherwise.

16. **The policy or guideline.**
Describe the policy or guideline itself, preferably in summary form or in short bullet points.

One method of writing this section of a BHSCT policy or guideline is to refer to, and if appropriate include as an appendix (pdf. format), a standard document from an outside agency or organisation e.g. NICE clinical guideline, NPSA document. Then, this section would only require the variations, exceptions or non-compliance with that standard document's recommendations to be outlined here in detail.

These exceptions would require a work plan and time scale for correction or alignment with the standard.

17. **Policy Statement(s)**
The policy or guideline may give rise to policy statement(s) and these should be indicated at this point. These are statements of the standard of service that is to be provided. They should be repeated in the executive summary.

Short bullet points are preferable.

Does not include operation procedures – these should be written separately.

18. **Implementation**
Each policy or guideline will ordinarily require an Implementation Report. This document is to outline:

i. The method for implementation.
ii. The evidence of implementation.
iii. The magnitude of the change in practice required.
iv. The expected benefits from implementing the change.
v. The specialties / departments affected by the change.
vi. The resource impacts of the implementation.
   - Clinical impact.
   - Financial impact.
   - Training/educational impact.

19. **Source(s) / Evidence Base**
This section should include a brief summary of the information sources for this policy / guideline. This may be from Government and/or the DHSSPSNI and should include such items as legislative requirements, regulations and material from regulatory bodies.

20. **The references including relevant external guidelines.**
Provide reference material wherever possible. This is a primary source of the evidence base. This should include references in journals, relevant documentation (e.g. NICE, NPSA, SIGN documentation).

Include a reference list at the end of the policy or guideline. This will identify the source(s) of the information as well as assisting the user to review the topic if more information is required.

Important documents can be appended – only in Word or PDF format.

Try not to append hyperlinks as these may cease to function in the future and may become obsolete.

21. **Consultation Process**
Indicate in this section the
- Internal external, professional / staff side representatives who were consulted in the development of this policy / guideline.
- name the internal/external individuals, committees, bodies and agencies that were involved.

22. **Equality screening**
Each policy or guideline will require an initial equality screening exercise to ascertain if the guideline should be subject to a full equality impact assessment and, if suitable, a statement included, such as:-

In line with its duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting social need Initiative and the Human Rights Act 1998 the BHSCT has carried out an initial equality screening exercise to ascertain if this policy should be subject to a full equality impact assessment.

23. **Procedure(s)**
The policy or guideline may give rise to procedural statement(s). This is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and to ensure efficiency, consistency and safety.

Short bullet points are preferable.

24. **Signature of Chief Executive/Medical Director**
Policies belong to the Trust, not the individual author and are therefore signed off by the Chief Executive/Director once approved by Executive Team.

All Trust policies or guidelines must be dated and signed.

Appendix 4

Definitions (adopted from the United States National Library of Medicine)

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition that generally have been approved by a recognized standards organization or is accepted as a de facto standard. They are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research, and health services. A guideline is something you should do i.e. a recommendation, that may be ignored in particular circumstances but the full implications must be understood and therefore, practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical guidelines are systematically developed recommendations which assist healthcare professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help healthcare professionals in their work, but they do not replace their knowledge and skills.

A **policy** is a statement of the standard of service that is to be provided or the means by which a strategy is to be delivered. It is a statement of **what** must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures – these should be written separately.

A **procedure** is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and ensure efficiency, consistency and safety. It is a statement of **how** to do something. They may be specific to a particular work area or group of people but would be aligned with an overarching policy statement belonging to the parent organisation.

A **protocol** is a clear decision making process. It is in the form of explicit step by step instructions, on a specific aspect, giving a precise and detailed plan that should be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is that only one course of action(s) is considered appropriate – it is not discretionary. The terms 'procedure' and 'protocol' are often interchangeable.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 5

Guidance on Version Control of Documents

Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee etc.

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First Approval of a Document

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Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1.0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1.0.1'. Subsequent changes during the review of document 'Version 1.0', will be versioned as 'Version 1.0.2', 'Version 1.0.3' etc.

How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1.0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1.1'; or

- If the changes are considered to be **major** e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2.0'.

Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

If further changes are to be made to document 'Version 2.0', the draft version will be described as 'Version 2.0.1, 'Version 2.0.2', 'Version 2.0.3' etc.

The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:
- The version number;
- The date the version number was assigned;
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- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

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The author should retain the more detailed Change Log of a document between draft versions.

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

Belfast Health and Social Care Trust

Reference No: SG 24/12

Title:	Writing and approval of trust documents			
Author(s)	Christine Murphy, Standards, Quality and Audit Manager Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,			
Ownership:	Standards, Quality and Audit Department (SQA)			
Approval by:	Standards & Guidelines Committee Policy Committee		**Approval date:**	13/9/12 15/10/12
Operational Date:	December 2007		**Next Review:**	**June 2014**
Version No.	5	**Supercedes**	4	
Key Words:	Writing, Approval, Approving, Policy Template,			
Links to other policies	Policy Template			

Date	Version	Author	Comments
23/04/09	2	C Murphy	Final version
01/07/2009	3	C Murphy	Changes to reflect service group level approval processes
3/11/2009	3.1	J Shaw O'Doherty	Changes 4.15 - authors
25/11/2009	3.2	JR Johnston	Reinforce Evidence-based policies 4.3
14/02/2010	3.3	C Murphy	Review – update committee details in appendix 1.
06/04/2011	3.4	J Shaw-O'Doherty	Appendix 1 local service group arrangements updated & linked policy description added
07/06/2011	3.5	C Murphy	Update to Appendix 2 – Local approval of documents
10/01/2012	4.1	C Murphy	Updating template (Appendix 3) with Regional template
28/08/2012	4.2	JRJ	Consultation with Patients and Carers. 3.3.1; New Policy template
October 2012	4.3	JRJ	Changes after S&G 13/9/12
October 2012	4.4	JSO'D	Changes to details of local approval process.

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Purpose

This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT). It also outlines the approval processes to be followed and contact details for key committees.

1.2 Objectives

This document ensures a

- standard style of policies or guidelines throughout the BHSCT
- clear, uniform, comprehensive and consistent approach to writing and approving a policy or guideline.

This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

2.0 SCOPE OF THE POLICY

This policy applies to all policies, protocols, guidelines etc. developed for implementation within the Trust.

3.0 POLICY STATEMENT(S):

3.1 Writing a trust document

Where a policy or guideline potentially applies to more than one service group, it must be written for all areas in the Trust.
Consultation should take place across the relevant service groups and approval from the Trust wide committees sought. *(See Appendix 1)*

3.2 Where a policy or guideline is specific to one Service Area or group, then they can be authorised through agreed service level governance arrangements. *(See Appendix 2)*

3.3 Consultation

The lead author is responsible for identifying key areas for consultation prior to seeking approval of a policy / guideline.

The author(s) should primarily use regional and national policy as the basis to formulate policy. They will be expected to seek out this and other external guidance. Certain bodies hold primacy e.g. NICE, NPSA.

This evidence base should be included in the section on consultation and referenced. Where the policy deviates or is at variance from such external guidance, it should be highlighted.

3.3.1 Consultation with patient's, their carers, the 'public' and/or other parties with an interest should be considered for consultation at a stage early enough in the development to enable constructive engagement. If help is needed contact a Senior Manager for Personal and Public Involvement (e.g. Sandra McCarry, Community Development and PPI) for advice.

3.3.2 Any amendments requested during consultation / committee approval will be the responsibility of the lead author.

Authors should acknowledge comments from staff or carers who review policies especially if they are not going to take the comments into account.

3.3.3 Where a policy / guideline or protocol mentions medicines or refers to the process of managing medicines, the document should be reviewed by a pharmacist, where there is no pharmacist for the particular service area, the pharmacy services manager should be contacted in the first instance.

3.4 The lead author / group must identify areas to which the policy / guideline should be disseminated and include this in the document.

3.5 The lead author / group must identify what actions are needed for implementation and include these in the policies as so they can be reviewed by approving committees.

If there are implications for training of staff this should be clearly indicated; which staff, at what grade(s) and who will provide the training. If the policy needs to be discussed at appraisal, this should be indicated here.

3.6 All documents must use the Trust template which can be downloaded from the Policies and Guidelines page on the Belfast Trust Intranet. It is important that all new documents created use the template, and are not an overwrite of an existing document. A guide for completing the template, including definitions of various fields is provided in *Appendix 3*.

3.7 All points should be numbered for ease of referencing and editing.

3.8 All documents should have page numbering also with the total number indicated.

3.9 Documents should be titled appropriately. The title should be reflective of the content and include the appropriate definition as to the type of document that it is. *Appendix 4 provides a detailed set of definitions*.

3.10 Version control should be used for the writing and approval of documents. *Appendix 5 provides guidance on version control*.

3.11 Each page should identify the parent committee or service area issuing the policy or guideline, a running title, the version number and the date of production.

3.12 Where a document is endorsement of external guidance that is in an appropriate format for dissemination – then the cover pages of the trust template should be used, outlining the BHSCT reviewer, service area etc.

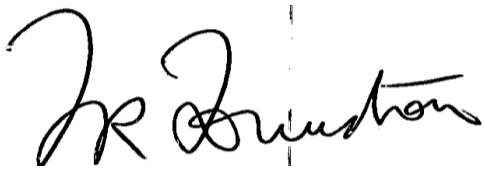
3.13 The lead author will be responsible for carrying out an equality impact screening process to identify if a full equality impact assessment is required.

3.14 The Standards, Quality & Audit Department will contact the lead author at review date time to instigate a review.

3.15 Approval
The Author should be invited, by the Chair, to committee meetings where the policy is on the agenda for approval

4. Appendices

Appendix 1 – Approval of Trust documents
Appendix 2 – Approval of documents relevant to only one service area / group
Appendix 3 – Regional Policy Template
Appendix 4 – Definitions of documents, Policies, Protocols etc.
Appendix 5 – Version Control of documents.



Director Dr A Stevens
Date: October 2012

Author J Johnston
Date: October 12

Appendix 1

Approval of Trust Documents. (i.e. those which apply to more than one service group)

The Trust Standards & Guidelines Committee and Trust Policy Committee are responsible the review and approval of trust documents.

Their remits are:

(i) Trust Policy Committee

Approval of all trust policy documents which relate to the operation of corporate functions e.g. HR, IT. This committee is chaired by June Champion, Head of Office.

(ii) Standards & Guidelines Committee

Approval of all documents relating to the management of patients and clients in the Belfast Trust. This committee is co-chaired by Dr Julian R Johnston, Consultant Anaesthetist, and Dr David Robinson, Co-Director of Nursing.

(iii) Specialist Committees

Where a document pertains to one of these specialities, it should be sent to the specialist committee for approval and it will then be ratified by the Trust Standards & Guidelines prior to being authorised by the Exec team. This follows through the process of accountability as outlined in the Trust Assurance Framework.

Committee	Chair
Drugs & Therapeutics Committee	Prof Gary McVeigh
All documents relating to the use of medicines. [redacted]	
(for details refer to section 3.3.3 of this policy).	
Transfusion Committee	Dr Helen Gilliland
Documents relating to transfusion processes. [redacted]	
Resuscitation Committee.	Joanna McCormick
All documents relating to resuscitation. [redacted]	
Medical Devices Committee	Ms Karen Brookes

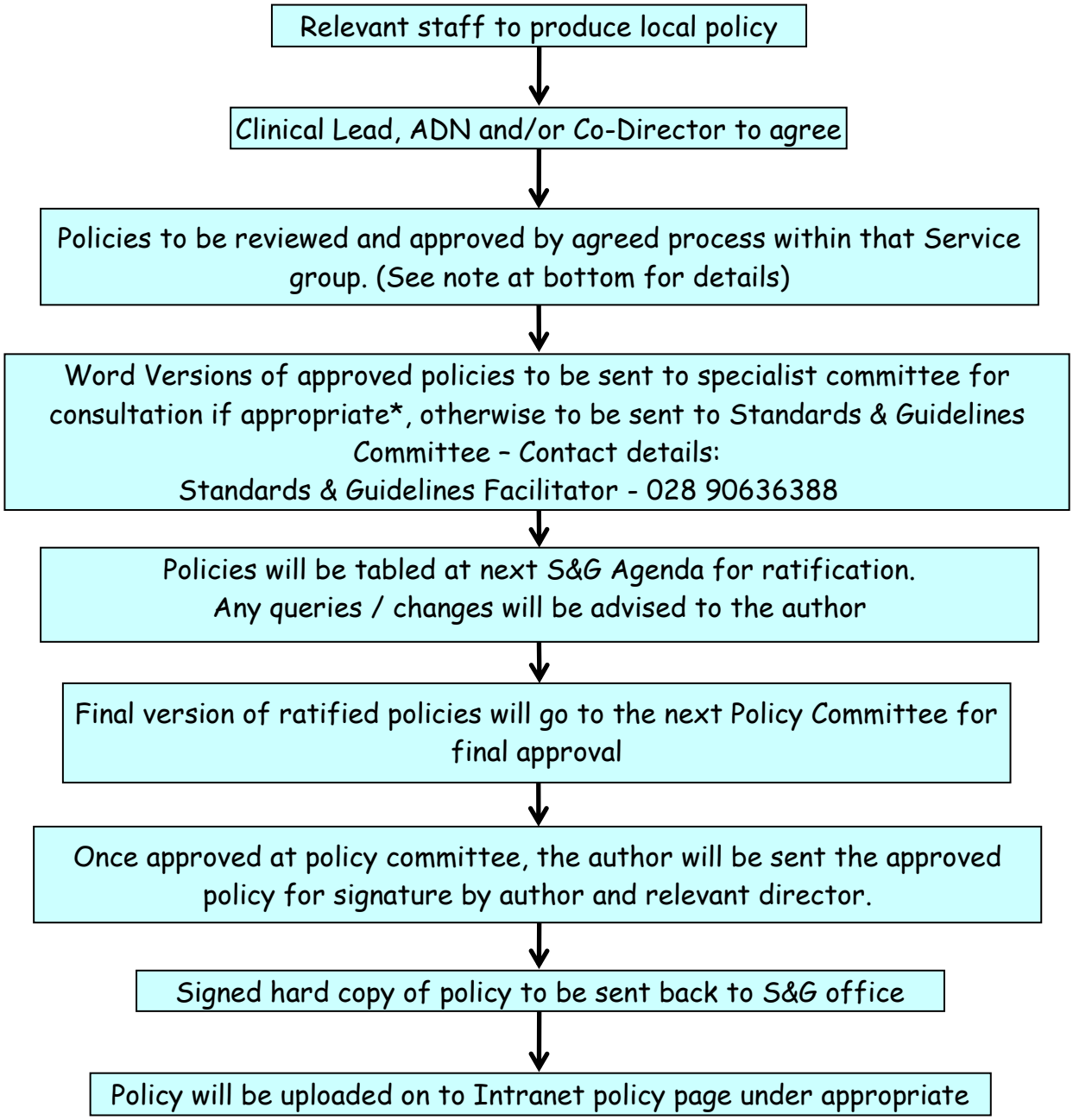
Contact Details:

For all inquiries regarding the writing, approval or availability of policies / guidelines please contact the Standards, Quality & Audit Department:

Jill Shaw O'Doherty Standards & Guidelines Manager [redacted]

Standards & Guidelines Facilitator [redacted]

Approval of documents which pertain only to specific service areas. Appendix 2.



Approval of Local Policies within Directorates

Social Work, Family & Child Care Services

Social Care **–** Tabled at the Social Care professionals meetings.

Adult Social & Primary Care Services **-** signed off at governance meetings after full consultation with in the service.

Specialist Hospitals, Womens Health

Paediatrics – Tabled at the Paediatric Governance Group meeting

Womens **–** Tabled at the Obstetrics & Gynae Governance meetings.

Cancer & Specialist Services –

Signed off by the relevant 'named Medicine/Nursing lead' and tabled at the Senior Management team meeting. If you have any queries, contact the relevant Service Manager in the first instance.

Acute Services – To be confirmed

Appendix 3

POLICY TEMPLATE

Reference No:

Title:	**Insert name of policy (Arial 12)**			
Author(s)	List name and titles of lead and additional author(s) or group responsible for drafting policy Include contact details			
Ownership:	Insert name of Director / service area / group / directorate			
Approval by:	Insert name of Trust committee / group responsible for approval		**Approval date:**	Insert date each committee approved
Operational Date:	Insert date on which policy issued		**Next Review:**	Insert next review date
Version No.	V()	**Supercedes**		
Key words:	Insert key words			
Links to other policies				

Version control for drafts: (This box to be removed prior to issue).
This helps to identify where changes have been made to a document and ensure that authors / reviewers are using the most recent version.

- The first draft should be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0.
- Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
- If major changes are made to the document then it will be issued as version 2.0.

Date	**Version**	**Author**	**Comments**
01/03/2011	0.1	A Trust	Initial Draft
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16/08/2011	0.3	A Trust	Proposed final version incorporating feedback from Trusts.
12/10/2011	V0.4	A Trust	WHSCT comments incorporated
16/11/2011	V1	A Trust	Final Version issued.

Completion guidelines

- Page numbering – to indicate total number of pages. e.g. 1 of 10.
- Type font – Arial 12
- Section headings in bold, underlined and should be numbered 1.0, 2.0, 3.0 tc.
- Paragraphs should be numbered under each section heading e.g. 1.1, 1.2 etc.
- If sub-headings are to be used then these should be in bold/lower case and numbered 1.1 with paragraphs numbered 1.1.1, 1.1.2, 1.1.3 etc

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Short introduction.

1.2 Purpose

State why is policy needed – rationale, reference to any relevant legislation, statutory requirements, relevant information.

Make reference to any other policies, procedures or guidelines which should be read in conjunction with this policy – these policies/procedures/guidelines should be listed below with their relevant codes:-

1.3 Objectives

Some policies may need a list of objectives i.e. aims to be met with the policy.

2.0 SCOPE OF THE POLICY

Provide clarity in relation to where and to whom the policy applies. Also includes situations where the policy does not apply.

3.0 ROLES/RESPONSIBILITIES

What are the roles/responsibilities of the various groupings within the Trusts right from the CE/CEO to the staff.

Who is responsible for implementing and adhering to the policy?

4.0 KEY POLICY PRINCIPLES

Definitions

Key Policy Statement(s)

Policy Principles

4.1 What needs to be done, when, where and on whom. In general, this section should hold pure statements of policy and then procedures and protocols are put in appendices at the end of the document.

However, certain policies – usually the larger ones and ones where the bulk of the text is from a regional document – have procedural processes given here along with the policy statements. This section sometimes has many subheadings outlining many procedures and approved ways of doing things. The opportunity should always be taken to try to collect defined principles and policy statements into one easily identified area.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

List the groups of staff for whom this policy has relevance.
Provide a realistic time scale for implementation and highlight any potential barriers.
Indicate who should be notified (usually the author) if there are significant barriers and timescales are not being met.

5.2 Resources

This should include training, awareness raising, testing of new documentation associated with the policy etc and who is responsible for this.

5.3 Exceptions

The scope should detail all areas where the policy is to apply - this is to note any area that has been noted as exempt because it is currently unable to comply with or implement the policy.

6.0 MONITORING

Provide detail of any inherent key performance indicators (KPI) relevant to the successful implementation of this policy.
Describe the process for monitoring the effectiveness of all of the above and who and how this will be done. This monitoring should include any section 75 implications of implementing the policy.

7.0 EVIDENCE BASE / REFERENCES

Insert a brief summary of the evidence base and list references used including relevant external guidelines.

8.0 CONSULTATION PROCESS

Insert a list of those groupings consulted in the development of this policy e.g. Trade Unions, Specialist Committees, User groups, Carer Groups, Section 75 groups,

9.0 APPENDICES / ATTACHMENTS

To be tabulated here and attached below as required.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** _____
Author

_____ **Date:** _____
Director

Appendix 4

Definitions (adopted from the United States National Library of Medicine)

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition that generally have been approved by a recognized standards organization or is accepted as a de facto standard. They are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research, and health services. A guideline is something you should do i.e. a recommendation, that may be ignored in particular circumstances but the full implications must be understood and therefore, practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical guidelines are systematically developed recommendations which assist healthcare professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help healthcare professionals in their work, but they do not replace their knowledge and skills.

A **policy** is a statement of the standard of service that is to be provided or the means by which a strategy is to be delivered. It is a statement of **what** must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures – these should be written separately.

A **procedure** is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and ensure efficiency, consistency and safety. It is a statement of **how** to do something. They may be specific to a particular work area or group of people but would be aligned with an overarching policy statement belonging to the parent organisation.

A **protocol** is a clear decision making process. It is in the form of explicit step by step instructions, on a specific aspect, giving a precise and detailed plan that should be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is that only one course of action(s) is considered appropriate – it is not discretionary. The terms ‘procedure’ and ‘protocol’ are often interchangeable.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 5

Guidance on Version Control of Documents

Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee etc.

The content of a document under version control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this document will assist in the application of Version Control of all documents, for example policies, procedures etc. To assist in the application of Version Control, an example flow diagram has been developed (See Appendix 1).

Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0.1'. Subsequent versions of the initial document shall be described as 'Version 0.2', 'Version 0.3' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

First Approval of a Document

When a document is formally approved for the first time by the organisation, it shall be issued as 'Version 1.0'.

Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1.0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1.0.1'.

Subsequent changes during the review of document 'Version 1.0', will be versioned as 'Version 1.0.2', 'Version 1.0.3' etc.
How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1.0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1.1'; or

- If the changes are considered to be **major** e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2.0'.

Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

If further changes are to be made to document 'Version 2.0', the draft version will be described as 'Version 2.0.1, 'Version 2.0.2', 'Version 2.0.3' etc.

The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:
- The version number;
- The date the version number was assigned;
- The author of the changes; and
- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions.

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

Belfast Health and Social Care Trust

Reference No: SG 24/12

Title:	Writing and approval of trust documents		
Author(s)	Christine Murphy, Standards, Quality and Audit Manager Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,		
Ownership:	Standards, Quality and Audit Department (SQA)		
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting	**Approval date:**	13/9/12 15/10/12 29/01/2014
Operational Date:	January 2015	**Next Review:**	June 2017
Version No.	V7	**Supercedes**	V6 – Dec 2014
Key Words:	Writing, Approval, Approving, Policy Template		
Links to other policies	Policy Template http://intranet.belfasttrust.local/policies/Documents/Policy%20Template%20V4.doc		

Date	Version	Author	Comments
10/01/2012	4.1	C Murphy	Updating template (Appendix 3) with Regional template
28/08/2012	4.2	JRJ	Consultation with Patients and Carers. 3.3.1; New Policy template
October 2012	4.3	JRJ	Changes after S&G 13/9/12
October 2012	4.4	JSO'D	Changes to details of local approval process.
October 2012	5	C Murphy	Approved and online
December 2014	6	CM	Minor changes to terms / directorates
February 2015	7	CM / D Robinson	Addition of Policy on a Page and revision of template to include

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Purpose

This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT). It also outlines the approval processes to be followed and contact details for key committees.

1.2 Objectives

This document ensures a

- standard style of policies or guidelines throughout the BHSCT
- clear, uniform, comprehensive and consistent approach to writing and approving a policy or guideline.

This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

2.0 SCOPE OF THE POLICY

This policy applies to all policies, protocols, guidelines etc. developed for implementation within the Trust.

3.0 POLICY STATEMENT(S):

3.1 Where a policy or guideline potentially applies to more than one Directorate, it must be written for all areas in the Trust.
Consultation should take place across the relevant Directorates and approval from the Trust wide committees sought. *(See Appendix 1)*

3.2 Where a policy or guideline is specific to one Directorate, then they can be authorised through agreed directorate level governance arrangements. *(See Appendix 2)*

3.3 Consultation

The lead author is responsible for identifying key areas for consultation prior to seeking approval of a policy / guideline.

The author(s) should primarily use regional and national policy as the basis to formulate policy. They will be expected to seek out this and other external guidance. Certain bodies hold primacy e.g. NICE, NPSA.

This evidence base should be included in the section on consultation and referenced. Where the policy deviates or is at variance from such external guidance, it should be highlighted.

3.3.1 Consultation with patient's, their carers, the 'public' and/or other parties with an interest should be considered for consultation at a stage early enough in the development to enable constructive engagement. If help is needed contact a Senior Manager for Personal and Public Involvement (e.g. Sandra McCarry, Community Development and PPI) for advice.

3.3.2 Any amendments requested during consultation / committee approval will be the responsibility of the lead author.

Authors should acknowledge comments from staff or carers who review policies especially if they are not going to take the comments into account.

3.3.3 Where a policy / guideline or protocol mentions medicines or refers to the process of managing medicines, the document should be reviewed by a pharmacist, where there is no pharmacist for the particular service area, the pharmacy services manager should be contacted in the first instance.

3.4 The lead author / group must identify areas to which the policy / guideline should be disseminated and include this in the document.

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If there are implications for training of staff this should be clearly indicated; which staff, at what grade(s) and who will provide the training. If the policy needs to be discussed at appraisal, this should be indicated here.

3.6 All documents must use the Trust template which can be downloaded from the Policies and Guidelines page on the Belfast Trust Intranet. It is important that all new documents created use the template, and are not an overwrite of an existing document. A guide for completing the template, including definitions of various fields is provided in *Appendix 3*.

3.7 Authors should summarise the key points of the policy for staff on the second Page (POP – Policy on a Page). This is to help in disseminating key principles and documents to staff.

3.8 All points should be numbered for ease of referencing and editing.

3.9 All documents should have page numbering also with the total number indicated.

3.10 Documents should be titled appropriately. The title should be reflective of the content and include the appropriate definition as to the type of document that it is. *Appendix 4 provides a detailed set of definitions*.

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Appendix 1 – Approval of Trust documents
Appendix 2 – Approval of documents relevant to only one service area / group
Appendix 3 – Regional Policy Template
Appendix 4 – Definitions of documents, Policies, Protocols etc.
Appendix 5 – Version Control of documents.

Director Dr A Stevens
Date: October 2012

Author J Johnston
Date: October 12

Appendix 1

Approval of Trust Documents. (i.e. those which apply to more than one Directorate)

The Trust Standards & Guidelines Committee and Trust Policy Committee are responsible the review and approval of trust documents.

Their remits are:

(i) Trust Policy Committee

Approval of all trust policy documents which relate to the operation of corporate functions e.g. HR, IT. This committee is chaired by Claire Cairns, Head of Office.

(ii) Standards & Guidelines Committee

Approval of all documents relating to the management of patients and clients in the Belfast Trust. This committee is co-chaired by Dr Julian R Johnston, Consultant Anaesthetist, and Dr David Robinson, Co-Director of Nursing.

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Where a document pertains to one of these specialities, it should be sent to the specialist committee for approval and it will then be ratified by the Trust Standards & Guidelines prior to being authorised by the Exec team. This follows through the process of accountability as outlined in the Trust Assurance Framework.

Committee	Chair
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Transfusion Committee	Dr Helen Gilliland
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Jill Shaw O'Doherty Standards & Guidelines Manager [redacted]

Standards & Guidelines Facilitator [redacted]

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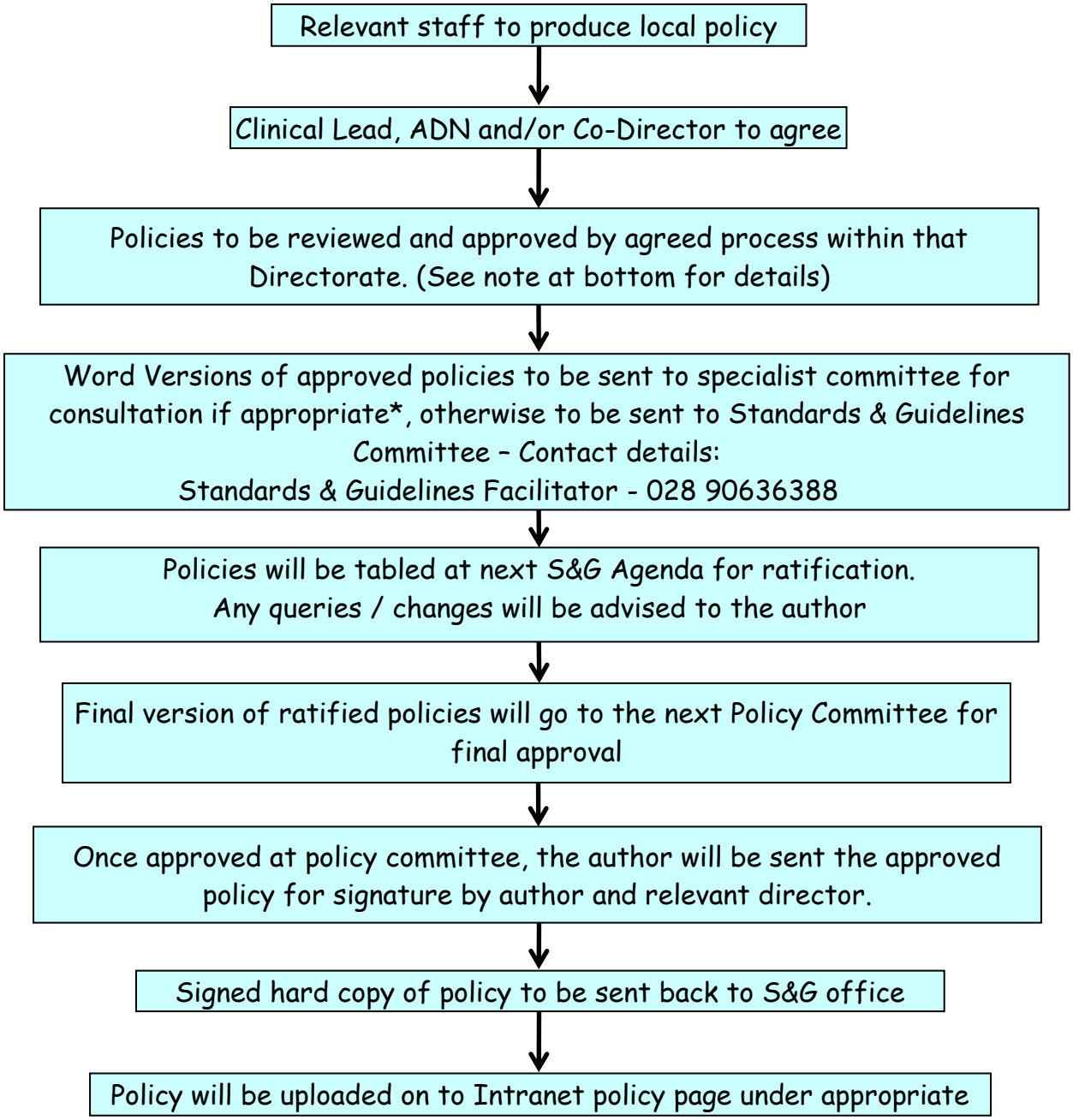

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Paediatrics – Tabled at the Paediatric Governance Group meeting

Womens **–** Tabled at the Obstetrics & Gynae Governance meetings.

Surgery & Specialist Services –

Signed off by the relevant 'named Medicine/Nursing lead' and tabled at the Senior Management team meeting. If you have any queries, contact the relevant Service Manager in the first instance.

Unscheduled and Acute Care

Signed off by the relevant leads and Director.

Appendix 3

POLICY TEMPLATE

Reference No:

Title:	**Insert name of policy (Arial 12)**			
Author(s)	List name and titles of lead and additional author(s) or group responsible for drafting policy Include contact details			
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Approval by:	Insert name of Trust committee / group responsible for approval		**Approval date:**	Insert date each committee approved
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- If sub-headings are to be used then these should be in bold/lower case and numbered 1.1 with paragraphs numbered 1.1.1, 1.1.2, 1.1.3 etc

Policy on a Page or, POP

Page 2 of every Policy should summarise its key policy principles, or 'headlines'.

One or two sentences should be included first to explain the background of the Policy. Then, the principles should be listed.

The principles should summarise what needs to be done, when, where and of whom. A useful note for the author is to consider 'what key information would I want colleagues to easily remember when caring for patients/clients?'

Some principles may reference procedures and protocols included as appendices at the end of the document.

The POP should finish with the following note:

This POP summarises the key policy principles, or 'headlines', of the Policy entitled (insert). For further information or to review the full policy, please read on:

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Short introduction.

1.2 Purpose

State why is policy needed – rationale, reference to any relevant legislation, statutory requirements, relevant information.

Make reference to any other policies, procedures or guidelines which should be read in conjunction with this policy – these policies/procedures/guidelines should be listed below with their relevant codes:-

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Some policies may need a list of objectives i.e. aims to be met with the policy.

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Provide clarity in relation to where and to whom the policy applies. Also includes situations where the policy does not apply.

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What are the roles/responsibilities of the various groupings within the Trusts right from the CE/CEO to the staff.

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Policy Principles

4.1 What needs to be done, when, where and on whom. In general, this section should hold pure statements of policy and then procedures and protocols are put in appendices at the end of the document.

However, certain policies – usually the larger ones and ones where the bulk of the text is from a regional document – have procedural processes given here along with the policy statements. This section sometimes has many subheadings outlining many procedures and approved ways of doing things. The opportunity should always be taken to try to collect defined principles and policy statements into one easily identified area.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

List the groups of staff for whom this policy has relevance.
Provide a realistic time scale for implementation and highlight any potential barriers.
Indicate who should be notified (usually the author) if there are significant barriers and timescales are not being met.

5.2 Resources

This should include training, awareness raising, testing of new documentation associated with the policy etc and who is responsible for this.

5.3 Exceptions

The scope should detail all areas where the policy is to apply - this is to note any area that has been noted as exempt because it is currently unable to comply with or implement the policy.

6.0 MONITORING

Provide detail of any inherent key performance indicators (KPI) relevant to the successful implementation of this policy.
Describe the process for monitoring the effectiveness of all of the above and who and how this will be done. This monitoring should include any section 75 implications of implementing the policy.

7.0 EVIDENCE BASE / REFERENCES

Insert a brief summary of the evidence base and list references used including relevant external guidelines.

8.0 CONSULTATION PROCESS

Insert a list of those groupings consulted in the development of this policy e.g. Trade Unions, Specialist Committees, User groups, Carer Groups, Section 75 groups,

9.0 APPENDICES / ATTACHMENTS

To be tabulated here and attached below as required.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** _____

Author

_____ **Date:** _____

Director

Appendix 4

Definitions (adopted from the United States National Library of Medicine)

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition that generally have been approved by a recognized standards organization or is accepted as a de facto standard. They are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research, and health services. A guideline is something you should do i.e. a recommendation, that may be ignored in particular circumstances but the full implications must be understood and therefore, practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical guidelines are systematically developed recommendations which assist healthcare professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help healthcare professionals in their work, but they do not replace their knowledge and skills.

A **policy** is a statement of the standard of service that is to be provided or the means by which a strategy is to be delivered. It is a statement of **what** must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures – these should be written separately.

A **procedure** is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and ensure efficiency, consistency and safety. It is a statement of **how** to do something. They may be specific to a particular work area or group of people but would be aligned with an overarching policy statement belonging to the parent organisation.

A **protocol** is a clear decision making process. It is in the form of explicit step by step instructions, on a specific aspect, giving a precise and detailed plan that should be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is that only one course of action(s) is considered appropriate – it is not discretionary. The terms ‘procedure’ and ‘protocol’ are often interchangeable.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 5

Guidance on Version Control of Documents

Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee etc.

The content of a document under version control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this document will assist in the application of Version Control of all documents, for example policies, procedures etc. To assist in the application of Version Control, an example flow diagram has been developed (See Appendix 1).

Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0.1'. Subsequent versions of the initial document shall be described as 'Version 0.2', 'Version 0.3' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

First Approval of a Document

When a document is formally approved for the first time by the organisation, it shall be issued as 'Version 1.0'.

Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1.0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1.0.1'.

Subsequent changes during the review of document 'Version 1.0', will be versioned as 'Version 1.0.2', 'Version 1.0.3' etc.
How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1.0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1.1'; or

- If the changes are considered to be **major** e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2.0'.

Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

If further changes are to be made to document 'Version 2.0', the draft version will be described as 'Version 2.0.1, 'Version 2.0.2', 'Version 2.0.3' etc.

The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:
- The version number;
- The date the version number was assigned;
- The author of the changes; and
- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions.

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

2.031

Belfast Health and Social Care Trust

Reference No: SG 24/12

Title:	Writing and approval of trust documents			
Author(s)	Christine Murphy, Standards, Quality and Audit Manager Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,			
Ownership:	Standards, Quality and Audit Department (SQA)			
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting		**Approval date:**	13/9/12 15/10/12 29/01/2014
Operational Date:	January 2015		**Next Review:**	June 2017
Version No.	V6	**Supercedes**	V5 – October 2012-2014	
Key Words:	Writing, Approval, Approving, Policy Template			
Links to other policies	Policy Template http://intranet.belfasttrust.local/policies/Documents/Policy%20Template%20V3.doc			

Date	Version	Author	Comments
10/01/2012	4.1	C Murphy	Updating template (Appendix 3) with Regional template
28/08/2012	4.2	JRJ	Consultation with Patients and Carers. 3.3.1; New Policy template
October 2012	4.3	JRJ	Changes after S&G 13/9/12
October 2012	4.4	JSO'D	Changes to details of local approval process.
October 2012	5	C Murphy	Approved and online
December 2014	6	CM	Minor changes to terms / directorates

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Purpose

This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT). It also outlines the approval processes to be followed and contact details for key committees.

1.2 Objectives

This document ensures a

- standard style of policies or guidelines throughout the BHSCT
- clear, uniform, comprehensive and consistent approach to writing and approving a policy or guideline.

This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

2.0 SCOPE OF THE POLICY

This policy applies to all policies, protocols, guidelines etc. developed for implementation within the Trust.

3.0 POLICY STATEMENT(S):

3.1 Where a policy or guideline potentially applies to more than one Directorate, it must be written for all areas in the Trust.
Consultation should take place across the relevant Directorates and approval from the Trust wide committees sought. *(See Appendix 1)*

3.2 Where a policy or guideline is specific to one Directorate, then they can be authorised through agreed directorate level governance arrangements. *(See Appendix 2)*

3.3 Consultation

The lead author is responsible for identifying key areas for consultation prior to seeking approval of a policy / guideline.

The author(s) should primarily use regional and national policy as the basis to formulate policy. They will be expected to seek out this and other external guidance. Certain bodies hold primacy e.g. NICE, NPSA.

This evidence base should be included in the section on consultation and referenced. Where the policy deviates or is at variance from such external guidance, it should be highlighted.

3.3.1 Consultation with patient's, their carers, the 'public' and/or other parties with an interest should be considered for consultation at a stage early enough in the development to enable constructive engagement. If help is needed contact a Senior Manager for Personal and Public Involvement (e.g. Sandra McCarry, Community Development and PPI) for advice.

3.3.2 Any amendments requested during consultation / committee approval will be the responsibility of the lead author.

Authors should acknowledge comments from staff or carers who review policies especially if they are not going to take the comments into account.

3.3.3 Where a policy / guideline or protocol mentions medicines or refers to the process of managing medicines, the document should be reviewed by a pharmacist, where there is no pharmacist for the particular service area, the pharmacy services manager should be contacted in the first instance.

3.4 The lead author / group must identify areas to which the policy / guideline should be disseminated and include this in the document.

3.5 The lead author / group must identify what actions are needed for implementation and include these in the policies as so they can be reviewed by approving committees.

If there are implications for training of staff this should be clearly indicated; which staff, at what grade(s) and who will provide the training. If the policy needs to be discussed at appraisal, this should be indicated here.

3.6 All documents must use the Trust template which can be downloaded from the Policies and Guidelines page on the Belfast Trust Intranet. It is important that all new documents created use the template, and are not an overwrite of an existing document. A guide for completing the template, including definitions of various fields is provided in *Appendix 3*.

3.7 All points should be numbered for ease of referencing and editing.

3.8 All documents should have page numbering also with the total number indicated.

3.9 Documents should be titled appropriately. The title should be reflective of the content and include the appropriate definition as to the type of document that it is. *Appendix 4 provides a detailed set of definitions.*

3.10 Version control should be used for the writing and approval of documents. *Appendix 5 provides guidance on version control.*

3.11 Each page should identify the parent committee or service area issuing the policy or guideline, a running title, the version number and the date of production.

3.12 Where a document is endorsement of external guidance that is in an appropriate format for dissemination – then the cover pages of the trust template should be used, outlining the BHSCT reviewer, service area etc.

3.13 The lead author will be responsible for carrying out an equality impact screening process to identify if a full equality impact assessment is required.

3.14 The Standards, Quality & Audit Department will contact the lead author at review date time to instigate a review.

3.15 Approval
The Author should be invited, by the Chair, to committee meetings where the policy is on the agenda for approval

4. Appendices

Appendix 1 – Approval of Trust documents
Appendix 2 – Approval of documents relevant to only one service area / group
Appendix 3 – Regional Policy Template
Appendix 4 – Definitions of documents, Policies, Protocols etc.
Appendix 5 – Version Control of documents.

Director Dr A Stevens
Date: October 2012

Author J Johnston
Date: October 12

Appendix 1

Approval of Trust Documents. (i.e. those which apply to more than one Directorate)

The Trust Standards & Guidelines Committee and Trust Policy Committee are responsible the review and approval of trust documents.

Their remits are:

(i) Trust Policy Committee

Approval of all trust policy documents which relate to the operation of corporate functions e.g. HR, IT. This committee is chaired by Claire Cairns, Head of Office.

(ii) Standards & Guidelines Committee

Approval of all documents relating to the management of patients and clients in the Belfast Trust. This committee is co-chaired by Dr Julian R Johnston, Consultant Anaesthetist, and Dr David Robinson, Co-Director of Nursing.

(iii) Specialist Committees

Where a document pertains to one of these specialities, it should be sent to the specialist committee for approval and it will then be ratified by the Trust Standards & Guidelines prior to being authorised by the Exec team. This follows through the process of accountability as outlined in the Trust Assurance Framework.

Committee	Chair
Drugs & Therapeutics Committee	Prof Gary McVeigh
All documents relating to the use of medicines. [redacted]	
(for details refer to section 3.3.3 of this policy).	
Transfusion Committee	Dr Helen Gilliland
Documents relating to transfusion processes. [redacted]	
Resuscitation Committee.	Joanna McCormick
All documents relating to resuscitation. [redacted]	
Medical Devices Committee	Ms Karen Brookes

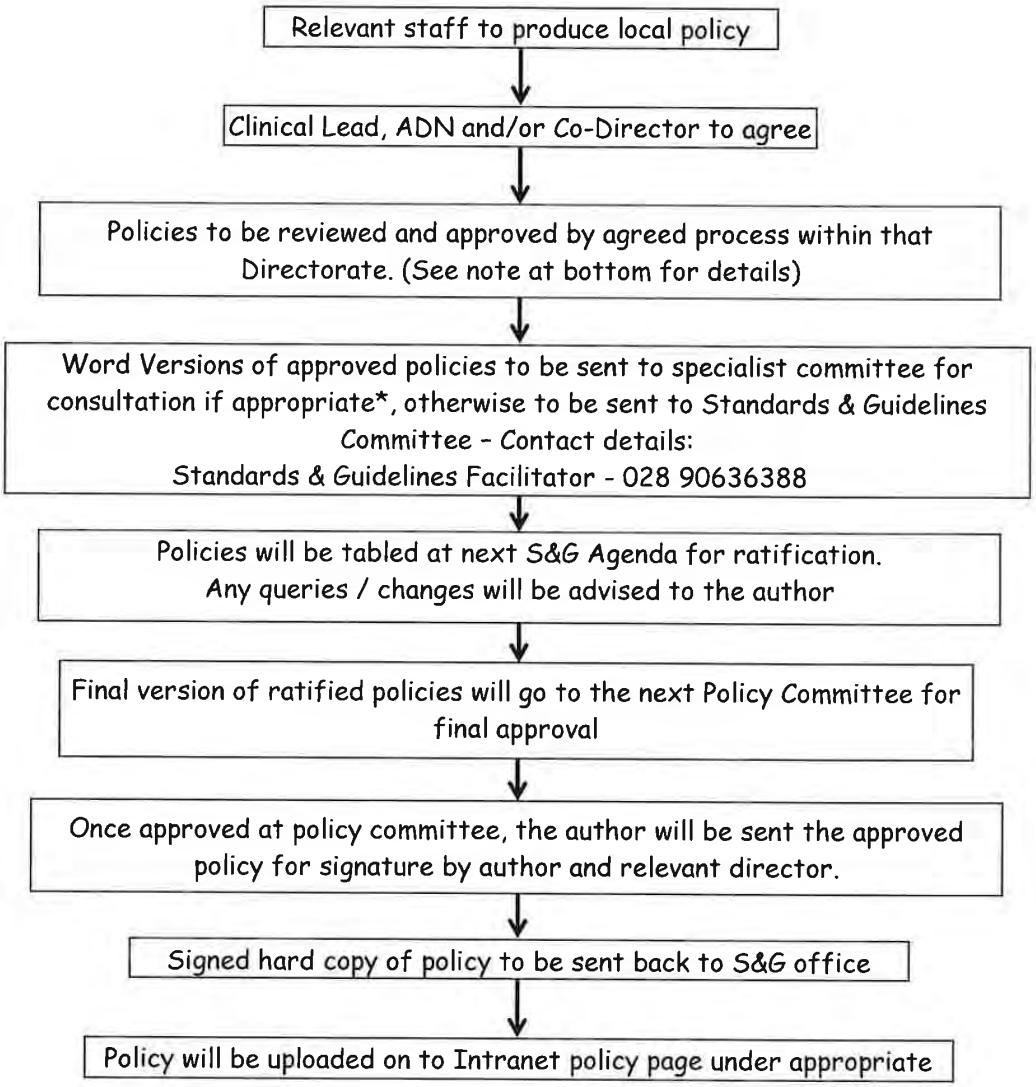
Contact Details:

For all inquiries regarding the writing, approval or availability of policies / guidelines please contact the Standards, Quality & Audit Department:

Jill Shaw O'Doherty Standards & Guidelines Manager [redacted]

Standards & Guidelines Facilitator [redacted]

Approval of documents which pertain only to specific service areas. Appendix 2.



Approval of Local Policies within Directorates

Adult Social and Primary Care

Social Care – Tabled at the Social Care professionals meetings.

Adult Social & Primary Care Services - signed off at governance meetings after full consultation with in the service.

Specialist Hospitals, Womens Health

Paediatrics – Tabled at the Paediatric Governance Group meeting

Womens – Tabled at the Obstetrics & Gynae Governance meetings.

Surgery & Specialist Services –

Signed off by the relevant 'named Medicine/Nursing lead' and tabled at the Senior Management team meeting. If you have any queries, contact the relevant Service Manager in the first instance.

Unscheduled and Acute Care

Signed off by the relevant leads and Director.

Appendix 3

POLICY TEMPLATE

Reference No:

Title:	**Insert name of policy (Arial 12)**		
Author(s)	List name and titles of lead and additional author(s) or group responsible for drafting policy Include contact details		
Ownership:	Insert name of Director / service area / group / directorate		
Approval by:	Insert name of Trust committee / group responsible for approval	**Approval date:**	Insert date each committee approved
Operational Date:	Insert date on which policy issued	**Next Review:**	Insert next review date
Version No.	V() **Supercedes**		
Key words:	Insert key words		
Links to other policies			

Version control for drafts: (This box to be removed prior to issue).
This helps to identify where changes have been made to a document and ensure that authors / reviewers are using the most recent version.

- The first draft should be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0.
- Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
- If major changes are made to the document then it will be issued as version 2.0.

Date	Version	Author	Comments
01/03/2011	0.1	A Trust	Initial Draft
14/03/2011	0.2	A Trust	Second draft incorporating changes agreed at regional meeting.
16/08/2011	0.3	A Trust	Proposed final version incorporating feedback from Trusts.
12/10/2011	V0.4	A Trust	WHSCT comments incorporated
16/11/2011	V1	A Trust	Final Version issued.

Completion guidelines

- Page numbering – to indicate total number of pages. e.g. 1 of 10.
- Type font – Arial 12
- Section headings in bold, underlined and should be numbered 1.0, 2.0, 3.0 tc.
- Paragraphs should be numbered under each section heading e.g. 1.1, 1.2 etc.
- If sub-headings are to be used then these should be in bold/lower case and numbered 1.1 with paragraphs numbered 1.1.1, 1.1.2, 1.1.3 etc

INTRODUCTION / PURPOSE OF POLICY

1.1 Background
Short introduction.

1.2 Purpose
State why is policy needed – rationale, reference to any relevant legislation, statutory requirements, relevant information.

Make reference to any other policies, procedures or guidelines which should be read in conjunction with this policy – these policies/procedures/guidelines should be listed below with their relevant codes:-

1.3 Objectives
Some policies may need a list of objectives i.e. aims to be met with the policy.

2.0 SCOPE OF THE POLICY

Provide clarity in relation to where and to whom the policy applies. Also includes situations where the policy does not apply.

3.0 ROLES/RESPONSIBILITIES

What are the roles/responsibilities of the various groupings within the Trusts right from the CE/CEO to the staff.

Who is responsible for implementing and adhering to the policy?

4.0 KEY POLICY PRINCIPLES

Definitions

Key Policy Statement(s)

Policy Principles

4.1 What needs to be done, when, where and on whom. In general, this section should hold pure statements of policy and then procedures and protocols are put in appendices at the end of the document.

However, certain policies – usually the larger ones and ones where the bulk of the text is from a regional document – have procedural processes given here along with the policy statements. This section sometimes has many subheadings outlining many procedures and approved ways of doing things. The opportunity should always be taken to try to collect defined principles and policy statements into one easily identified area.

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7.0 EVIDENCE BASE / REFERENCES

Insert a brief summary of the evidence base and list references used including relevant external guidelines.

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Insert a list of those groupings consulted in the development of this policy e.g. Trade Unions, Specialist Committees, User groups, Carer Groups, Section 75 groups,

9.0 APPENDICES / ATTACHMENTS

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Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** _____
Author

_____ **Date:** _____
Director

Appendix 4

Definitions (adopted from the United States National Library of Medicine)

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Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 5

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Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

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The Change Log

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The author should retain the more detailed Change Log of a document between draft versions.

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Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

Belfast Health and Social Care Trust

TITLE	**Writing and approval of trust documents**

Summary	Processes to be followed for writing a trust policy or guideline.
Purpose	To establish a clear, uniform and comprehensive approach to the writing and approval of trust policies and guidelines
Operational date	December 2007
Review date	April 2010
Version Number	V3.
Supersedes previous	V2
Director Responsible	Medical Director
Lead Author	Christine Murphy, Standards, Quality and Audit Manager
Lead Author, Position	Standards, Quality and Audit Manager
Additional Author(s)	Dr Julian R Johnston, Co-Chairman, Standards & Guidelines Committee,
Department / Service Group	Standards, Quality and Audit Unit (SQA)
Contact details	Jill Shaw-O'Doherty. Standards & Guidelines Manager Ext [redacted] (Royal site) [redacted]

Reference Number	
Supercedes	

Date	Version	Author	Comments
12/02/2007	1.0	JR Johnston	Initial Draft
12/12/2007	1.1	JR Johnston	BHSCT draft
6/01/2008	1.2	JR Johnston	BHCST minor changes
23/01/2008	1.3	JR Johnston	Final BHSCT Draft
25/01/2008	1.4	C Murphy	Final BHSCT
02/04/2009	1.5	C Murphy	Draft review
23/04/09	2	C Murphy	Final version
01/07/2009	3	C Murphy	Changes to reflect service grp level approval processes
3/11/2009	3.1	J Shaw O'Doherty	Changes 4.15 - authors
25/11/2009	V 3.2	JR Johnston	Reinforce Evidence-based policies 4.3

Policy Record

		Date	Version
Author (s)	Approval	23 Apr 09	2
Director Responsible	Approval	23 Apr 09	2

Approval Process – Trust Policies

Policy Committee	Approval	11 May 09	2
Executive Team	Authorise		
Chief Executive	Sign Off		

Writing and approval of trust documents

2.0 Purpose:

This document outlines the desired structure of a policy or guideline document in the Belfast Health and Social Care Trust (BHSCT). It also outlines the approval processes to be followed and contact details for key committees.

3.0 Objectives:

3.1 This document ensures a

- standard style of policies or guidelines throughout the BHSCT
- clear, uniform, comprehensive and consistent approach to writing and approving a policy or guideline.

3.2 This will help to

- provide a clear framework for all authors to adhere to.
- encourage team working.
- achieve a consistent and standardised approach to team working.
- achieve delivery of high quality patient care by working towards agreed goals.
- deliver consistent, and consequently, safer patient care.
- provide clarity for staff when delivering patient care.
- implement Corporate and Government policies.

4.0 Policy Statement(s):

WRITING A TRUST DOCUMENT

4.1 Where a policy or guideline potentially applies to more than one service group, it must be written for all areas in the Trust.

Consultation should take place across the relevant service groups and approval from the Trust wide committees sought. *(See Appendix 1)*

4.2 Where a policy or guideline is specific to one Service Area or group, then they can be authorised through agreed service level governance arrangements.*(See Appendix 1)*

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> The author(s) should primarily use regional and national policy as the basis to formulate policy. They will be expected to seek out this and other external guidance. Certain bodies hold primacy e.g. NICE, NPSA.
>
> This evidence base should be included in the section on consultation and referenced. Where the policy deviates or is at variance from such external guidance it should be highlighted.

4.4 Where a policy / guideline or protocol mentions medicines or refers to the process of managing medicines, the document should be reviewed by a pharmacist, where there is no pharmacist for the particular service area, the pharmacy services manager should be contacted in the first instance.

4.5 The lead author / group must identify areas to which the policy / guideline should be disseminated and include this in the document.

4.6 The lead author / group must identify what actions are needed for implementation and include these in the policies as so they can be reviewed by approving committees.

If there are implications for training of staff this should be clearly indicated; which staff, at what grade(s) and who will provide the training. If the policy needs to be discussed at appraisal, this should be indicated here.

4.7 All documents must use the Trust template which can be downloaded from the Policies and Guidelines page on the Belfast Trust Intranet. It is important that all new documents created use the template, and are not an overwrite of an existing document. A guide for completing the template, including definitions of various fields is provided in *Appendix 2*.

4.8 All points should be numbered for ease of referencing and editing.

4.9 All documents should have page numbering also with the total number indicated.

4.10 Documents should be titled appropriately. The title should be reflective of the content and include the appropriate definition as to the type of document that it is. *Appendix 3 provides a detailed set of definitions*.

4.11 Version control should be used for the writing and approval of documents. *Appendix 4 provides guidance on version control*.

4.12 Each page should identify the parent committee or service area issuing the policy or guideline, a running title, the version number and the date of production.

4.13 Where a document is endorsement of external guidance that is in an appropriate format for dissemination – then the cover pages of the trust template should be used, outlining the BHSCT reviewer, service area etc.

4.14 The lead author will be responsible for carrying out an equality impact screening process to identify if a full equality impact assessment is required.

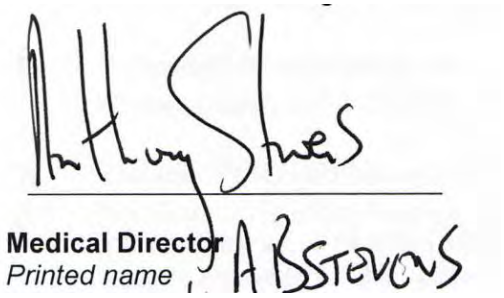
4.15 Any amendments requested during consultation / committee approval will be the responsibility of the lead author.

Authors should acknowledge comments from staff who review policies especially if they are not going to take the comments into account

4.16 The Standards, Quality & Audit Department will contact the lead author at review date time to instigate a review.

4.17 <u>APPROVAL</u>

The Author should be invited, by the Chair, to committee meetings where the policy is on the agenda for approval



Chief Executive/Director	**Author**
Date:	**Date:**

Appendix 1

1. Approval of Trust Documents. (i.e. those which apply to more than one service group)

The Trust Standards & Guidelines Committee and Trust Policy Committee are responsible for submitting approved documents for authorisation to the Executive Team. They have different remits as outlined below.

(i) Trust Policy Committee

All trust policy documents which relate to the operation of corporate functions e.g. HR, IT. This committee is chaired by Paul Ryan, Head of Office.

(ii) Standards & Guidelines Committee

All documents relating to the management of patients and clients in the Belfast Trust. This committee is co-chaired by Dr Julian Johnston, Consultant Anaesthetist, and Ms Olive MacLeod, Co-Director of Nursing.

The Standards & Guidelines committee membership includes the chairs of a number of trust wide committees, specialising in different areas of patient and client care. Where a document pertains to one of these specialities, it should be sent to the specialist committee for approval and it will then be ratified by the Trust Standards & Guidelines prior to being authorised by the Exec team. This follows through the process of accountability as outlined in the Trust Assurance Framework.

Committee	Chair
Drugs & Theraputics Committee	Prof Gary McVeigh
All documents relating to the use of medicines. (for details refer to section 4.4 of this policy).	[redacted]
Transfusion Committee	Dr Susan Atkinson
All documents relating to transfusion processes.	Trust e-mail
Resuscitation Committee.	Dr Michael Trimble
All documents relating to resuscitation.	Trust e-mail
Medical Devices Committee	Ms Karen Brookes

Contact Details:

For all inquiries regarding the writing, approval or availability of policies / guidelines please contact the Standards, Quality & Audit Department:

Jill Shaw O'Doherty	Standards & Guidelines Manager	[redacted]
Karen McCann	Standards & Guidelines Facilitator	[redacted]

Appendix 1 contd.

2. Approval of documents which pertain only to specific service areas.

Trust documents may be confined to one service area or group. It is the author's responsibility to identify whether or not their document relates only to their own service area / group. In the event that it is relevant to any other service groups, it must be developed in consultation with the relevant service areas and approved at the appropriate trust wide committees. Where it is found to pertain only to one service area / group, it can be approved within local service group arrangements.

Specialist Services –

Signed off by the relevant 'named Medicine/Nursing lead' and tabled at the Senior Management Team meeting. If you have any queries, contact the relevant Service Manager in the fist instance.

Mental Health & Learning Disability

Tabled at the Service group policy meeting, issued for consultation. When finalised the Senior Management Team will ratify prior to presentation at the Governance meeting

Social Services, Women, Family and Childcare

Paediatrics – Tabled at the Child Health Integrated Governance committee meeting

Womens – Tabled at the Obstetrics & Gynae Governance Meetings.

Social Care – Tabled at the Social Care Professionals meetings.

Older People Medicine & Surgery / Trauma & Orthopaedics

Tabled at the OPMS Policy committee, chaired by Brian Barry, co-director OPMS.

This document will be regularly updated as the formal approval processes for local area guidelines are developed over the coming year.

Appendix 2 Guide for completing the trust template.

1. **Title:**
   How to write and manage a policy or guideline.

2. **Introduction:**
   This document details how to write and set out a policy or guideline for the BHSCT.

3. **Each policy must include the following:**
   - 2 cover sheets - identifying document control features.
     - identification of where the policy / guideline originated
     - a title
     - Primary identification table
     - Policy / Guideline reference number table
     - Version table
     - Authorisation Record table(s)
   - a description of the policy / guideline which
     - may include an executive summary to include the purpose, objectives and policy statement(s).
     - must include the full description of the policy or guideline.
   - signature of the Chief Executive/Director and date
   - signature of the principal author and date

4. **Type of Document**
   This section below the BHSCT logo identifies where the policy / guideline originates.

5. **The title**
   This must reflect the policy or guideline.

6. **Primary identification table**
   This table will be used for document control purposes and includes details of
   - Summary
   - Purpose
   - Operational date
   - Review date
   - Version Number
   - Supersedes previous
   - Director Responsible
   - Lead Author
   - Lead Author Position
   - Additional Author (s)
   - Department / Service Group
   - Contact details

7. **Reference number table**
   Office use only: for document control purposes.
   Identifies policy or guideline on Trust Policy or Standards and Guidelines Database.
   Contains Reference Number which will be allocated by TP or S&GC.

8. **Version table**
Office use only: for document control purposes.
This helps to identify where changes have been made to a document and ensure that everyone is using the most recent version.
The first draft should be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0. Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
If major changes are made to the document then it will be issued as version 2.0.
See Guidance in Appendix 4 on version control of documents

9. **Authorisation record table(s)**
Identifies approval, endorsement or authorisation position for guideline.

BHSCT policies or guidelines are not valid until they receive Executive Team authorisation and are 'signed'. They will then be entered onto the Intranet.

10. **Policy / Guideline description – Summary**
An executive summary may be inserted particularly if the overall document is long or complex. It should include the purpose, objectives and policy statement(s) and be signed and dated.

11. **The purpose.**
This gives the underlying reason and justification for the policy or guideline in summary form. It could include a definition if required.

12. **The scope**
A definition of the target audience and where or for whom the policy or guideline will apply.

If appropriate, a common understanding of what, who or where is excluded from the guideline should be included here.

13. **The objectives.**
This gives the purpose, goal and aim(s) for the policy or guideline – why it is necessary.

14. **Roles and Responsibilities**
This section should identify the roles and responsibilities of all stakeholders involved with or affected by the policy / guideline. This can include personnel from the Trust (Board of Directors, Executive Team, Chief Executive, Directors, Managers, to all staff), individuals and committees, external individuals and agencies to include patients, relatives and members of the public.

15. **The definition and background of the policy or guideline.**
This gives a definition(s) and clear outline of the parameters of the policy or guideline identifying its boundaries.

This section will give the background and, if necessary, a context – historical, clinical or otherwise.

16. **The policy or guideline.**
Describe the policy or guideline itself, preferably in summary form or in short

bullet points.

One method of writing this section of a BHSCT policy or guideline is to refer to, and if appropriate include as an appendix (pdf. format), a standard document from an outside agency or organisation e.g. NICE clinical guideline, NPSA document. Then, this section would only require the variations, exceptions or non-compliance with that standard document's recommendations to be outlined here in detail.

These exceptions would require a work plan and time scale for correction or alignment with the standard.

17. **Policy Statement(s)**
The policy or guideline may give rise to policy statement(s) and these should be indicated at this point. These are statements of the standard of service that is to be provided. They should be repeated in the executive summary.

Short bullet points are preferable.

Does not include operation procedures – these should be written separately.

18. **Implementation**
Each policy or guideline will ordinarily require an Implementation Report. This document is to outline:

i. The method for implementation.
ii. The evidence of implementation.
iii. The magnitude of the change in practice required.
iv. The expected benefits from implementing the change.
v. The specialties / departments affected by the change.
vi. The resource impacts of the implementation.
    - Clinical impact.
    - Financial impact.
    - Training/educational impact.

19. **Source(s) / Evidence Base**
This section should include a brief summary of the information sources for this policy / guideline. This may be from Government and/or the DHSSPSNI and should include such items as legislative requirements, regulations and material from regulatory bodies.

20. **The references including relevant external guidelines.**
Provide reference material wherever possible. This is a primary source of the evidence base. This should include references in journals, relevant documentation (e.g. NICE, NPSA, SIGN documentation).

Include a reference list at the end of the policy or guideline. This will identify the source(s) of the information as well as assisting the user to review the topic if more information is required.

Important documents can be appended – only in Word or PDF format.

Try not to append hyperlinks as these may cease to function in the future and may become obsolete.

21. **Consultation Process**
Indicate in this section the
- Internal external, professional / staff side representatives who were consulted in the development of this policy / guideline.
- name the internal/external individuals, committees, bodies and agencies that were involved.

22. **Equality screening**
Each policy or guideline will require an initial equality screening exercise to ascertain if the guideline should be subject to a full equality impact assessment and, if suitable, a statement included, such as:-

In line with its duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting social need Initiative and the Human Rights Act 1998 the BHSCT has carried out an initial equality screening exercise to ascertain if this policy should be subject to a full equality impact assessment.

23. **Procedure(s)**
The policy or guideline may give rise to procedural statement(s). This is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and to ensure efficiency, consistency and safety.

Short bullet points are preferable.

24. **Signature of Chief Executive/Medical Director**
Policies belong to the Trust, not the individual author and are therefore signed off by the Chief Executive/Director once approved by Executive Team.

All Trust policies or guidelines must be dated and signed.

Appendix 3

Definitions (adopted from the United States National Library of Medicine)

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition that generally have been approved by a recognized standards organization or is accepted as a de facto standard. They are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research, and health services. A guideline is something you should do i.e. a recommendation, that may be ignored in particular circumstances but the full implications must be understood and therefore, practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical guidelines are systematically developed recommendations which assist healthcare professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help healthcare professionals in their work, but they do not replace their knowledge and skills.

A **policy** is a statement of the standard of service that is to be provided or the means by which a strategy is to be delivered. It is a statement of **what** must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures – these should be written separately.

A **procedure** is a set of detailed step by step instructions that describe the appropriate method for carrying out tasks or activities to achieve the highest standards possible and ensure efficiency, consistency and safety. It is a statement of **how** to do something. They may be specific to a particular work area or group of people but would be aligned with an overarching policy statement belonging to the parent organisation.

A **protocol** is a clear decision making process. It is in the form of explicit step by step instructions, on a specific aspect, giving a precise and detailed plan that should be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is that only one course of action(s) is considered appropriate – it is not discretionary. The terms ‘procedure’ and ‘protocol’ are often interchangeable.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Appendix 4

Guidance on Version Control of Documents

Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee etc.

The content of a document under version control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this document will assist in the application of Version Control of all documents, for example policies, procedures etc. To assist in the application of Version Control, an example flow diagram has been developed (See Appendix 1).

Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0.1'. Subsequent versions of the initial document shall be described as 'Version 0.2', 'Version 0.3' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

First Approval of a Document

When a document is formally approved for the first time by the organisation, it shall be issued as 'Version 1.0'.

Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1.0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1.0.1'. Subsequent changes during the review of document 'Version 1.0', will be versioned as 'Version 1.0.2', 'Version 1.0.3' etc.

How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1.0':

□ If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1.1'; or

□ If the changes are considered to be **major** e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2.0'.

Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1.1', the draft version will be described as 'Version 1.1.1', 'Version 1.1.2', 'Version 1.1.3' etc.

If further changes are to be made to document 'Version 2.0', the draft version will be described as 'Version 2.0.1, 'Version 2.0.2', 'Version 2.0.3' etc.

The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:
□ The version number;
□ The date the version number was assigned;
□ The author of the changes; and
□ A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions. An example of a Change Log is contained in Appendix 2.

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1.0	10 February 2005	Information Services	
Version 1.1	30 September 2005	Information Services	Updated Contact Details
Version 2.0	31 March 2006	Information Services	New section added on Communication Channels

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 84/12

Title:	**Policy Development and Approval Process**		
Policy Author(s)	Martine McNally, Corporate Risk and Standards Senior Manager Tel: 0289 50 42129 [redacted]		
Responsible Director:	Dr Chris Hagan, Medical Director		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	**Non Clinical Trust Wide** ☒
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved** **Name:** **Date:**			

Approval process:	Trust Policy Committee Executive Team Meeting	**Approval Date:**	06/02/2020 26/08/2020
Operational Date:	August 2020	**Review Date:**	August 2025

Version No.	8.2	**Supercedes**	V7 – October 2018 – October 2023 Previously known as "Writing and Approval of Trust Documents"
Key Words:	Writing, Approval, Approving, Policy Template, policy, screening, monitoring, consultation, review		
Links to other policies	Trust Policy Template		

Date	Version	Policy Author	Comments
October 2012	5	Christine Murphy	Approved and uploaded to HUB.
December 2014	6	Christine Murphy	Minor changes to terms/Division or Directorates.
May 2018	7	Jill Shaw-O'Doherty	Addition of Rural Assessment Needs, and the Privacy Impact Assessments for people – either service users, patients or staff who have a disability.
February 2020	8	Martine McNally	Revision of format and title change. Amendments to development of local/speciality policies. Amendment of appendices and links added to templates on the HUB.
27/01/2021	8.1		Revision to include reference to RBHSC D&T Committee and approval process for D&T policies
24/06/2021	8.2	Karen Fay	Addition of keyword approval in section 5.7

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Appendices

1.0 INTRODUCTION / SUMMARY OF POLICY

The Trust must ensure it has a robust process in place for the development, approval, implementation and review of all Trust policies. This mandatory process has been designed to ensure the Trust complies with corporate governance requirements. There is no precise definition of a policy but it is generally accepted a policy is a written statement of intent or principle that directs individual and organisational responses towards the achievement of objectives and goals.

All Trust policies, are classified into three types i.e. ***Clinical Trust Wide, Directorate Specific*** and ***Non Clinical Trust Wide,*** which must follow the process for development, approval, referencing and review of all policies.

This document defines how Trust policies must be developed and provides a way to ensure consistency in development, format, approval, dissemination and review. All Directors and managers are responsible for compliance with the guidance and ensuring relevant staff within their areas of responsibility adhere to the policy as appropriate to their roles and responsibilities. The process has been approved by the BHSCT Policy Committee and all steps must be followed.

A Flowchart detailing the policy development and approval process has been attached at *Appendix 2* to provide step by step guidance on the process to ensure uniformity to policy development.

2.0 SCOPE OF THE POLICY

This process has been designed to ensure the Trust complies with various legislative requirements such as Section 75 of the Northern Ireland Act 1998, Human Rights, Disability Discrimination Act and Freedom of Information as well as Corporate Governance requirements and will ensure the Trust Board fully discharges its responsibilities. It will ensure there is a robust process in place for development, approval and implementation of all Trust documents that guide a course of action.

The process has been reviewed by the Standards and Guidelines (S&G) Committee and the BHSCT Policy Committee and **all** steps must be followed by the Policy Author. The administration of the process will be undertaken by the S&G Department.

3.0 ROLES AND RESPONSIBILITIES

Where a policy applies to more than one area, it must be written for all areas. Consultation must take place across relevant Division/Directorate/Service Areas and approval from Directorate/Trust wide Committees sought as appropriate. All staff are responsible for adhering to the policy.

For clarification a **Clinical Trust Wide** policy or a ***Non Clinical Trust Wide*** policy refers to a policy that applies to staff in a number of Directorates. A ***Directorate Specific*** policy refers to a policy that is applicable to staff in a particular Directorate only.

4.0 CONSULTATION

The following have been consulted in the writing of the policy -

- Trust Policy Committee
- S&G Committee
- Governance Managers
- Equality & Planning Team

5.0 POLICY STATEMENT/ IMPLEMENTATION

5.1 Dissemination

The policy will affect all staff.

5.2 Resources

The policy will be made available on the Policies and Guidelines page on the Trust intranet. The policy will also be publicised on the front page of the Policies and Guidelines page and the News section of the Trust intranet.

5.3 Exceptions

There will be no exceptions as the policy will apply to all staff.

5.4 Policy Definitions

All policies which guide a course of action and which staff are required to implement, must be officially referenced by the S&G Department. This applies to ***Clinical Trust Wide*** policies, ***Non Clinical Trust Wide*** policies, and ***Directorate Specific*** policies, the only exception from this rule are those 'internal protocols/procedures/guidelines that stem from policies, e.g. if a Division/Directorate/Service Area/Speciality develops an internal process e.g. a Standard Operating Practice – such as the Management of Attendance protocol.

The Policies and Guidelines page on the Trust intranet site (Hub) is the central point for staff to access official Trust policies – anything outside of this (other than internal policies as outlined above) are not official Trust policies.

All policies developed within the Trust are subject to the requirements of the policy writing process in this document. Documents which guide a course of action are not called a policy but are still within the scope of the process.

Such documents may be titled as follows - (*See Appendix 1* for policy definitions)

- Procedures
- Protocols
- Guidelines
- Clinical Guidelines
- Guidance
- Strategies
- Codes of Practice
- Standards
- Frameworks
- Best Practice

5.5 Aim of the Policy

The policy must have a title that accurately describes its focus. The Policy Author must be clear about the need for, and intent of the policy, and describe the type of policy and the policy aim.

The following must be considered by the Policy Author –

- Why are you producing the policy?
- Has the need come about because of, e.g. a DoH circular, to clarify internal procedures or to comply with new or revised legislation?
- Have you checked to make sure no one else is working on a similar policy?
- Does another Trust have a similar policy the trust can adapt / adopt?
- Are there any related Trust polices or current policies that could be updated?
- What are the risks / benefits associated with the policy?
- What research or evidence will be used to support the policy?
- Is legal advice required? If so, when?

5.6 Policy Format

The policy template must be downloaded from the Policies and Guidelines page on the Trust Intranet and used for all policies. The Trust's written style guide (available on the Trust intranet) must also be used.

The following **must** also be undertaken -

- Use plain language - abbreviations and use of jargon must be avoided.
- Keep to the minimum length required to communicate the policy's intent.
- Words like 'could' and 'may' imply a choice, the word 'must' is specific.
- All policies must reflect the corporate font, i.e. Arial, font 12.
- Page numbering to indicate total number of pages, e.g. 1 of 10.
- Version control to be used.
- Single line spacing to be used.
- "Align left" or "block" format to be used to produce a left hand margin.
- Section headings to be bold, underlined and numbered 1.0, 2.0, etc.
- No block capitals to be used.
- No Italics.
- Size or shape of the BHSCT logo must not be changed. No other logos to be used.

Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English. Please contact the Equality & Planning Team by emailing equality@belfasttrust.hscni.net or Tel: 028 95 048734 to assist with this.

The Policy Author as detailed on the policy title page must be contacted with regard to any queries on the content of the policy.

5.7 Consultation

The Policy Author is responsible for ensuring those affected, or likely to be affected by the policy are involved in its development.

The following must be considered when consulting -

- Begin as early as possible.

- Ensure appropriate method(s) are chosen e.g. face to face meetings, consultation papers, focus groups.
- Adequate time must be allowed for groups to consult amongst themselves as part of the process of forming a view. Where internal consultation is required a suggested timescale of four weeks should be allocated.
- Adequate steps must be taken to ensure full participation in all consultation exercise, i.e. consider time of day, venue etc.
- Ensure all appropriate information/documentation is included or referenced to ensure meaningful consultation takes place.
- Ensure appropriate keywords are used by consulting with the relevant staff i.e. staff within wards, departments and facilities who may use specific keywords to describe a policy that may not be mentioned in the title or body of the policy.

There are two main types of consultation - internal consultation (e.g. within Directorates, Divisions and with Trade Unions) or external public consultation (e.g. with affected representative groups, other public authorities etc.).

Internal Consultation

The Policy Author must provide details of how they have involved/consulted with those affected by this policy, e.g. clinical leads/specialist Committees/user groups.

Where a policy mentions medicines or refers to the process of managing medicines, it must be reviewed by a Pharmacist, if there is no Pharmacist attached to that speciality, a Pharmacy Services Manager must be contacted.

If the policy has any implications for staff there must be consultation with the Workforce Policy Sub Committee (or the Local Negotiating Committee for medical and dental staff) – contact HR Case Management Team on Tel: 028 9063 5678 for further information.

External Consultation

The Policy Author must contact the Senior Manager for Personal and Public Involvement if advice is required on Tel: 028 950 46739.

Any amendments requested during consultation / Committee approval will be the responsibility of the Policy Author. There must also be acknowledgment of any comments received. It is the responsibility of the Policy Author to ensure all those who responded during consultation are informed of the outcome of the exercise and have access to a final version of the policy.

If a reviewed policy is being updated any changes must be highlighted by the Policy Author to ensure the relevant Committee is aware of the changes. All documents forwarded must be in MS Word format so relevant details can be added prior to issue.

Once the S&G Department is in receipt of this documentation they will advise the Policy Author that it has been added to the S&G Committee Agenda for noting/approval as appropriate or if the policy has been forwarded to the Trust Policy Committee Facilitator for adding to the Trust Policy Committee Agenda.

5.8 Equality Screening

All Policy Authors must complete an equality screening template. The template has been designed in such a way as to enable clinical/technical policies to be easily 'screened out' at an early stage and to ensure complex policies are considered more fully from an equality perspective.

A screening template and toolkit for Policy Authors are available on the Trust intranet or via this link. For further queries please contact the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Once the policy has been finalised and the above template has been signed off by the Equality & Planning Team, the policy is ready to be approved.

The Equality & Planning Team will send the signed off template back to the Policy Author for counter-signature and copy to the S&G Department. The Policy Author is responsible for sending the final version of the policy and the signed off equality screening template to the S&G Department.

The following documentation must be sent to the S&G Department via the generic email address internalguidance@belfasttrust.hscni.net

- Final version of the policy completed on the most recent version of the Trust policy template
- Completed and signed off equality screening template *(Appendix 5)*

Approved equality screening documents are publicly available documents, available on the Trust website.

5.9 Approval

A ***Clinical Trust Wide*** policy or a ***Non Clinical Trust Wide*** policy refers to a policy applicable to staff trust wide or in a number of Directorates. *A* ***Directorate Specific*** policy refers to a policy applicable to staff in a particular Directorate only.

The relevant Committee will approve the policy or request clarification or revision of the policy. In some instances the Committee will recommend the policy is tabled at another Committee within the Trust's Assurance Framework to be approved before coming back to the Committee to be noted.

The Trust has established two policy approval Committees to ensure Trust wide policies are approved appropriately. This follows through the process of accountability as outlined in the Trust Assurance Framework.

- The **Standards and Guidelines (S&G) Committee** is responsible for the approval of all ***Clinical Trust Wide*** policies. It approves any new, reviewed or amended clinical policies which are applicable Trust wide or which would be applicable over several Directorates. The Policy Author would be required to attend the meeting to discuss the policy.

  All ***Clinical Trust Wide*** policies developed externally to the Trust e.g. regional or national guidance requiring implementation/adoption must be converted into the Trust Policy Template format; follow the Trust approval process; and must be approved/noted at the S&G Committee.

- All new, reviewed or amended ***Directorate Specific*** policies must be approved at a relevant Committee within their Directorate Governance Arrangements. The ***Directorate Specific*** approved policies are then tabled at the S&G Committee for noting only.

- Any ***Clinical Trust Wide*** or ***Directorate Specific*** policy which pertains to a Specialist Committee must be sent to the Committee's chair for approval (see table below). It will then be tabled at the S&G Committee for noting. All ***Directorate Specific*** policies approved via specialist Committee should be approved at directorate level before they are sent to a specialist Committee for second approval before being noted at the S&G Committee.

- Any ***Clinical Trust Wide*** or ***Directorate Specific*** policy which is approved by the RBHSC Drugs and Therapeutics Committee which is also applicable to other areas should be forwarded to the BHSCT Drugs and Therapeutics Committee for second approval before being noted at the S&G Committee.

Specialist Committees	**Chair**
RBHSC Drugs and Therapeutics Committee All policies relating to the use of medicines relevant to the Children's Hospital	Ms Anne Burns
* BHSCT Drugs and Therapeutics Committee All policies relating to the use of medicines	Post Vacant
* Hospitals Transfusion Committee All policies relating to transfusion processes	Mr Ray Hannon
* Resuscitation Committee All policies relating to resuscitation processes	Mr Brian McCloskey
* Medical Devices Committee All policies relating to the use of medical devices	Ms Karen Brookes

- All approved ***Clinical Trust Wide*** policies and ***Directorate Specific*** policies will then be noted at the Executive Team meeting.

- The **Trust Policy Committee** is responsible for the approval of all ***Non Clinical Trust Wide*** policies. It approves any new, reviewed or amended non clinical policies which are applicable Trust wide. The Policy Author would be required to attend the meeting to discuss the policy.

- All approved ***Non Clinical Trust Wide*** policies will then be noted at the Executive Team meeting.

5.10 Official Referencing

Once approved and noted by the Executive Team the list of policies will be returned to the S&G Department and details of the policy will be entered onto the S&G Policy database. The policy will be allocated a new or existing official reference number (SG number for ***Clinical Trust Wide*** policies and ***Directorate Specific*** policies and a TP number for ***Non Clinical Trust Wide*** policy) and a database number.

Policy Authors will be emailed a copy of the policy by the S&G Department and asked to confirm it is the final version of the policy, it is the correct version

number, to confirm that they approve of the policy title which will be used and the area and section of the Policies and Guidelines page on the Trust intranet to which the policy will be uploaded.

The previous version of the policy will be withdrawn (along with any separate appendices) from the Policies and Guidelines page on the Trust intranet and replaced with the new version.

5.11 Dissemination

The S&G Department will advise the Policy Author and relevant Director via email once the policy has been uploaded to the Policies and Guidelines page on the Trust intranet.

It is the responsibility of the Policy Author to ensure policies are circulated to the target audience (including those who do not have access to e-mail/intranet).

5.12 Publication Scheme

Approved Trust policies will be made available to Corporate Communications. Policy Authors may be asked by the S&G Department to submit a synopsis of their updated/ new approved policy to be submitted to Corporate Communications for uploading to the News page of the Trust intranet with a link to the updated/new policy (a News story).

Approved Trust policies are also publicised on the Policies and Guidelines page on the Trust intranet on an 8 weekly basis as either a New or a Featured policy with a link to the updated/new policy. Policy Authors will be advised when their policy is publicised by the S&G Department

6.0 MONITORING AND REVIEW

All approved policies must include a specific review date, ie, month and year. In the interests of good practice the S&G Department will give a five year period for each policy from the month of the Executive Team meeting at which the policy was noted.

Three months prior to the review date of the policy the S&G Department will inform the Policy Author, or in the absence of the Policy Author the appropriate Directorate representative that the policy is due for review. They will also be sent a MS word copy of their policy and the Equality screening template. A one month deadline will be set for an advisory response, i.e.

**** No changes – front page to be updated only** Policy Author to update the policy and submit to the S&G Department by the review date	** Equality screening template must also be completed by the Policy Author and sent with the amended policy to the Equality & Planning Team.
**** Policy to be updated** Policy Author to update the policy and submit to the S&G Department by the review date	** Equality screening template must also be completed by the Policy Author and sent with the updated policy to the Equality & Planning Team.

Policy now obsolete and can be archived on the S&G Policy database and removed from the Policies and Guidelines page on the Trust intranet site (Hub) Policy Author to advise the S&G Department by the review date.	

The **S&G Committee** is responsible for monitoring ***Clinical Trust Wide*** approved out of date policies and ***Directorate Specific*** approved out of date policies.

Once a policy has passed its review date it will be viewed as an out of date policy unless an update of the policy has been received by the S&G Department or the policy has been archived on request of the Policy Author.

A quarterly report is tabled at the S&G Committee listing all ***Clinical Trust wide policies*** that are out of date. A report listing all ***Directorate specific*** policies will also be noted at the meeting.

Directorate representatives are responsible for sharing the ***Directorate specific*** reports within their Directorate Governance Arrangements and seeking an update on out of date policies which would be reported back to the S&G Department. Directorate Representatives must also share this report with their relevant Director. The S&G Department will follow up with Policy Authors on ***Clinical Trust Wide*** policies. If the policies continue to remain out of date, the reports will be escalated and shared with the Executive Team quarterly.

The **Trust Policy Committee** is responsible for the monitoring of all ***Non Clinical Trust Wide*** approved out of date policies. The S&G Department is responsible for providing a quarterly report to the Trust Policy Committee to assist with its escalation process. If the policies continue to remain out of date, the report will be escalated and shared with the Executive Team quarterly by the Trust Policy Committee.

7.0 EVIDENCE BASE/REFERENCES

BHSCT Writing and Approval of Trust Documents SG 24/12 V7
Good governance arrangements

8.0 APPENDICES

Appendix 1 Policy Definitions
Appendix 2 Flowchart detailing the Policy Development and Approval Process
Appendix 3 Flowchart detailing the Process for Equality Impact Assessment Screening for Policy Authors
Appendix 4 Policy Template
Appendix 5 Equality, Good Relations and Human Rights Screening Template

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **(insert name of policy related practice/skill)**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link** *(Appendix 5)*

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be

carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☒
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

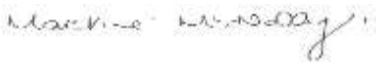
13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make **Reasonable Adjustments** to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA

SIGNATORIES

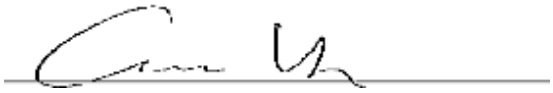
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director). A handwritten signature scanned to the S&G Department must be used.



06/02/2020

_____ **Date:** _____

Author
Martine McNally
Corporate Risk and Standards Senior Manager



26/08/2020

_____ **Date:** _____

Director
Dr Chris Hagan

26/08/2020

_____ **Date:** _____

Dr Cathy Jack
Chief Executive

Belfast Health and Social Care Trust
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Appendix 1

Policy Definitions

A ***policy*** is a statement of the standard of service/care to be provided or the means by which a strategy is to be delivered. It is a statement of what must be done. It is to enable management and staff to make correct decisions, deal effectively and comply with relevant legislation, Trust rules and good working practices. They are to be followed. They do not include operational procedures, these are written separately.

A ***Clinical Trust Wide*** **policy** or a ***Non Clinical Trust Wide*** **policy** refers to a policy that applies to staff in a number of Division or Directorates.

A ***Directorate Specific*** **policy** refers to a policy that is applicable to staff in a particular Division/Directorate/Service Area/Speciality only.

A ***procedure*** is a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities. They may be specific to a particular work area or group of people, but would be aligned with an overarching policy statement belonging to the parent organisation.

A ***protocol*** is a clear decision-making process. It is in the form of explicit step-by-step instructions, on a specific aspect, giving a precise and detailed plan that must be rigidly adhered to. They tend to be measurable. The underlying difference from a guideline is only one course of action(s) is considered appropriate - it is not discretionary. The terms 'procedure' and 'protocol' are often interchangeable.

Guidelines are statements of principles or procedures that assist professionals in ensuring quality in such areas as clinical practice, biomedical research and health services. A guideline is something the staff member must do, i.e. a recommendation, which may be ignored in particular circumstances, but the full implications must be understood and practitioners will generally use these concepts and principles in meeting their obligations and objectives.

Clinical Guidelines are systematically developed recommendations which assist health care professionals and patients in making decisions about the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. They help health care professionals in their work, but they do not replace their knowledge and skills.

Guidance is advice or information aimed at resolving a problem or difficulty. Guidance differs from a procedure, which establishes a specific way of doing something.

A ***Strategy*** is a high level framework for achieving long term objectives

A ***Code of Practice*** enables activities to be carried out to a required organisational standard and provides a basis for dispute resolution.

Standards are published documents that contain technical specifications or other precise criteria designed to be used consistently as a rule, guideline or definition in general have been approved by a recognised standards organisation, or are accepted as de facto standards. They are Policy Authoritative statements that articulate minimal, acceptable or excellent levels of performance or describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care.

Frameworks are a broad overview or outline of interlinked items which support a particular approach to a specific objective, and serves as a guide that can be modified as required by adding or deleting items.

Best practice is a process which has been agreed as the most effective and efficient way of doing that action, but has not been officially accepted as a guideline.

Other Document Types:

Legislation is law enacted by a legislative body.

National/Regional Guidance is guidance written by DoH, HSC Board, Public Health Agency or professional bodies.

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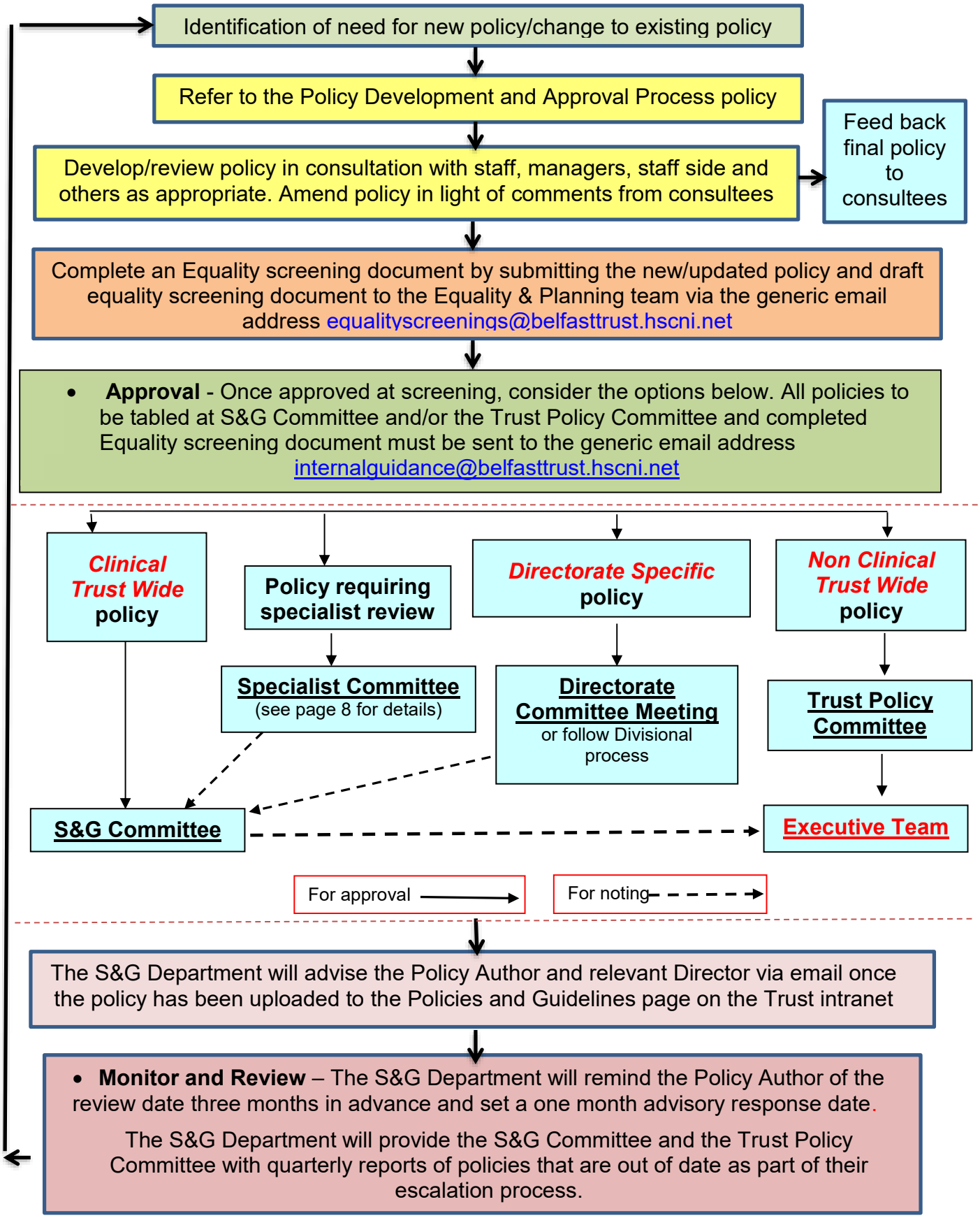
Appendix 2

Flowchart detailing the Policy Development and Approval Process



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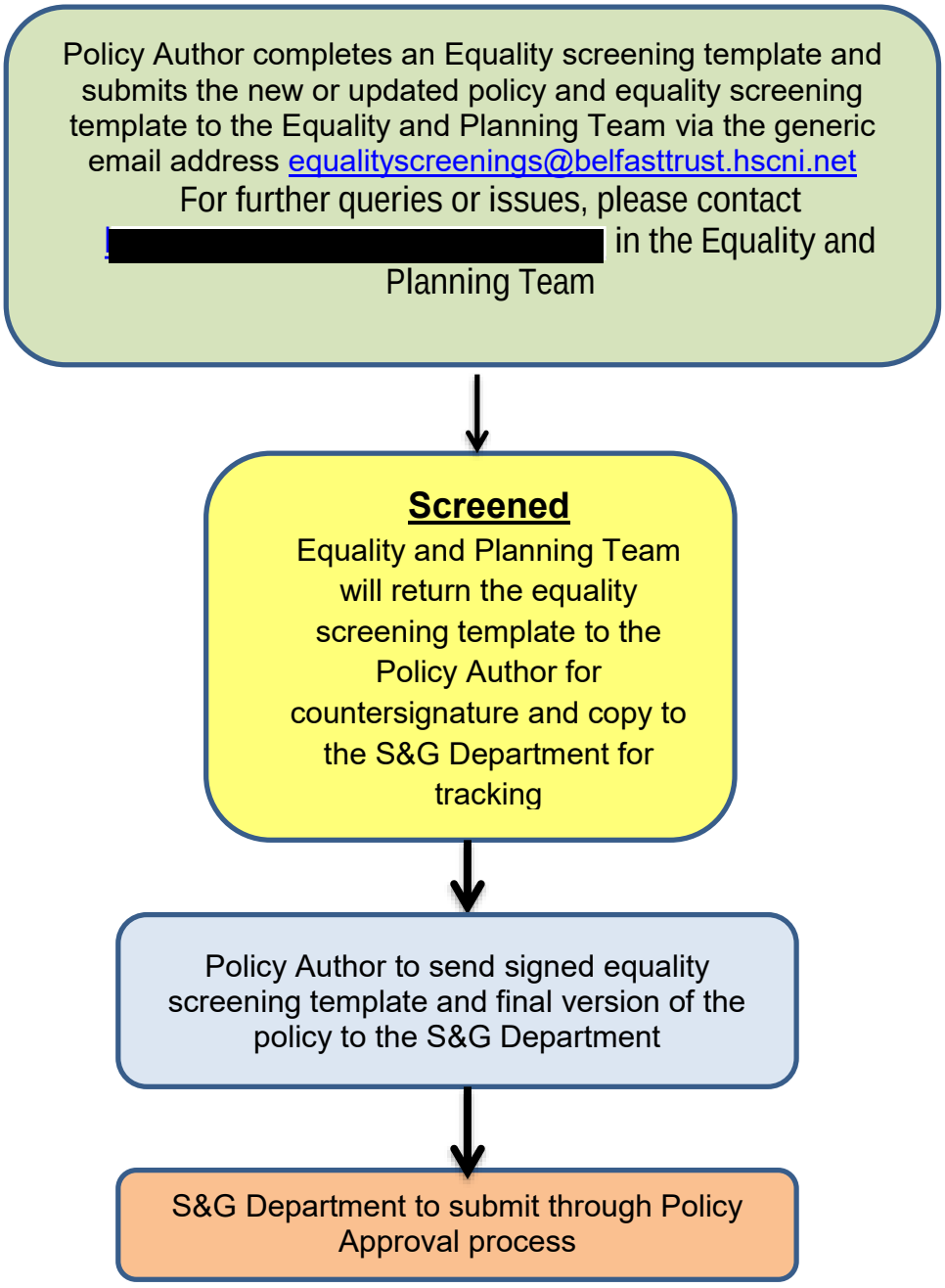
Appendix 3

Flowchart detailing the Process for Equality Screening for Policy Author



Policy Template **Appendix 4**

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Reference No:

Title:	**Please ensure the title reflects the content of the policy and does not commence with words such as Policy, Procedure, Guideline, Management of etc. Title must be kept to a limit of 15 words.**		
Policy Author(s)	List name and titles of lead and additional Policy Author(s) or group responsible for drafting policy Include telephone number and email address		
Responsible Director:	Insert name of Director, (Director of) Directorate		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved** **Name:** **Date:**			
Approval process:	Specialist Committee Name (if applicable) Standards and Guidelines Committee (***Directorate Specific*** and ***Clinical Trust Wide*** policies only) Trust Policy Committee (***Non Clinical Trust Wide*** policies only) Executive Team Meeting	**Approval date:**	Insert date each Committee approved/ noted
Operational Date:	To be completed by S&G Department	**Review Date:**	To be completed by S&G Department
Version No.		**Supercedes**	V( ) - Operational dates (Insert reference of policy this new/ updated policy supersedes)
Key Words:	Insert key words that staff may use to find the policy		
Links to other policies	Insert name of policy and link (if applicable)		

Version control for drafts: (box to be removed prior to issue).
Identifies where changes have been made to a document and ensure Policy Authors are using the most recent version.

- The first draft must be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.
- Reviews will then be versioned 1.2, 1.3.
- If major changes are made to the document then it will be reissued through the committee process and renamed as version 2.0.

Date	Version	Policy Author	Comments
01/01/2020	0.1	A Trust	Initial draft

14/03/2020	0.2	A Trust	Second draft incorporating changes agreed at regional meeting.
16/07/2020	1	A Trust	Final version issued.

Completion guidelines

- Page numbering – to indicate total number of pages e.g. Page 1 of 10.
- Type font – Arial 12
- Section headings in bold, underlined and must be numbered 1.0, 2.0, 3.0 etc.
- Paragraphs must be numbered under each section heading e.g. 1.1, 1.2 etc.
- If sub-headings are to be used then these must be in bold/lower case and numbered 1.1 with paragraphs numbered 1.1.1, 1.1.2, 1.1.3 etc.

1.0 INTRODUCTION / SUMMARY OF POLICY

This should be an overview of the policy and a summarising of the key points contained within. It must be clear and concise and include the background and purpose of the policy.

2.0 SCOPE OF THE POLICY

List the reasons as to why the policy has been written.

3.0 ROLES AND RESPONSIBILITIES

List who is responsible for implementing and adhering to the policy.

4.0 CONSULTATION

Detail how Policy Authors have involved/consulted with those affected by the policy, either internal or external, eg, clinical leads/ trade unions/ special Committees or user groups.

5.0 POLICY STATEMENT/IMPLEMENTATION

Detail the main body of the policy and provide clarity at to what needs to be done, when, where and to whom the policy applies. It must also include situations where the policy does not apply.

5.1 Dissemination

List the groups of staff for whom the policy has relevance.
Provide a timescale for implementation and highlight any potential barriers.
Indicate who must be notified (usually the Policy Author) if there are significant barriers and timescales not being met.

5.2 Resources

Include training, awareness raising, testing of new documentation associated with the policy and who is responsible.

5.3 Exceptions

Detail all areas where the policy is to apply and any area noted as exempt because it is unable to comply with or implement the policy.

6.0 MONITORING AND REVIEW

Detail how the effectiveness of the policy will be monitored.
Detail how the policy will be reviewed.
Provide details of key performance indicators which are relevant to its successful implementation.

Examples of assurance include monitoring and review of incidents/ Serious Adverse Incidents, review of complaints, service user feedback, and audits. All audits must be registered with the Quality Improvement Team, outcomes reported and an action plan prepared, where appropriate. Audit Project Registration and Post Project Report and Action Plan Forms can be obtained by contacting Tel 028 950 48734.

State which Committee will oversee implementation of the policy and monitor the assurance provided.

7.0 EVIDENCE BASE/REFERENCES

A brief summary of the evidence base and list of the references used, including relevant external guidance. Procedures and protocols must be put in Appendices at the end of the document. Check all web links used are still operational at time of policy finalisation.

8.0 APPENDICES

To be tabulated here and attached below as required.

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **(insert name of policy related practice/skill)**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link** *(Appendix 5)*

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** _____
Policy Author

_____ **Date:** _____
Director

Equality, Good Relations and Human Rights SCREENING TEMPLATE with GUIDANCE

Appendix 5

****Completed and Signed Screening Templates are public documents posted on the Trust's website****

- All policies / proposals require an Equality Screening
- Policy authors are responsible for Equality Screenings

Section 1: Information about the Policy / Proposal							
(1.1) Name of the policy/proposal Give the policy or proposal a title that accurately describes its focus. This is very important – this is what is being screened – nothing else							
(1.2) Status of policy/proposal *(please underline)*		New		Existing		Revised	
(1.3) Department/Service Group: *(please underline)*	Corporate Services Group *(Please specify)*	Nursing and User Experience	Un-scheduled and Acute Care	Surgery & Specialist Services	Specialist Hospitals & Women's Health	Children's Community Services	Adult Social & Primary Care
(1.4) Description of the policy/ proposal? • State the aims and objectives/key elements of the policy/proposal • Who will it impact? • Detail the changes the policy/proposal will introduce • What is the rationale (mitigation)? • How will the policy/proposal be communicated to staff /service users? • Process to implementation (involvement of stakeholders) • Describe how the policy/proposal will be rolled out/put into practice e.g. will there be changes in working patterns/changes to how services will be delivered etc? • How will the policy/ proposal be monitored to assess if effective?							

(1.5) Who owns the policy/proposal? Where does it originate? ie: DoH/HSCB. Is it Regional/following NICE guidance etc.	
(1.6) Who are the main stakeholders affected (Internal and External)? • For example, if the proposal relates to an internal reorganisation it would be reasonable to assume that staff and trade union representatives are the main stakeholders but also consider if service users or others are affected. • If the decision relates to a change in service provision it is likely that actual and potential service users will be affected. You should also consider if staff or others are affected.	
(1.7) Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders when screening this policy/proposal. • The screening process should involve engagement with stakeholders at the earliest opportunity. • In this section you should provide details of how you intend to or have involved stakeholders, views of colleagues, service users and staff and trade unions when screening this policy/proposal. Detailing stakeholder involvement will also provide evidence on meeting Personal and Public Involvement (PPI) requirements.	
(1.8) Other policies/strategies with a bearing on this policy/proposal • Specify if the policy/proposal being screened relates to a regional strategy, policy or proposal by another body,	

whether the DHSSPS, HSC Board, BSO, Trusts or agencies. • There can be a wide range of policies that are in some way linked with others. You should also include here details of relevant strategies or information that might relate to the policy. Please note that information that is not published may also be relevant to the screening. This can include working papers, results from workshops, technical reports, press coverage or conference reports. • If the policy impacts on staff, you should ensure that the Management of Staff Affected by Organisational Change Framework is followed. The modernization team in HR can assist you in the application of this framework	
(1.9) Are there any factors that could contribute to/detract from the intended aim/outcome of the policy/proposal? These may be financial, legislative or other contributions or constraints. It allows you to specify if the policy is dependent on obtaining funding or part-funding which may have an impact on the intended aim/outcome and may require an on-going screening to determine the final impact on those directly affected.	

Section 2: Classification of the Policy / Proposal

- The purpose of this Section is to consider the policy/proposal in terms of its **relevance** and likely **impact (actual/potential)** on **equality of opportunity, disability duties, good relations and human rights & *t*o consider what Reasonable Adjustments may be needed for patients/service users/staff including any information e.g. leaflets / letters in accessible/alternative formats.** Guidance on how to promote accessible services
- To **determine** the **impact (actual and potential)** of a policy/procedure on **equality of opportunity, disability duties, good relations and human rights** please **complete the screening questions at 2.1 – 2.6.**

Section 75 ('S75') equality categories include: Age, Dependent Status, Disability, Gender, Marital Status Ethnicity, Religion, Political Opinion and Sexual Orientation.

Screening Questions	**Yes**	**No**
(2.1) Is there an **impact** on **Equality of Opportunity** for those affected by this policy, for each of the S75* equality categories? I.e. is there a differential impact for one S75 group rather than the others?		
(2.2) Are there better **opportunities** to promote equality of opportunity for people within the S75 categories?		
(2.3) Does the policy **impact** upon **Good Relations** between people of a different religious belief, political opinion or racial group?		
(2.4) Are there **opportunities** to better promote good relations between people of a different religious belief, political opinion or racial group?		
(2.5) Are there **opportunities** to encourage **disabled people** to **participate** in public life and promote **positive attitudes** toward disabled people? (Disability Duties)		
(2.6) Does the policy/proposal **impact** on **human rights**?		

Screening Statement:

- If you have answered **Yes** to **<u>any</u>** of the above questions on the basis of:

  - **Positive Impact** please complete **section 2.7 'Screening Decision' and provide detail in section 2.8**

- **Negative Impact** please complete **sections 3-10**

- If you have answered **No** to **all** of the above questions the policy may be **screened out** - go to section **2.7 'Screening Decision'**

  - It should be noted that all policies are likely to have some impact on equality in how they are communicated to stakeholders (particularly in relation to disability or ethnic minority languages). You must ensure that you have considered this in line with the guidance document Making Communication Accessible for All.
  - Ethnic minority interpreters are available from NIHSCIS in a range of 35 different languages and ISL/BSL interpreters can be accessed via Action on Hearing Loss. Further guidance is available from the Planning & Equality Team

N.B: All Staff must complete their **mandatory equality, good relations and human rights training** once every five years. This can be booked via HRPTS or completed online at www.hsclearning.com. The online programme is called 'Making a Difference.' Belfast Trust staff can also access a suite of equality and diversity training including: disability awareness, human rights and embracing diversity in HSC – please contact [redacted] for more information. An Equality, Good Relations and Human Rights training manual has also been produced for staff.

(2.7) Screening Decision:

This policy / proposal is **'screened out'** on the basis that: (please tick appropriate box below)

IMPACT:	OUTCOME:
No Impact	☐ **Screened Out** as it is purely clinical or technical nature and has **no relevance** or **impact (actual / potential)** in terms of **equality of opportunity, disability duties, good relations and human rights.** ☐ **Screened Out** as Policy author has worked with the Equality & Planning team to ensure **the policy best promotes equality of opportunity** ☐ **Screened Out without mitigation** on basis policy has a **positive impact**

(2.8) Any other reasons: Please detail

Approved Lead Officer: **Position:** **Date:**		***Countersigned by*:*** **Equality Manager:** **Date:**	

Please sign and date and forward to the Planning and Equality Team for consideration - equality.team@belfasttrust.hscni.net

***Equality screenings are completed with information provided by the policy author subject to advice and assistance provided by the Trust's Equality Managers**

Section 3: Consideration of Equality and Good Relations issues and evidence used

This section records the quantitative and qualitative data you have used to consider equality and good relations issues including:

- The assessment of impact on staff and service users
- The identification of mitigation factors to reduce/remove any adverse impact
- Opportunities to better promote equality of opportunity

What do we mean by impact?

- Impact means the effect that something has on a situation, on individuals or on a group of people.
- Will there be a differential impact? Will the proposal or policy have a more significant or negative effect on some people than others?
- Evidence to help inform the screening process may be quantitative and qualitative. For example: previous consultations and equality impact assessments (EQIAs), statistics, research, complaints, feedback, referrals, grievances, inspection reports, focus groups, user groups etc.
- The absence of evidence does not mean there is no likely impact. Arrangements should be made to obtain relevant information, whether quantitative or qualitative. It is acknowledged that there is more available evidence for some of the equality categories than for others, so if having explored the available evidence, you still do not know what the implications are, it would indicate that you need to gather additional information and an equality impact assessment should be considered.
- Using the information you have gathered regarding the S75 groups, you now need to determine the level of impact of the policy/proposal. E.g. does the policy/proposal disproportionately impact on men or women? Think about multiple identities, for example women with caring responsibilities, or older people with disabilities. Please ensure you give details of the reasons for the decision taken.

(3.1) Quantitative and Qualitative Data: Service Users

Your own information systems might contain qualitative data relating to patients/service users. If you only have some of the data, just complete what you have and use proxy indicators for other groups e.g. political opinion or sexual orientation. In the absence of data it may be useful to do a survey or a snapshot of who your service users are. For the qualitative data, consider using anecdotal or professional experience in this section.

Equality Category	**Service Users**	**Quantitative Data** *(2011 Census Data unless otherwise stated)*		**Qualitative Data** (Needs, Experiences, Priorities)
		Belfast / Castlereagh population	**Service users affected %**	

1. Age	0-15 16-24 25-34 35-44 45-54 55-64 65+	22% 11% 12% 14% 14% 12% 15%		
2. Dependent Status	Caring for a child dependent older person/ person with a disability	12% of usually resident population provide unpaid care - 36% of whom are male and 64% are female		
3. Disability	Yes No	21% 79%		
4. Gender	Female Male	49% 51%		
5. Marital Status	Married/Civil Partnership Single Other/Not known	34.21% 46.6% 19.19%		
6. Race Ethnicity	White Black/Minority Ethnic	98% 2%		
7. Religion	Roman Catholic	41%		
	Presbyterian Church of Ireland Methodist Other Christian	42%		
	Buddhist Hindu Jewish Muslim Sikh Other None	17%		
8. Political Opinion Based on Council seats on Belfast City Council, October 2017. Excludes Castlereagh	DUP SF SDLP UUP APNI Green PBP IND PUP	13 19 4 6 8 1 1 5 3	*(Based on Council seats on Belfast City Council * Excludes Castlereagh)*	
9. Sexual Orientation	Opposite sex Same sex	Estimated 6-10% of persons identify as lesbian, gay, bisexual		

	Same and Opposite sex Do not wish to answer /Not known	*Source: 2012 report by Disability Action & Rainbow Project*		

(3.2) Quantitative and Qualitative Data: Staff

This information will be provided together with analysis and advice by the Employment Equality Team in the Human Resources department.

Quantitative Data: For staff data please contact Martin McGrath on [redacted] / [redacted]

Qualitative Data: Consideration will be given to the different needs, experiences and priorities of each of the categories in relation to the policy / proposal.

Should any equality/modernisation related issues arise, they will be managed through the Organisational Change Framework

When organisational/policy change is necessary, regardless of whether it is a permanent or temporary change, the Trust is committed to treating staff fairly and equitably. Staff can be assured that the change process will be properly managed. This includes consultation with staff and the opportunity for staff to discuss in one to one meetings any adverse equality impacts resulting in changes to their employment.

This Framework also works alongside other Human Resources policies including, for example, the Disability and Reasonable Adjustment Framework, the Work Life Balance Policy and Procedure, the Recruitment and Selection Policy and Procedure and Agenda for Change Terms and Conditions Handbook.

Equality Category	Groups	Quantitative Data		Qualitative Data
		Belfast Trust workforce (@January 2018)	Staff affected by the Policy/Proposal %	
1. **Age**	16-24 25-34 35-44 45-54 55-64 65+	4% 24% 26% 28% 16% 2%		
2. **Dependant Status**	Dependants No Dependants Not known	23% 19% 58%		

3. Disability	Yes No Not known	2% 67% 31%		
4. Gender	Female Male	78% 22%		
5. Marital Status	Married/ Civil P'ship Single Other/Not known	56% 34% 10%		
6. Race **a) Ethnicity**	BME White Not Known	4% 76% 20%		
b) Nationality	GB Irish Northern Irish Other Not known	18% 10% 2% 1% 69%		
7. Religion **a) Community Background**	Protestant Roman Catholic Neither	42% 50% 8%		
b) Religious Belief	Christian Other No religious belief Not known	28% 1% 8% 63%		
8. Political Opinion **** 2011 Assembly election***	Broadly Nationalist Broadly Unionist Other Do not wish to answer/Unknown Not known	6% 7% 8% 79%		
9. Sexual Orientation	Opposite sex Same sex or both sexes Do not wish to answer	41% 1% 58%		

Section 4: Consideration of Impacts, Mitigation, Alternative Policies / Proposals

Given the **evidence** gathered in Section 3 please identify for each of the **nine equality categories** the level **of impact, mitigation measures** and **alternative** policies / proposals that better **promote equality of opportunity**.

(4.1) SERVICE USERS

Equality Category	**Level of Impact**	

	Major	Minor	None	Mitigation measures and alternative policies or actions that might lessen the severity of the equality impact
Age				
Dependant Status				
Disability				
Gender				
Marital Status				
Race (Ethnicity)				
Religion				
Political Opinion				
Sexual Orientation				
Multiple Identity e.*g. disabled minority ethnic people or young Protestant men.*				

(4.2) STAFF

Equality Category		**Level of Impact**			**Mitigation measures and alternative policies or actions that might lessen the severity of the equality impact** (where Major or Minor Impact identified)
		Major	**Minor**	**None**	
Age					
Dependant Status					
Disability					
Gender					
Marital Status					
Race	**Ethnicity**				
	Nationality				
Religion	**Community Background**				
	Religious Belief				
Political Opinion					
Sexual Orientation					
Multiple Identity e.g. female staff with caring responsibilities					

Section 5: Good Relations				
Based on the **evidence** collected in Section 3 & 4: • To what extent is the policy/proposal likely to **impact Good Relations** i.e. between people of different religious belief, political opinion or racial group? • Are there any **additional measures** that could be suggested to ensure the policy or proposal **promotes Good Relations?**				
Good Relations category	**Level of impact**			**Mitigation Measures and Alternative Policies or Actions that might lessen the severity of the equality impact** (where Major or Minor Impact identified)
	Major	**Minor**	**None**	
Religious belief				All Trust staff attend mandatory Equality, Human Rights and Good Relations training which includes reference to the Good Relations duty. The Trust has a clear and well defined Good Relations strategy 'Healthy Relations for A Healthy Future 2' whereby the corporate commitment to Good Relations is underlined. The Trust will ensure that all services and all facilities are welcoming to all patients their carers and advocates regardless of their religious affiliation, political opinion and racial group. Appropriate and inclusive means of communication will be used to contact and communicate with patients, their families and carers who do not speak English as their first language. An interpreter will be booked and/or letters translated using established protocols within the Trust as appropriate.
Political opinion				
Racial group				

Section 6: Disability Duties	
How does the policy / proposal: • **encourage disabled people to participate in public life** *and* • **promote positive attitudes towards disabled people?** Consider what **other measures** you could take to meet these **duties.**	Appropriate and inclusive means of communication will be used to communicate with patients and carers. Staff will be mindful of any reasonable adjustments required in the implementation of this policy for both patients and carers. All Health and Social Care staff are required to undertake mandatory equality training which includes disability duties. Disability Awareness Training is provided throughout the year, available on HRPTS. Bespoke Disability awareness training sessions can also be provided for staff teams on demand, when it is feasible to do so.

For example, have staff received disability equality training.	The Trust has produced a suite of guidance for increasing access to services and information. These are all available on the hub or on request from the Planning & Equality team.

Section 7: Human Rights
Belfast Health and Social Care Trust is committed to providing the **highest attainable standard of health** within our resources.

Does the policy/proposal engage any of the following human rights?
The rights particularly relevant in the delivery of health and social care, are emboldened below. Examples for these rights and further info can be found in the Toolkit.

Article	Yes	No
A2: Right to life		
A3: **Right to freedom from torture, inhuman or degrading treatment or punishment**		
A4: Right to freedom from slavery, servitude & forced or compulsory labour		
A5: Right to liberty & security of person		
A6: Right to a fair & public trial within a reasonable time		
A7: Right to freedom from retrospective criminal law & no punishment without law		
A8: Right to respect for private & family life, home and correspondence.		
A9: Right to freedom of thought, conscience & religion		
A10: Right to freedom of expression		
A11: Right to freedom of assembly & association		
A12: Right to marry & found a family		
A14: Prohibition of discrimination in the enjoyment of the convention rights		
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property		
1st protocol Article 2 – Right of access to education		

If you answered **YES** to any of the above, please refer to the Human Rights Screening Tool below to check if the policy is likely to be human rights compliant.

- If the flowchart indicates that the policy is **unlikely** to be human rights compliant, you may need to seek legal advice at this point.
- If the flowchart indicates that the policy is **likely** to be human rights compliant please **continue to section 7.1**

(7.1) Outline any actions you will take to **promote awareness of human rights** and **evidence** that human rights have been taken into consideration in decision making processes:

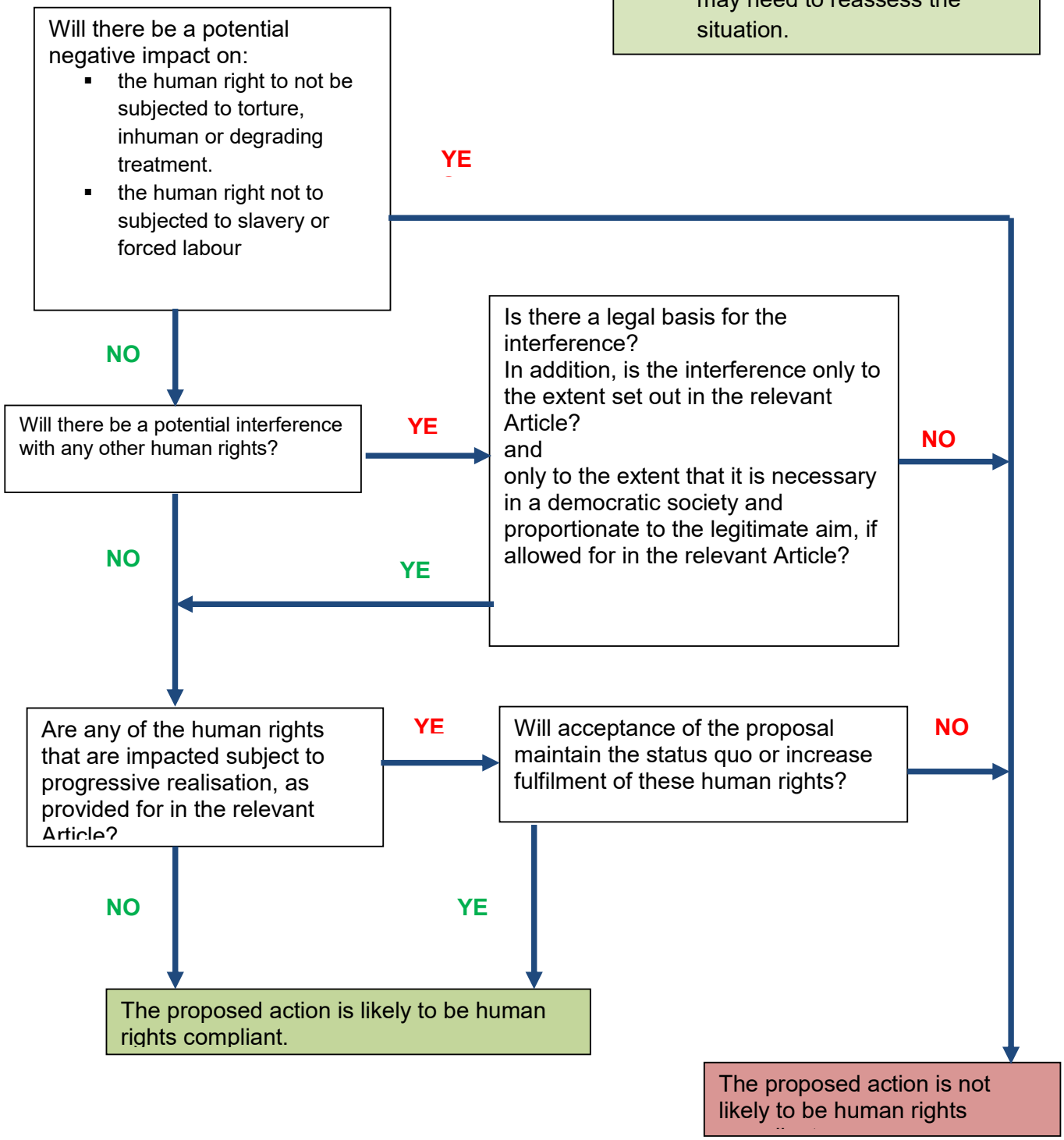
The Trust is committed to promoting, protecting and respecting human rights in all aspects of its work and will ensure that human rights are considered as an integral part of its actions and decision-making processes. The Trust acknowledges the importance of taking a human rights based approach and will endeavor to ensure that the principles of human rights underpin all areas of work across the organisation.

Human rights training is available throughout the year for any staff member who wishes to attend. Bespoke human rights training sessions can be delivered for staff groups on demand and a large number of resources relating to human rights in health and social care can be made available by the Equality and Planning team. As referenced in section 2.6, mandatory Equality training for staff and Managers also covers the area of human rights.

Human Rights Screening Tool

To be used by staff who have received human rights training

- Be alert to any possibility that the proposal may **discriminate** against someone in the exercise of their human rights.
- Legal advice may still be necessary.
- Things may change and you may need to reassess the situation.



Section 8: Screening Decision

(8.1) Given the detail provided from sections 1-7 of this template, how would you categorise the impacts of this policy / proposal?

(Please complete details required for one of the options below)

Tick ONE:	IMPACT:	OUTCOME: (Tick as appropriate)
	Major Impact	☐ **Screened In for EQIA** as it is **significant i**n terms of its **strategic importance.** ☐ **Screened In for EQIA** as it is **significant** in terms of **expenditure.** ☐ **Screened In for EQIA** as **further assessment** offers a valuable way to examine the evidence and **develop recommendations.**
	Minor Impact	☐ **Screened Out with Mitigation Required to** better promote equality of opportunity, disability duties, good relations and human rights. ☐ **Screened Out with Mitigation & Ongoing** to adopt appropriate mitigating measures and monitor accordingly.
	No Impact	☐ **Screened Out** as it is purely clinical or technical nature and has **no relevance** or **impact (actual / potential)** in terms of **equality of opportunity, disability duties, good relations and human rights.** ☐ **Screened Out** as Policy author has worked with the Equality & Planning team to ensure **the policy best promotes equality of opportunity** ☐ **Screened Out** on basis policy has a **positive impact**

(8.2) Please give reasons for your decision and detail any mitigation you have considered.

Section 9: Monitoring
(9.1) Please detail how you will **monitor** the effect of the policy/proposal for impact in terms of **equality of opportunity**, **good relations, disability duties** and **human rights?**

Section 10: Sign Off			
Please sign /date and forward to the Equality and Planning Team for consideration - [redacted].			
Equality screenings are completed with information provided by the policy / proposal author subject to advice and assistance from the Trust's Equality Managers.			
Please note that Completed and Signed Screening Templates are public documents and are posted on the Trust's website.			
Approved Lead Officer		**Countersigned by:**	
Position		**Equality Manager**	
Date		**Employment Equality Manager**	

Belfast Health and Social Care Trust
caring supporting improving together

INVOLVING YOU

from 'Them and Us' to 'We'

Connecting Personal and Public Involvement, Co-production and Patient Experience in Belfast Health and Social Care Trust

2021 - 2024

Personal and Public Involvement (PPI) Involving you, improving care

Working together Excellence Openness & Honesty Compassion

HSC Values

Contents

Introduction

Belfast Health and Social Care Trust delivers a wide range of health and social care services to the population of Belfast. In addition, the Trust provides the majority of regional specialist services across Northern Ireland.

This Strategy sets out Belfast Health and Social Care Trust's vision, commitment and integrated approach to Patient and Client Experience (PCE), Personal and Public Involvement (PPI) and Co-production (see Appendix 1).

Service users and carers will be at the heart of everything we do. Belfast Health and Social Care Trust actively seeks the views and involvement of our service users and carers and aims to engage them in developing and improving our services in partnership with BHSCT staff. Involvement of service users and carers will be central to the work of all staff in order to help us to shape our services to meet their needs, improve patient experience, and enable us to use our resources in ways that have the greatest impact on their health and wellbeing.

Involvement is a priority for all Health and Social Care organisations, as well as other statutory organisations, for example, Councils. BHSCT will work with partner organisations to develop involvement opportunities and share learning.

Whilst those service users and carers who become involved in helping us shape and develop our services give freely of their time, they are not recruited as part of the Trust volunteer programme.

For further information on the Trust Volunteering programme, please contact:

VolunteerRecruit@belfasttrust.hscni.net

[1] For the purpose of this strategy the term "service user" is used to describe patients, clients, service users and the general public accessing our services. The term "carer" is used to describe unpaid family carers who provide significant care to a relative or friend.

Context

Effective involvement is a priority outlined in the Department of Health's (DOH) Health and Wellbeing 2026 – Delivering Together Strategy. PPI has been a legal requirement since 2009 (Appendix 2) and has been further enhanced by the DOH Co-production Guidelines which were published in 2018. Patient and Client Experience standards have been in place since 2009. These standards relate to:

- Respect
- Attitude
- Behaviour
- Communication
- Privacy and dignity

In August 2018, the Chief Nursing Officer for Northern Ireland asked Trusts to create a single plan which builds on and brings together existing PPI, Co-production and Patient Experience work. Within Belfast Trust, this includes Patient Experience Standards, the Patient Experience Collaborative/real time feedback, 10,000 More Voices and Care Opinion.

The involvement work which will be progressed through this strategy will complement and link closely with work on Equality, Human Rights, Community Development and Community Planning.

Our Approach

Health and Social Care values (working together, excellence, openness and honesty, and compassion) underpin everything we do and support our commitment to achieving safe, effective and compassionate care for everyone. We recognise that a culture that supports involvement has a major part to play in achieving these values. This Strategy puts these values and the people who use our services at the centre of decision making so a positive change can be made to the services we deliver.

This Strategy has been co-produced with services users, carers and staff, using a range of methods including a workshop, a working group which included service users and carers, and consultation with service users, carers and community and voluntary sector groups.

Purpose

The Strategy is underpinned by the Belfast HSC Trust strategic vision "to be one of the safest, most effective and compassionate health care organisations". Involving our service users and carers in improving our services and our patient experience is pivotal to realising this vision.

This Strategy sets out through a range of actions, how we will:

- Develop meaningful involvement of service users and carers in setting direction and transforming our services, particularly in light of the Covid-19 pandemic in 2020 and recent service and governance reviews
- Make better use of service user and carer experience data to improve opportunities for involvement
- Provide assurance on how the legal duty to involve service users and carers is being achieved
- Continue to develop a culture of involvement within Belfast Trust, working at all levels within the organisation.
- Ensure that involvement is core to the work of all staff within Belfast Trust.

The Ladder of Involvement

In this plan, the term "involvement" is used to describe a wide range of activities across the ladder of involvement, from patient feedback to co-production.

The Ladder of Involvement (Appendix 3) is a widely used model within healthcare and other sectors for describing the range of service user and carer involvement. This comprises a wide range of activities that includes giving feedback on services, sharing stories and experiences, involvement in focus groups and consultation sessions and working as equals on strategy groups.

Different levels of involvement are appropriate at different times and in different circumstances. Service users and carers should be involved at a level that is most appropriate for them.

An Impact Framework

Linking to the Ladder of Involvement and, in recognition of co-production being a mind-set, capturing the journey to meaningful involvement is essential if we are to demonstrate positive change across the organisation.

We want to enable and facilitate staff, service users and carers to plan projects and capture the impact of their work. We have proposed tools for staff to do this in partnership with service users and carers. These are detailed below and the tools are included in Appendix 4 of this document.

1) Involvement Project Impact Template

Teams can use this template to consider and capture the anticipated impact of their involvement work. It uses Theory of Change model as a practical framework to apply in thinking about, planning for and capturing outcomes.

2) Involvement Star Tool

This tool is based on best practice within co-production. We have adapted this for use with teams to provide a 'before and after' snapshot of their work. It aims to look at where a team starts at the initial project stage and then capture and measure how much progress they have made at the end of the project.

Key Themes

The Strategy sets out five key themes against which progress will be measured:

1. **Structures and Co-operation** – we will create an integrated process for governance and accountability for involvement

2. **Building Relationships and Involvement** – we will create a range of meaningful and influential involvement opportunities for individual service users, carers, relevant groups and networks

3. **Training and Capacity Building** – We will provide opportunities and tools for enhancing learning, leadership and personal development to increase understanding of involvement and enable strong collaborative relationships and impactful involvement, for staff, service users and carers

4. **Communication** – we will communicate about our work in a way which is informative and engaging to motivate genuine involvement across our stakeholder communities

5. **Impact of Involvement** – we will demonstrate clearly, and evidence the effectiveness and impact of involvement on BHSCT services and the improved outcomes for service users and carers.

These key themes tie directly with the Department of Health's co-production principles as outlined in the table on the next page:

STRATEGY THEME		CO-PRODUCTION
1.	Structures and co-operation	Enabling and facilitating Reciprocal recognition
2.	Building relationships and Involvement	Building representative networks Valuing people Cross-boundary working
3.	Training and capacity building	Building people's capacity Reciprocal recognition Enabling and facilitating
4.	Communication	Cross-boundary working Building representative people networks Valuing people
5.	Impact of involvement	Valuing people Enabling and facilitating

https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

KEY THEME 1: Structures and Co-operation

We will create processes and structures to support a positive culture of involvement.

We will achieve this by:

- Developing a process for governance and accountability for involvement, agreed at executive level and communicated throughout the organisation. This will ensure a joined-up approach to patient experience and PPI work
- Ensuring that each Division has a named senior leader for involvement
- Ensuring that Directorates and Divisions develop and implement annual Involvement plans as an integral part of their management plans, and submit 6 monthly progress reports – these should focus on strategic priorities within the service
- Ensuring service user and carer representation on the Trust Involvement Steering Group
- Developing the role of the Involvement Steering Group to quality assure involvement activity across Divisions and provide feedback to them
- Creating opportunities for shared learning and joint working between patient experience, PPI and Co-production
- Developing a business partnership model between the Trust Involvement team and Divisions, to ensure that there is appropriate support in place

We will measure our progress by:

✓ Having in place a clear accountability and governance structure and processes for involvement

✓ The production of Annual Involvement Plans from each Directorate

✓ The production of six-monthly Progress Reports on Annual Involvement Plans from each Directorate/Division

KEY THEME 2: Building Relationships & Involvement

We will create a range of meaningful and influential involvement opportunities as appropriate to individual service users and carers, and relevant groups and networks.

We will achieve this by:

- Divisions identifying opportunities for involvement to directly influence transformation of services and quality improvement, aligned with the strategic direction of the Trust
- Ensuring that Divisions analyse a wide range of data to identify potential service developments and opportunities for involvement, including complaints, service user and carer feedback, care opinion, surveys and other relevant reports
- Divisions actively recruiting new service users and carers to become involved in the work of the Trust, and identify opportunities which align with their areas of interest
- Capitalizing on the enhanced capacity within the Carer Support Service to develop a programme of target involvement with family carers
- Ensuring that specific efforts are made to include representation from BAME communities and other harder to reach groups
- Developing an involvement network of service users, carers and groups to strengthen connections with the Trust
- Strengthening relationships with colleagues and partnerships in the community and voluntary sector to promote opportunities for involvement
- Recognising and valuing the involvement of service users and carers, through annual recognition events, Involvement awards and ensuring that service users and carers are provided with feedback on changes they have influenced
- Ensuring the implementation of the regional policy to pay out of pocket and other expenses
- Supporting staff to develop a range of opportunities to seek service user and carer feedback, including 10,000 Voices and Care Opinion and develop the work of Annie Laverty to ensure more opportunities for real-time feedback

We will measure our progress by:

- ✓ Increasing the number of service users and carers involved by 10% year on year, broken down across Involvement projects, quality improvement work, transformation work
- ✓ Having a detailed profile of our existing databases and other information assets across the organisation which can be potentially linked / co-ordinated to support our Involvement Network
- ✓ Increasing the number of service users and carers being reimbursed for out of pocket expenses by 10% year on year
- ✓ Evaluating the Involvement celebration event
- ✓ Carrying out sample surveys with service users and carers and other partners to capture their experience of involvement with BHSCT services and projects
- ✓ Capturing stories of success and awards we receive to reflect achievement

KEY THEME 3: Training & Capacity Building

We will provide opportunities and tools for enhancing learning, leadership and personal development to increase understanding of involvement and enable strong collaborative relationships and impactful involvement, for staff, service users and carers

We will achieve this by:

- Having a more detailed understanding of teams' training and learning needs to enable them to develop the required skills and confidence to lead their own involvement approaches to deliver on their business plans
- Developing, implementing and reviewing a programme of induction and training for service users and carers who are involved at all levels
- Reviewing current training to ensure that it incorporates all levels of involvement as defined in this document
- Introducing and capturing best practice and innovative approaches to involvement work and share this across the BHSCT and other HSC organisations
- Continuing with the delivery of our suite of Involvement training and tools (such as GREAT, Engage and Involve and SCOPE).
- Working with colleagues in Organisational Development and Quality Improvement to nurture involvement skills, develop Quality Improvement and online learning resources for staff, service users and carers
- Creating a menu of learning and training opportunities liaising with Divisional teams (e.g. group facilitation, appreciative inquiry and collective leadership skills).
- Surveying service users and carers on the learning and capacity building support they would like us to develop. This should include capacity building in virtual engagement tools and technologies.
- Reviewing the information on the involvement page of the Trust intranet HUB and the Involving You section of the internet page
- Facilitating at least 4 networking / sharing good practice events per year

We will measure our progress by:

- ✓ Increasing the number of staff from all professions and grades completing the involvement e-learning/face to face training by 10% year on year
- ✓ Increasing the number of service users and carers trained by 10% year on year
- ✓ The number of people attending good practice and networking events
- ✓ Evaluating the participants experience of training, good practice and networking events
- ✓ Analysing visitor traffic to our Involvement HUB page and Involving You section of the Trust website

KEY THEME 4: Communication

We will communicate about our work in a way which is informative and engaging to motivate genuine involvement across our stakeholder communities.

We will achieve this by:

- Clearly communicating the aim of the plan to service users and carers and staff across the Trust and developing different communication approaches which generate opportunities for services users and carers to actively engage with our involvement plan
- Developing innovative ways to maintain involvement communication through remote and virtual technologies, including creating virtual spaces to connect and continue involvement work remotely
- Developing our range of updates and feedback information on service achievements and outcomes of service user and carer involvement
- Publicising opportunities for service users and carers to get involved and give feedback, including Care Opinion https://www.careopinion.org.uk/
- Developing a plan for digital engagement through our BHSCT social media platforms to expand our online community to promote involvement opportunities, communicate updates/ feedback and good news stories
- Publicise opportunities for involvement in local community and voluntary newsletters and via health forums and support groups across Belfast

We will measure our progress by:

✓ The number of social media posts relating to involvement opportunities

✓ Production of PPI newsletters and updates in a variety of formats, including easy read, for service users, carers and community stakeholders distributed on a quarterly basis.

✓ Increasing the number of people receiving the newsletter by 10% year on year

✓ The number of virtual involvement opportunities developed

✓ Producing an Involvement report each year

✓ Analysing feedback from social media activity and Care Opinion

KEY THEME 5: Impact of Involvement

We will evaluate and evidence the effectiveness and impact of Involvement on BHSCT services

We will achieve this by:

- Establishing a baseline of current Involvement activity across the Trust
- Each Directorate Involvement plan will develop measures to demonstrate the impact of involvement, with a focus on transformation and strategic work
- Piloting and implementing impact indicators to chart and capture how involvement has made a difference in strategic development and service outcomes, including piloting the Involvement Impact Template and Involvement Star Tool and the Involvement Outcomes Framework for Health and Social Care
- Producing an Annual Involvement Report to meet our PPI and performance reporting requirements
- Working with the Patient Client Council and Public Health Agency to develop a process which will provide external monitoring of the implementation of this strategy

We will measure our progress by:

✓ Increasing the range of opportunities for service users and carers to provide feedback and as a result demonstrate a reduction in complaints

✓ The use of our impact framework and tools across Divisional staff teams, recording how they have developed and their 'distance travelled' in their involvement approaches to improve their service outcomes

✓ Surveying staff and service users, carers and other relevant stakeholders on the impact of the involvement support provided on their work and personal development.

Next Steps

A yearly action plan will be produced to provide detail on how the actions outlines under each key theme will be delivered.

If you would like further information about involvement in Belfast Health and Social Care Trust, or are interested in getting involved, please contact: PPI@belfasttrust.hscni.net

Appendix 1 - Definitions

Personal and Public Involvement (PPI)

As defined in the Health and Social Care order (2009), PPI is the term used to describe the active and meaningful involvement of patients, clients, service users, carers and communities in Health and Social Care in ways that are relevant to them.

PPI is the active participation of patients, clients, service users, carers and the public in how services are planned, delivered and evaluated. This includes developing relationships, building strong active partnerships, and having meaningful conversations with a range of stakeholders to create services that best meet patients' needs.

Personal refers to service users, patients, carers, consumers, customers, relations, advocates or any other term to describe people who use Health and Social Care services as an individual or part of a family.

Public refers to the general population and includes locality, community and voluntary groups and other collective organisations.

Involvement means more than consulting and informing. It includes engagement, active participation and partnership working.

In 2015, the Public Health Agency (PHA), working with partner health and social care organisations, service users and carers, developed five standards and associated key performance indicators for PPI in health and social care. The aim of the PPI standards is to set out what is expected of health and social care organisations and forms the basis against which progress will be monitored. More information about PPI and the five standards can be found here:

https://www.publichealth.hscni.net/publications/setting-standards-%E2%80%93-personal-and-public-involvement-ppi

Co-production

Co-production is a highly person centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery and experience of Health and Social Care. It is a genuine partnership approach to finding shared solutions.

In practice, this involves staff, service users and carers partnering from the start to the end of any change that affects them. It empowers people to influence decision-making and service delivery. Achieving genuine and meaningful co-production takes time and commitment.

More information about co-production can be found in the Department of Health's Co-Production Guide, Connecting and Realising Value Through People:

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSCB-Co-Production-Guide.pdf

Patient and Client Experience

Patient & Client Experience (PCE) is about people's perception of the quality of the care they receive. It relates directly to the experience the patient receives when they are interacting with the health and social care system. PCE is a key indicator of quality and is measured against a set of five standards, published in the Department of Health's 'Improving the Patient and Client Experience' document in April 2009, which focus on:

1. RESPECT
2. ATTITUDE
3. BEHAVIOUR
4. COMMUNICATION
5. PRIVACY AND DIGNITY

The development of the standards included a significant consultation and involvement of patients, carers and services users or their representatives. More information about the patient experience standards can be found here:

https://www.nidirect.gov.uk/articles/patient-standards

The Trust has undertaken a comprehensive programme of work since 2009 to support the implementation of the Patient and Client Experience standards.

The range of tools and methodologies for monitoring compliance against the five standards include:

- Gathering Patient/Client stories
- Reviewing compliments and complaints
- Completing observations of practice
- Completing patient satisfaction surveys
- Completing audits of organisational arrangements

The Trust monitors progress towards meeting the standards through its Patient Client Experience Work Plan.

In addition, the 10,000 More Voices project continues to capture the experiences of people involved in healthcare services, including patients, clients, carers and staff. It is a powerful technique to support commissioning decisions, which offer improved quality, safety and patient/client experience.

Understanding and improving how patients experience their care is a key component to the successful delivery of high quality care. The Trust remains committed to exploring new, innovative ways to collect patient and service user feedback, and use the information to improve care. Recently, the Trust, in partnership with a number of Trusts from across the UK, joined the Patient Experience Collaborative. Using established and evidenced domains of care, the Trust collects real time feedback from patients in Inpatients areas. The Trust provides this vital information back to the service area to inform and enable real time service improvement where required. Real time patient feedback provides a platform to inform staff of things they are doing well and things that have a positive impact on patient experience, and also highlight things that are not being done so well, need improvement or have a negative impact on patient experience.

Appendix 2

The Health and Social Care (Reform) Act (NI) 2009 placed a statutory duty of involvement and consultation on health and social care organisations. The legislation requires that service users and carers are involved in and consulted on the:

- Planning and provision of care;
- Development and consideration of proposals for change in the way that care is provided; and
- Decisions that affect the provision of care.

Involvement Level	What This Means	Examples
Co-producing	Involving service users and carers in equal partnership and involving them at the earliest stages of service design, development and evaluation	Involvement on strategy groups and steering groups
Co-designing	Sharing decision making power with service users and carers and working in partnership to improve experience	Involvement in reference groups, citizens panels, task and finish groups
Engaging	Service users and carers can make suggestions and influence outcomes	Involvement in service user / carer panels and groups, focus groups, 1-1 interviews
Consulting	Service users are asked what they think about pre-determined plans. There is limited influence	Surveys, focus groups, 1-1 interviews
Educating	Service users and carers are told what is happening and reasons for this	Information leaflets, newsletter, promotional materials
Informing	Service users and carers are told what is happening and have no influence	Websites, newsletters, letters, press releases

Adapted from Arnstein's Ladder of Participation (S. Arnstein, 1969)

Appendix 4 - Integrated Involvement Planning and Reporting Tools

1. Involvement Project Impact Template

Plan sections	What is recorded
Strategic outcomes	Impacts from the work relevant to: • Trust Corporate Plan • Five Key Themes for • involvement
Service / project outcomes	The difference the work has made for service users/carers communities/staff e.g. Changes made to service pathways as a result of this work have resulted in…
Outputs	What is produced from the project e.g. We have a new service pathway and 40 staff are now trained in our new processes and policies.
Activities	What the work was about and how the team worked e.g. We created with service users, carers and community partners a Collaborative Forum. This Forum developed our project plan and decided the outcomes we wanted to achieve. Staff with service users also co-designed and co-delivered a training programme for staff.
Enablers (internal and external factors)	What the work depends on to be successful e.g. willingness of service users and carers to work with the team and the openness of senior managers to change our existing pathway.
Inputs	What was used to support the work e.g. guidance and training from the PPI team and a best practice visit to another local project.
Evidence	Why the work happened – what information supported this e.g. patient experience feedback
Assumptions	The team check and question their assumptions about their work across all of the above project levels. E.g. if we do X here, that will lead to Y result.

2. Involvement Star Tool

We have drafted this Involvement Star Tool for teams to use at their earliest stages of thinking about their involvement work. It aims to help the team gauge realistically where they are starting from. It also helps them to identify support their work may need and to draft a good project plan.

This tool would also be used to capture where the team feel they are at when their project has finished to measure impact and distance travelled.

Involvement Star Tool - A Project Team Example

5 KEY THEMES	NOT THERE YET	BASIC	MAKING PROGRESS	EXCELLENT
Structures and co-operation	We have very limited experience in doing PPI reports or developing PPI plans.			
Building relationships and involvement		We have good relationships with two small local charities. We have no structures or groups set up where we have worked directly with a group of our service users.		
Training and capacity building			All of our team have recently completed collaborative leadership training as part of our QI work as we really want to develop our involvement work with service users.	

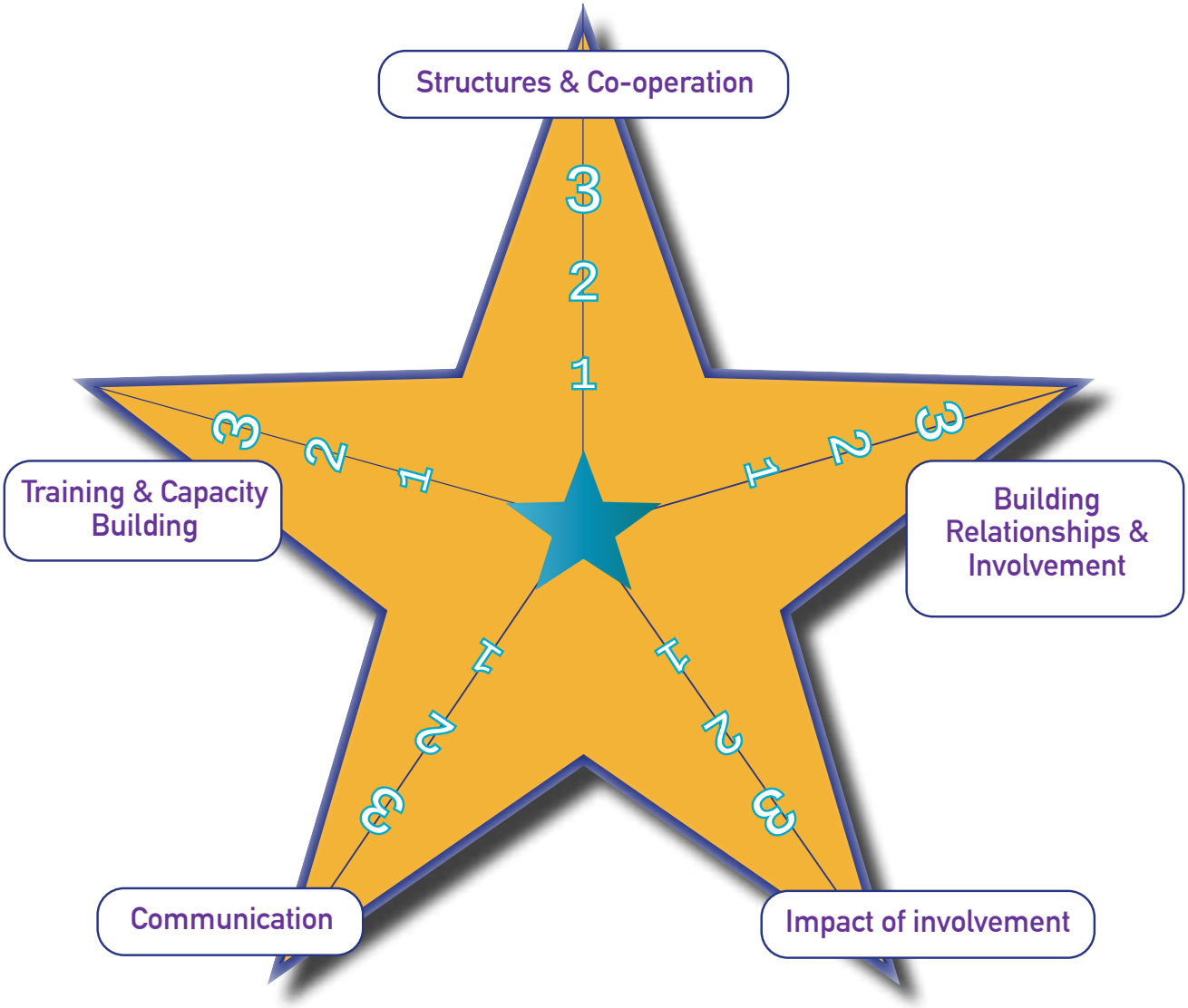
5 KEY THEMES	NOT THERE YET	BASIC	MAKING PROGRESS	EXCELLENT
Communication				We have a quarterly email newsletter about our work to service users. Our team also use Twitter a lot to profile our work.
Impact of involvement	Again, we have not recorded a lot of PPI information about our work.			

Communication Help we think we need for our involvement project	• Help with developing a proper PPI project plan and how we go about capturing impacts and reporting on these. • How we go about connecting and setting up a group of service users and other relevant stakeholders for this project. We're not sure what help we can access in the Trust to support us on this. • How we can do really good community outreach for this project to get different people involved who we might never have worked with before.

Involvement Star Tool

Scoring:

- 'not there yet' = 0
- 'basic = 1
- 'making progress' = 2
- 'excellent'= 3



Appendix 5: Glossary of Terms

Directorates

The Trust is broken down into 10 Directorates. Each Directorate has responsibility for delivering a range of different services. Some Directorates deliver clinical services, while some deliver support services for example finance and estates management.

The Trust Directorates are:

- Medical Directorate
- Unscheduled and acute care
- Surgery and Specialist Services
- Specialist Hospitals and Women's Health
- Children's Community Services
- Adult Social and Primary Care
- Finance, Estates and Capital Development
- Human Resources and Organisational Development
- Nursing and User Experience
- Planning, Performance and Informatics

Divisions

Each Directorate is broken down into smaller Divisions, which have responsibility for the delivery of specific services, for example, within Adult Social and primary care there are three Divisions – Learning Disability, Mental health and Older peoples services. Each Division is managed by 3 senior leaders, who form a collective leadership team.

SCOPE training

SCOPE is a training programme for service users and carers which was developed in partnership with the Southern Trust. It stands for Service user and carer – opportunities for participation and engagement. The training programme in an introduction to involvement and aims to help service users and carers become more confident about getting involved with the Trust.

Engage and Involve Training

This is a training programme which is primarily aimed at staff. The training aims to help staff develop the knowledge and skills that they need to be able to develop effective involvement within the areas where they work.

GREAT Checklists

The GREAT checklists were developed to support staff, service users and carers who want to get involved in quality improvement work. The checklists provide a list of useful points for people to consider when planning involvement.

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Safety, Quality & Standards Directorate
Office of the Chief Medical Officer

Department of
Health, Social Services and Public Safety
An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

Castle Buildings
Stormont Estate
Belfast BT4 3SR
Tel: [redacted]
Fax: [redacted]
Email: [redacted]

Your Ref:
Our Ref:
Date: 12th September 2007

Circular: HSC (SQSD) 29/07

For action:

Chief Executive Designate, HSC Authority
Chief Executives, HSS Boards
Regional Director of Public Health and Care Standards Designate, HSC Authority
Chief Executives, HSC Trusts
- for cascade to relevant staff, including CSCG leads

Chief Executives, Special Agencies
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices.

For information:

Chief Officers, HSC Councils
Directors of Public Health, HSS Boards
Directors of Social Services, Dentistry, Pharmacy, Nursing, Primary Care in HSS Boards and HSC Trusts
Director of Social Care & Children's Services Designate, HSC Authority
Regional Director of Commissioning Designate, HSC Authority
Medical Directors, HSC Trusts
Chief Executive, Regulation & Quality Improvement Authority
NI Children's Commissioner
NI Commissioner for Complaints
Equality Unit, OFMDFM
Professor R Hay, Head of School of Medicine and Denistry, QUB
Professor James McElnay, Dean of Life and Health Science, QUB
Professor Hugh Mc Kenna, Dean of Life and Health Science, UU
Professor Jean Orr CBE, Head of School of Nursing and Midwifery, QUB
Professor Sean Gorman, Head of School of Pharmacy, QUB
Dr Carol Curran, Head of School of Nursing, UU
Professor Geraldine Macdonald, School of Sociology, Social Policy and Social Work
Ms Mary Mc Colgan, Head of School of Sociology and applied Social Studies
Director, Northern Ireland Clinical and Social Care Governance Support Team

Chief Executives NIMDTA, NICPPET, NIPEC, NISCC

Dear Colleague

GUIDANCE ON STRENGTHENING PERSONAL AND PUBLIC INVOLVEMENT IN HEALTH AND SOCIAL CARE

1. INTRODUCTION

1.1 This guidance is intended to assist Health and Social Care (HSC) organisations improve the quality and effectiveness of user and public involvement as an integral part of good governance arrangements and to support the development of a more patient and user-centred HSC envisaged by the reform programme.

1.2 It does not place new requirements on the HSC, rather it seeks to clarify and standardise good practice in implementing existing policy requirements and statutory responsibilities. As such, the guidance provides explicit, strategic direction about what the Department means and expects of HSC organisations in terms of implementing user and public involvement and seeks to build on what already exists. It sets out principles of good practice and provides a framework of self-evaluation to assist HSC organisations integrate PPI into the organisation's governance arrangements.

1.3 Effective service user and public involvement is central to the delivery of safe, high quality services and as such is a key element of clinical and social care governance which provides the framework for quality improvement and assurance of the quality of services commissioned or provided by HSC organisations[1].

1.4 Statutory requirements to consult and involve people are already enshrined in Equality[2] and Disability[3] legislation. The proposed new statutory duty of public involvement and consultation in the draft Health and Social Services (Reform) (Northern Ireland) Order 2007 (draft Reform Order[4]) will place a new requirement on all HSC organisations. It is therefore timely for the DHSSPS (the Department) to provide guidance to support HSC organisations to maintain and strengthen the voice of service users and carers in the new arrangements for the commissioning and delivery of services under the Reform of Public Administration (RPA).

1.5 This circular provides HSC organisations with guidance to strengthen and improve service user and public involvement in the planning, commissioning, delivery and

[1] The following are the Health and Social Care organisations: -
(a) the 4 HSS Boards (and in time, the appropriate regional structure(s));
(b) HSC Trusts;
(c) HSC Councils (and in time, the appropriate regional structure(s));
(d) Family Practitioner Services; and
(e) Special Agencies.

[2] Section 75 of the Northern Ireland Act 1998

[3] Section 49A of the Disability Discrimination Act 1995 (as amended by the Disability Discrimination (Northern Ireland) Order 2006)

[4] Now the HSS (Reform) Bill

evaluation of services as part of their clinical and social care governance arrangements. It has been developed in collaboration with service users, carers, local communities and service providers (See Annex 1 for summary of methodology).

This circular should be read in the context of guidance already issued on the implementation of clinical and social care governance (HSS (PPM) 10/2002) and the associated ***Quality Standards for Health and Social Care – Supporting Good Governance and Best Practice in the HPSS*** (DHSSPS, March 2006) (the Quality Standards).

It should also be noted that The Health & Social Care Authority Designate is working with a wide range of people, organisations and representative groups to establish a 'Stakeholder Involvement Network' for Northern Ireland. This will include individuals, organisations and groups not directly involved in the provision of health and social care services, but who may represent those who use the service or who make a contribution in fields that impact on broader determinants of Health and Wellbeing, for example the Northern Ireland Housing Executive, District Councils or Department of Social Developement.

The network is expected to be formally established in late autumn 2007, and the Department will work with them to ensure there is a consistent and transparent approach to stakeholder involvement at the regional level.

1.6 The Department recognises that many HSC organisations already have excellent systems and processes in place and are effectively involving people in plans and decisions about service provision. However, it is also recognised that more can always be done to improve the uniformity of approaches and to enhance the commitment to involve people in the planning, commissioning and delivery of services.

1.7 The purpose of this circular is to:

- strengthen personal and public involvement (PPI) in every HSC organisation;
- promote greater uniformity and consistency in PPI activity across HSC organisations;
- improve the quality of the individual's experience of HSC services by involving people in plans and decisions about their own care or treatment and learning from their experiences to improve service delivery;
- ensure HSC organisations take the public's views into account in the planning, commissioning, delivery and evaluation of services; and
- support the integration of PPI into individual and organisational clinical and social care governance arrangements within HSC organisations.

1.8 This guidance is intended to help HSC organisations improve their current practice of involvement through a process of self-evaluation against principles of good practice. It is for each organisation, together with service users, carers, staff and local communities to determine how best to involve people in the planning, commissioning,

delivery and evaluation of services using the principles set out in this paper as a framework for good practice. The core aim is to strengthen PPI in HSC organisations as a means of improving the quality of services.

1.9 This guidance is intended for use by all HSC organisations including policymakers, planners, commissioners, service providers (including primary, community and tertiary care), inspectors and regulators. Therefore, it applies to all HSC staff and requires their commitment to effect change. As such, the guidance should be circulated widely throughout the organisation.

1.10 The guidance is not intended to cover relationships between different professions or services within HSC organisations or relationships between HSC organisations and other external health or social care agencies.

2. PERSONAL AND PUBLIC INVOLVEMENT (PPI) – A WORKING DEFINITION

2.1 People have a wide variety of relationships with HSC organisations. Most obviously when they are users of these services. They can also be relatives, friends or neighbours of service users. They can be voluntary workers, members of community groups or employees of voluntary organisations. In short, there is already significant involvement by people and the public in relation to HSC services.

2.2 There is no consensus on the use of terms or definitions for these people and public. Therefore, for the purpose of this guidance '*Personal and Public Involvement*' is used as an umbrella term to encompass the many different terms in use.

2.3 "*Personal*" refers to service users, patients, carers, consumers, customers, relations, advocates or any other term used to describe people who use HSC services as individuals or as part of a group, e.g. a family. "Personal" is the preferred term for anyone who uses the service because:

- there is no consensus among people who use services about how they wish to be described;
- it is a generic term that is inclusive of persons in receipt of a health service or a social care service;
- it reflects the personal nature of the care or treatment people receive from our services.

2.4 "*Public*" refers to the general population and includes locality, community[5] and voluntary groups and other collective organisations. Individuals who use health and social care services are also members of the general public.

2.5 "*Involvement*" means more than consulting and informing. It includes engagement, active participation and partnership-working. "Involvement" is the preferred term

[5] A community may define itself by geography, by affiliation or by interest, as for example a community affected by a specific disease, disability or chronic condition.

because it is the term used in the proposed new statutory duty of public involvement and consultation in the draft Reform Order.

2.6 PPI should be part of everyday working practice, underpinning communications and decisions regarding care or treatment. It should be an integral part of service planning, commissioning and delivery. It means discussing with those who use our services and the public: their ideas, your plans; their experiences, your experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.

2.7 Involving individuals, who use your services, in plans and decisions about their specific care or treatment needs is an integral part of PPI. PPI is also about involving local communities or the general population where the issues are of broad public concern or interest, such as, the location or nature of local services. PPI is about empowering people and communities to give them more confidence and more opportunities to influence the planning, commissioning and delivery of services in ways that are relevant and meaningful to them.

3. REFORM AND MODERNISATION OF HSC SERVICES

3.1 The reform and modernisation of HSC services under RPA aims to put in place structures which are person-centred and responsive. Structures, where individuals and local communities are actively engaged in their own health and wellbeing and in improving and shaping local services.

3.2 The Department's commitment to strengthening the voice of those who use the services and ensuring the public has a stronger voice in priority setting and decisions is reflected in the proposed new statutory duty of public involvement and consultation in the draft Reform Order. This will require all organisations to embed PPI as part of organisational activity.

3.3 This guidance sets out the principles of good practice in PPI which will provide a benchmark of good practice for involvement activity.

4. THE CASE FOR PERSONAL AND PUBLIC INVOLVEMENT

4.1 High quality PPI can really change things for people who use services, both in their experience of services and the quality and safety of care. PPI can also increase service responsiveness and accountability to local communities and the wider population by involving them in the debates and decisions about service provision. Staff morale and satisfaction can also improve when staff know they are providing a responsive service that is valued by individuals and appreciated by the wider public.

4.2 The reasons for involving individuals who use services are different but complementary to those for involving the wider public in plans about services as set out in the table below.

The case for personal involvement	**The case for public involvement**
To ensure appropriate care or treatment.	To improve service design.
To improve individual outcomes and	To improve population health and social

improve the patient and user experiences of care.	wellbeing. To determine priorities for commissioning and to ensure access to safe, quality services for people living and working in Northern Ireland based on need, evidence of effectiveness and available resources.
To reduce risk factors, promote health and social wellbeing, prevent disease or harm and encourage self-help/care.	To raise population awareness of risk factors, promote positive health and social wellbeing, and prevent disease or harm. To manage demand.
To improve safety and quality of treatment and care for the individual and their family.	To improve safety and quality of treatment and care at community and population levels. To discuss public expectations and agree how these can best be met, taking account of local and regional needs, the evidence of effectiveness and the availability of resources.
To understand how, when and why care goes wrong, and to ensure an apology and redress are made, where appropriate To reduce complaints and litigation.	To strengthen local decision making and accountability for the safety and quality of services. To promote social inclusion.

5. VALUES AND PRINCIPLES OF PERSONAL AND PUBLIC INVOLVEMENT

5.1 The values and principles of PPI set out below complement the *Quality Standards for Health and Social Care*. "Public and service user involvement" is one of the principles underpinning the Quality Standards and this is reflected in the criteria for all of the standards. The principles of PPI can be used as a benchmark of good practice to assess the quality of involvement activity as specified in the criteria for each of the Quality Standards.

5.2 There are 3 key premises which underpin PPI. They are that:

- people in receipt of services should be actively involved in decisions affecting their lives and should fully contribute to any planning, decisions and feedback about their own care or treatment;
- the wider public has a legitimate entitlement to have opportunities to influence health and social care services policy and priorities;
- PPI is part of everyday practice within HSC organisations and should lead to improvements in an individual's personal experience of the service and the overall quality and safety of service provision.

6. CORE VALUES

6.1 The quality and effectiveness of PPI is dependent on the values underpinning the interaction and relationships between staff, people who use the services and the public. The following values are recommended as the core values underpinning the behaviour and attitude of HSC staff in their interactions with individuals and the public. These core values can be built upon by the mutual agreement of participants in public involvement activities.

DIGNITY AND RESPECT	Each person is treated with dignity and respect. This includes individual responsibility to respect the views of all participants be they individuals, communities or HSC staff.
INCLUSIVITY, EQUITY AND DIVERSITY	The PPI process should facilitate the inclusion of all those who need to be involved and who chose to do so. It must be sensitive to the needs and abilities of each individual. Each person's background, culture, language, skills, knowledge and experience will be valued, accommodated and respected.
COLLABORATION AND PARTNERSHIP	The PPI process is based on collaboration and partnership working. Each person has a responsibility to build constructive relationships with others involved in the process.
TRANSPARENCY AND OPENNESS	The PPI process should be open and transparent and each person has a responsibility to be open and honest in their interactions and relationships with others.

7. PRINCIPLES

7.1 The following principles provide a framework that should underpin PPI across HSC organisations. The principles are applicable to the whole of HSC, including those services, which are commissioned or provided by HSC organisations and Family Practitioner Services. These are underpinned by the statutory duty of quality placed on HSS Boards and HSC Trusts in the 2003 Order[6].

7.2 The 12 principles are set out under three themes reflecting:

- the organisational context – an attitude of mind, a way of working;
- implementation – do what you do, do well; and
- outcomes – making a difference.

An attitude of mind, a way of working

1. Leadership and accountability
2. Part of the job
3. Supporting involvement
4. Everyone's an expert
5. Creating opportunity

Do what you do, do well

6. Clarity of purpose
7. Doing it the right way
8. Information and communication
9. Accessible and responsive

Making a difference

10. Developing understanding and accountability
11. Building capacity
12. Improving safety and quality.

[6] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

8. WHAT DO THE PRINCIPLES MEAN?

AN ATTITUDE OF MIND, A WAY OF WORKING

Principle 1: Leadership and accountability	
The commitment to PPI will be reflected in the leadership and accountability arrangements in HSC organisations.	*The leadership for PPI within organisations will be the key to creating the culture and environment whereby organisations can show they are accountable to the populations they serve.* *This requires establishing and maintaining clear lines of responsibility and accountability for the planning, implementation, monitoring and evaluation of PPI activity as part of corporate governance arrangements within the organisation.*

Principle 2: Part of the job	
PPI is the responsibility of everyone in HSC organisations.	*PPI needs to be seen as the job of all involved in HSC organisations, integral and not incidental to their daily work. PPI should be part of staff development and appraisal.* *PPI has significant implications for the way staff carry out their roles and responsibilities and their attitudes to the people who use the service. Recognising and seeking to minimise the power differential between those who provide the services and those who use the services is the first step.* *PPI requires staff to be confident and competent in engaging with individuals and the public in ways that respect them as active partners with a right to be involved and voice their views about services.*

Principle 3: Supporting involvement

Appropriate assistance is required to support and sustain effective PPI.	*Successful PPI requires building the capacity of people to get involved as well as building the capacity of staff to involve individuals who use the services and the wider public.* *The process of PPI needs to be supported by the organisation with dedicated time and resources to make it happen. Resources may include staff time, training and development and practical or financial support.* *This requires PPI to be part of organisational planning and management processes including budgets, workloads and training plans to ensure the organisation's commitment to PPI can be sustained.*

Principle 4: Everyone's an expert

Everyone is an expert in their own right, whether by experience, by profession or through training.	*The experiences and views of all participants are valid and should be respected.* *It should be recognised that people may have different viewpoints. Understanding different, and at times, competing viewpoints and recognising that decision-making is complex and may involve hard choices is part of involvement. Decisions should take account of the views and opinions of individuals, the public and professionals.* *This requires information sharing and dialogue between individuals, communities, and those planning, commissioning and delivering services including policy makers.*

Principle 5: Creating opportunity

Opportunities should be created to enable people to be involved at the level at which they choose.	*PPI can occur at different levels:* • ***Personal Level*** *– being involved in plans, decisions or giving feedback about the individual care or treatment plan for themselves or for someone they are caring for;* • ***Commissioning Level*** *– being involved in the planning and commissioning of services to meet agreed local and/or regional needs;* • ***Delivery Level*** *– being involved in plans, decisions and giving feedback about the ways in which the services are run;* • ***Monitoring & Review Level*** *– being involved in monitoring and review of the quality and effectiveness of services; and* • ***Policy Level*** *– being involved in developing local regional policies* *The number of people who volunteer to give substantial amounts of time to PPI will always be limited and as such is a valuable resource. They may not, however, be fully representative of the population profile. Opportunities, therefore, need to be created to enable a wide range of people to be involved who are representative and have a legitimate interest in the work. Opportunities also need to be created to promote engagement with under-represented or unrepresented groups, including those who do not normally get involved or who may find it hard to give their views, for example because of age or ability. PPI needs to be flexible enough to adapt to the needs of those who need to be and wish to be involved. Some people may choose not to be involved and this choice should be respected.*

DO WHAT YOU DO, DO WELL

Principle 6: Clarity of purpose

The purpose and expectations of PPI are clearly understood.	*Each PPI activity needs to have clear objectives, realistic timeframes and a shared sense of purpose communicated to all participants from the outset. Clear, succinct and understandable information needs to be available at the point of invitation to enable participants to make an informed decision about being involved, to be clear about expectations of involvement and to contribute meaningfully. People's right to confidentiality and/or anonymity should be made explicit from the outset.* *The purpose of the PPI activity will inform who should be involved. Decisions about who needs to be involved will depend on what you are asking people to be involved in and why. The aim is to gain the best representative spread of views from those who are affected or may be affected by the service or issue under discussion. Other individuals or groups (or representatives of these) who have a legitimate interest in the work should also be involved.* *Decisions about the right time to involve people will depend on the purpose. If people are expected to contribute to planning they need to be involved from the start. However, if the purpose is to consult on proposals for implementation which have already been developed, involvement may come at a later stage. Involvement at an early stage can help prevent misunderstandings or accusations of tokenism at a later stage.*

Principle 7: Doing it the right way

Different forms of PPI need to be used to achieve the required outcomes and to meet the needs of the people involved.	*No single method or approach can be taken to constitute PPI. There are many different ways and methods of involving people from staff showing respect, listening actively and responding to what people say to more formal and explicit methods such as focus groups, citizen's panels, surveys and community development.* *PPI may be a one-off event or a longer term arrangement involving regular dialogue between the organisation and the people involved.* *There are a range of targeting methods which can be employed to ensure appropriate representation and a range of voices from self-selection to specific invitation. The choice of method will depend on the earlier decision about who to involve.* *Doing it the right way requires practical advice and guidance on the range of methods and approaches including training and development for those responsible for implementing them and learning from good practice both locally and internationally. Partnerships with community groups, voluntary organisation or self-help groups provide an excellent channel to involve a diversity of local voices.*

Principle 8: Information and Communication

Timely, accurate, user-friendly information and effective two-way communication are key to the success of PPI activities.	*People need timely information to be able to be involved meaningfully; information needs to be presented in ways that can be understood by the target audience; people need to know how to make their views known, including how to make a complaint; and they need to be informed of outcomes and decisions.* *This requires appropriate systems and mechanisms to be in place to facilitate ongoing dialogue and information exchange between participants before, during and after the PPI process.* *BEFORE* • *The need for advance information which is clear and focused on the purpose and topic for discussion with sufficient background information to support understanding and meaningful involvement.* *DURING* • *The need for participants to feel they are being actively listened to;* *AFTER* • *The need for timely feedback from the involvement activity; and* • *The need for follow-up communication on the impact of the involvement on decisions.*

Principle 9: Accessible and responsive

The organisation's commitment to PPI will be demonstrated through its recognition of the right of people to initiate engagement with it.	*Traditionally, PPI has been shaped around the organisational priorities, rather than the concerns those in a local community identify as important. Organisations need to be prepared to listen to the issues and concerns of individuals, groups or communities.* *This requires a more open culture and a willingness to listen to what is important to people.*

MAKING A DIFFERENCE

Principle 10: Developing understanding and accountability	
People's understanding of HSC services and the reasons for decisions are improved through PPI activity.	*Making decisions about service provision can involve hard choices. The PPI process itself will not necessarily lead to a consensus about what should happen. However, the opportunity to register a viewpoint in a transparent and open process and to hear other viewpoints can foster a greater appreciation of the issues and competing perspectives involved and clarify the choices policy makers, commissioners and service providers face.* *This in turn can lead to a greater understanding of the reasons for decisions and accountability of the decision-makers to make explicit the reasons for their decisions based on evidence.*

Principle 11: Building capacity	
People's capacity to get involved is increased and the PPI processes are improved through learning from experience.	*The experience and learning from being involved should help build the capacity of individuals, communities and staff to be more confident and effective in engaging with and listening to each other. Being involved should help people to better understand the issues and the business of health and social care and to make an informed contribution.* *This requires appropriate mechanisms for reviewing and learning from the involvement process and the outcomes of each PPI activity.*

Principle 12: Improving safety and quality

Learning from PPI should lead to improvements in the safety, quality and effectiveness of service provision in HSC organisations.	*PPI should support the clinical and social care governance agenda of developing an open culture that promotes and safeguards high standards and improvements in the safety and quality of services delivered to individuals and communities.* *This requires a culture of openness, transparency, listening to the views of individuals, communities and staff, learning from feedback, where appropriate learning from an analysis of complaints, sharing information and working in partnership.* *Through a partnership approach with people and communities, HSC organisations can improve the safety, quality and effectiveness of services and make them more accountable to the public. The difference PPI makes to the safety and quality of services should be communicated throughout the organisation to share and encourage good practice.* *This requires appropriate mechanisms for evaluating the impact of PPI in improving the safety, quality and effectiveness of health and social care services.*

9. THE CHALLENGE

9.1 PPI needs a genuine commitment from senior managers and all staff to make it happen. This requires developing a culture of openness, respect, listening and a willingness to change within the workplace. Genuine PPI takes time and commitment to achieve. It challenges the way organisations and staff go about their daily work. Developing the right culture is perhaps one of the biggest challenges in ensuring PPI is both meaningful and effective.

9.2 The leadership provided within HSC organisations will be the key to creating a culture and environment where PPI is accepted as everyone's responsibility within the organisation.

10. STRENGTHENING PPI - A PROCESS OF SELF-EVALUATION

10.1 In order to strengthen PPI, a systematic process of self-evaluation should be adopted. Four basic questions lie at the heart of self-evaluation:

- ***How are we doing?***
- ***What are our strengths, what do we need to do better?***
- ***What action do we need to take to bring about improvement?***
- ***How will we know if improvements are being made?***

10.2 In the first year, this guidance provides a basis within new HSC Trusts (and other HSC/HSS organisations) to recognise the importance of PPI and to take account of it in their evolving governance work programmes.

10.3 Thereafter, from 2008/09 the following steps should be taken by all HSC organisations as part of the self-evaluation process to strengthen and improve PPI.

Step 1: Confirm or establish leadership and accountability arrangements for PPI;

Step 2: Using the principles in this guidance as a framework, review current PPI work to establish the baseline from which improvements can be made;

Step 3: Prioritise the areas for improvement;

Step 4: Develop and implement an action plan with clearly defined targets to strengthen and improve PPI securing agreement and support for this plan across the organisation;

Step 5: Clarify reporting arrangements for PPI as part of organisational management and clinical and social care governance. Arrange for the inclusion of PPI as part of the organisation's annual report on what has been achieved and agree the priorities and targets for the subsequent year.

The following paragraphs set out guidance in relation to each of the 5 steps.

STEP 1: LEADERSHIP AND ACCOUNTABILITY ARRANGEMENTS

The Head[7] of each organisation is accountable to his/her board for the availability, quality and effectiveness of services.

The Head of each organisation will designate a senior professional at board level to provide leadership in relation to PPI throughout the organisation. He/she will support and encourage good practice and compliance with the 12 principles in this guidance and ensure that where problems are identified, appropriate action is taken.

The senior professional will be expected to put in place mechanisms for ensuring the production of PPI reports (see Step 5 below). The senior professional will look to other key professionals and staff groups to provide support.

STEP 2: REVIEW/BASELINE ASSESSMENT

For those organisations which have already established a policy and PPI systems, a review of current arrangements should be taken in light of this guidance. The review should include a report on the progress made towards complying with the principles set out in this guidance.

For those organisations which do not have a policy or systems for PPI, a baseline assessment should be carried out.

The review/baseline assessment should provide the basis for a strategy and associated action plan to strengthen and improve PPI. Agreement should be reached by the organisation regarding the resources required and available to implement the plan.

STEP 3: PRIORITISE THE AREAS FOR IMPROVEMENT

Decisions will have to be made about priorities for improvement and timescales so there is a realistic and feasible plan to strengthen PPI.

STEP 4: STRATEGIC AND ACTION PLANNING

The strategy should provide a clear vision in respect of improving PPI throughout the organisation. This should be a shared vision which people who use the services, the wider public and staff should contribute to, support and endorse. The strategy should provide the long-term (3 year) plan for PPI work and draw upon and incorporate the findings from the baseline assessment. The strategy should specify how the organisation will provide support and resources for the implementation of the strategy. The PPI strategy should be reflected in the organisation's strategic plan.

The action plan (1 year) will set out short-term priorities and targets to support the achievement of the longer-term strategy. In larger organisations action plans may need to be developed for different parts of the organisation to ensure work can build on existing good practice and strengthen and improve what already exists. This may vary throughout large organisations. The PPI action plan should be reflected in the organisation's annual business plan.

[7] Head of organisation denotes Chief Executive or equivalent senior officer.

STEP 5: REPORTING ARRANGEMENTS

Organisations will be expected to include an up-date on progress against action plans for PPI in their organisational Annual Reports for 2008-09. Thereafter, they will be expected to devote a specific section in subsequent Annual Reports, giving a full account of their PPI work related to clinical and social care governance, what has been achieved and what is planned for subsequent years.

In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine updates to their board on progress and outcomes from PPI work in the organisation.

PPI reports should answer 3 broad sets of questions.

- ***What have we done?*** – overview of PPI activities with feedback and learning from the process.

- ***What difference has it made?*** – feedback from people and communities who have been involved and learning about the outcomes in terms of people's experiences of care and decisions about safety, quality and delivery of services.

- ***What do we need to do next?*** – action planning for following year.

11. MONITORING PERFORMANCE

11.1 Monitoring of PPI will take several forms.

(a) **Internal monitoring**. Each organisation should monitor the impact of PPI work through their clinical and social care governance arrangements with routine updates to their board and the inclusion of PPI in their Annual Report.

(b) **External monitoring**. The 4 Boards (and in time the appropriate regional structure(s)) will monitor PPI activity for all HSC commissioning and provider organisations. The Department through its accountability arrangements through the 4 Boards (and in time through the appropriate regional structure(s)) will monitor the impact of PPI work.

(c) **Independent monitoring**. The Regulation and Quality Improvement Authority (RQIA) will monitor PPI as part of its review of clinical and social care governance arrangements. The principles contained in this guidance will contribute to the framework for PPI monitoring /or a thematic review of the specific requirements for public and service user involvement as outlined in the Quality Standards. The principles set out here are seen to complement those set out in the Quality Standards.

12. FURTHER GUIDANCE

This circular will be supplemented by further guidance as necessary.

Yours sincerely

DR MAURA BRISCOE
Safety, Quality & Standards Directorate

Annex 1

GUIDANCE ON STRENGTHENING PERSONAL AND PUBLIC INVOLVEMENT

SUMMARY OF DEVELOPMENT PROCESS

This work was commissioned by the Clinical and Social Care Governance Sub-Group.

The process of developing the guidance and associated values and principles was managed by a small project team, chaired by Christine Smyth (Office of Social Services, DHSSPS). Membership included a service user and representation from Medicine, Nursing, Pharmacy, Performance Management, HSS Council and the NI Clinical and Social Care Governance Support Team.

Following two planning meetings, an inclusive and reiterative process of involvement was agreed and implemented. This involved a variety of involvement activities and methodologies including:

(i) Departmental Board endorsement for work;

(ii) focus groups with expert users and carers, and HSC staff involved in PPI activities;

(iii) engagement with relevant Department Directorates in policy trawl and quality assurance;

(iv) individual meetings with experts and key stakeholders including David Sissling;

(v) a regional workshop of service users, carers and other key stakeholders organised by the HSS Councils to inform the development of the values and principles;

(vi) redrafted principles were circulated to all regional workshop participants following the above event for further comment;

(vii) an independent evaluation of the draft values and principles with participants involved in a Departmental public consultation activity;

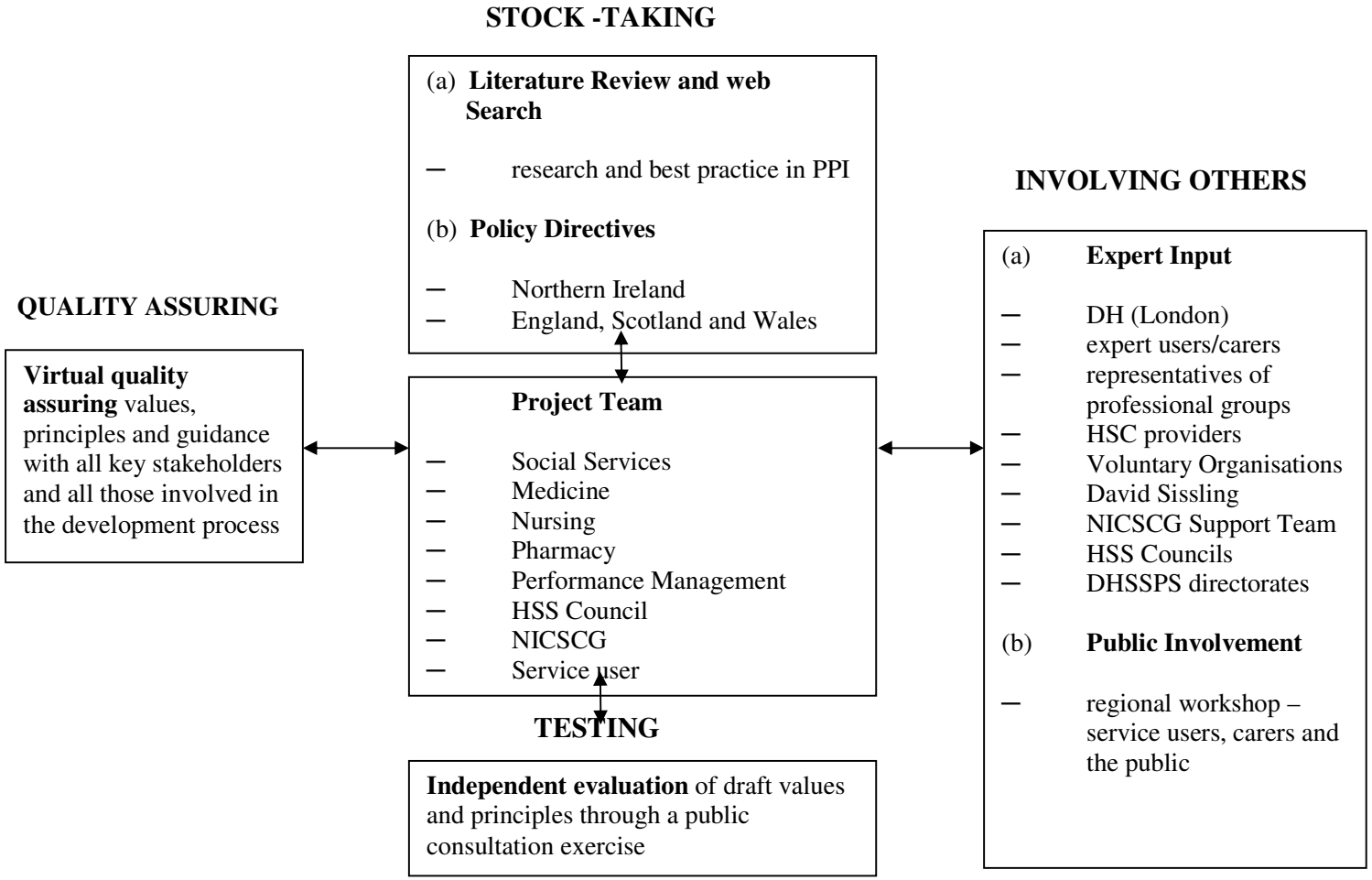
(viii) values and principles were redrafted in light of recommendations from the independent evaluation and circulated to all those who had contributed for further comment;

(ix) a 'virtual' quality assurance process involving key shake holders and all those who were involved in the development of the values and principles and final draft of guidance;

(x) final draft presented for endorsement by Departmental Board.

Annex 1

PERSONAL AND PUBLIC INVOLVEMENT DEVELOPMENT PROCESS



Jim Livingstone
Director of Safety, Quality and Standards

POLICY CIRCULAR

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Subject:

Guidance for HSC organisations on arrangements for implementing effective personal and public involvement in the HSC

Circular Reference: HSC (SQSD) 03/2012

20 September 2012

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive, NIGALA
- Chief Executive, NIMDTA

For Information to:

- Chief Executive, Patient and Client Council
- Chief Executive, Business Services Organisation
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, NI Social Care Council
- Chief Executive, NIPEC
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts

Related document

HSC (SQSD) 29/07
HSC (SQSD) 01/12

Superseded documents

Summary of Contents:
The purpose of this Circular is to advise HSC organisations of their roles and responsibilities in meeting the statutory duty of public involvement and consultation placed upon them by the Health and Social Care (Reform) Act (Northern Ireland) 2009

Status of Contents:

Action

Enquiries:
Any enquiries about the content of this Circular should be addressed to:

Implementation:

From 1 October 2012

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Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars/sqsd-circulars-2011-2012.htm

Dear Colleague

GUIDANCE FOR HSC ORGANISATIONS ON ARRANGEMENTS FOR IMPLEMENTING EFFECTIVE PERSONAL AND PUBLIC INVOLVEMENT POLICY IN THE HSC

Introduction

Personal and Public Involvement (PPI) is a central component of the quality agenda, which aims to improve health and social care service provision in Northern Ireland and the individual experiences of those who use these services. As a key Departmental policy it is integral to the delivery of high quality services. It is one of the key strands underpinning the Department's 10-year Quality Strategy, *Quality 2020,* which was published in November 2011. It is also seen as one of the key features of effective clinical and social care governance, and is one of the central tenets running through the five key themes of the *Quality Standards for Health and Social Care*. Our success in protecting and improving quality of services as safe, effective and patient/client focused will be the greater with effective involvement.

The Department issued guidance to the HSC in September 2007 which was intended to strengthen the various programmes of work and requirements for service user and carer involvement and establish a consistent regional definition of, and approach to, involving people in the planning and delivery of health and social care services. It also introduced and defined the concept of PPI as an agreed regional terminology for all aspects of user involvement within health and social care. This terminology was chosen to reflect the integrated nature of the health and social care system in Northern Ireland, but it is recognised that for the future more work needs to be done to develop a PPI label that is more easily and widely recognised and understood.

The guidance was intended to provide agreed guidelines for service commissioners and providers to improve the level of user and carer involvement across Health and Social Care Organisations, as well as strengthening the impact of user involvement on decisions that are made about services. In turn it was envisaged that this would support the implementation of effective and meaningful user involvement in clinical and social care governance and, in this way support the influence of user perspectives in the planning and decision-making processes of the Health and Social Care Services.

Since this guidance was issued, the second stage of the Review of Public Administration and the enactment of the enabling legislation, the Health and Social Care(Reform) Act (Northern Ireland) 2009 ('the Reform Act'), has introduced a number of significant changes in how health and social care services are organised and delivered here. A number of new HSC organisations have been established, including the Health and Social Care Board, the Public Health Agency and the Patient Client Council, who each have particular responsibilities in respect of promoting involvement of service users, carers and the public. In addition, the Reform Act also places a statutory duty of public involvement and consultation on Health and Social Care organisations.

In light of these changes, the primary purpose of this circular is to provide specific guidance on the roles and responsibilities of Health and Social Care organisations in meeting the statutory duty of public involvement and consultation placed upon them by sections 19 and 20 of the Reform Act, and the accountability arrangements which will be in place within the Health and Social Care system to provide assurance to the Minister that all HSC organisations are compliant with their duties in this regard.

This guidance builds on the values and principles which were set out in the 2007 Departmental guidance on PPI.

You are asked to ensure that this circular is widely communicated to all staff within your organisation.

Yours sincerely

Dr J F Livingstone
Director Safety, Quality and Standards Directorate

SECTION 1: Roles and responsibilities of HSC organisations

Department of Health, Social Services and Public Safety

1.1 The Department (through Safety, Quality and Standards Directorate) has responsibility for policy on PPI, including reviewing, developing and refining the policy. It will also be responsible for reviewing and issuing appropriate guidance as necessary, and for setting regional priorities and standards in this area. The Department will also be responsible for providing assurance to Minister that HSC organisations are meeting the requirements placed upon them by the statutory duty of involvement as laid down in the Reform Act, including the requirement to develop consultation schemes.

1.2 The Department and all other relevant HSC bodies should publish and maintain a PPI consultation scheme, in accordance with statutory requirements, detailing the arrangements they have in place, to involve and consult with service users, carers and the wider public, and the Patient Client Council, in the discharge of their business.

1.3 All HSC organisations are directly and individually accountable to the Department for the discharge of their statutory functions, but the following arrangements, which relate specifically to the duty of involvement, reflect the mainstream planning and performance management system for the HSC.

Public Health Agency

1.4 The Public Health Agency (PHA) has responsibility for leading implementation of policy on PPI across the HSC. This responsibility is taken forward through the Regional PPI Forum, which is chaired and serviced by the PHA and which includes representation from all HSC organisations as well as community and voluntary sector representatives, service users and carers. The Forum is a key vehicle by which the PHA, working with other organisations, ensures the effective implementation of PPI policy across the HSC. It should operate in a collaborative manner, seeking to ensure consistency and co-ordination in the approach to PPI. The Forum also seeks to identify and share best practice in terms of PPI across the HSC. The PHA, working through the Forum, will publish an Annual Report on PPI activity.

1.5 The PHA, working with the HSC Board through established performance management arrangements, has responsibility for ensuring that HSC Trusts meet their PPI statutory and policy responsibilities. The PHA will in turn provide assurances to the Department in this regard through established accountability arrangements.

1.6 The PHA has responsibility for the operational aspects of successfully implementing policy on PPI in a consistent regional manner across HSC organisations, including capacity building (for example through commissioning of training), communication and awareness raising of the PPI agenda (for example through the Engage website and newsletter), and monitoring (for example through work to evaluate the impact of PPI). The PHA will consult with the PCC on best practice in carrying out these responsibilities.

1.7 The PHA will liaise with the HSCB to ensure effective and efficient delivery of these responsibilities.

Health and Social Care Board

1.8 Internally, the HSCB has a responsibility to maintain and build on the work that had been developed with respect to involvement of service users and carers by each of the legacy HSS Boards, and will provide assurance to the Department, through the PHA, utilising agreed mechanisms, that it is discharging its statutory duty of involvement. It will also work along with the PHA, through the Regional PPI Forum, to ensure that HSC organisations are adequately discharging their responsibilities with respect to PPI.

1.9 In particular, the HSCB should ensure that arrangements for effective PPI are established in Local Commissioning Groups, and other commissioning structures developed under Transforming Your Care, to ensure that the views of stakeholders feed into and inform commissioning plans, and that family practitioner services are effectively encouraged to apply Departmental guidance and best practice on PPI.

Family Practitioner Services

1.10 While the Reform Act does not place a statutory requirement on Family Practitioner Services (defined as general medical, community pharmacy, general dental and ophthalmic practices) to involve their patients and carers in decisions about their treatment and care, the Department is committed to the principle that effective involvement of patients and carers is a key component of a quality service, as set out in *Quality 2020*. Family Practitioner Service contractors should therefore ensure that their practices maintain and build upon the arrangements they introduced in response to the 2007 Departmental guidance, and should continue to work towards compliance with the requirements of this revised guidance. As an integral part of the HSC system, they are accountable to the HSCB for the discharge of this function.

HSC Trusts

1.11 HSC Trusts are responsible for establishing appropriate organisational governance arrangements to meet their statutory duty of involvement, and for maintaining and building on progress already made in relation to embedding in line with the requirements contained in the 2007 PPI guidance circular (and any subsequent Departmental guidance).

1.12 Under the established performance management arrangements, HSC Trusts will report to the PHA, working with the HSCB, on the implementation of PPI policy. The PHA will be responsible for providing assurance to the Department that Trusts are meeting their obligations in respect of these functions.

Special Agencies

1.13 The Reform Act provides that special agencies have responsibilities in respect of PPI. The NI Blood Transfusion Service (NIBTS) and the NI Guardian Ad Litem Agency (NIGALA) were expected to comply with the requirements of the 2007 guidance, and these organisations should therefore continue to build on progress already made in this area.

1.14 However, as the 2007 guidance did not apply to the NI Medical and Dental Training Agency (NIMDTA), this organisation should establish appropriate arrangements to ensure it complies with the legislative requirements placed on it by sections 18-20 of the Reform Act.

1.15 Each of these three special agencies will be accountable directly to the Department for the discharge of these functions.

Patient and Client Council

1.16 The Reform Act gives the PCC the function of representing the interests of the public in order to ensure a strong patient and client voice at both regional and local level. It also has the function of promoting public involvement in decisions about the provision of health and social care. Certain HSC bodies[1] are required by the Act to co-operate fully with the PCC in the discharge of these statutory responsibilities, and the Department may consult the PCC in respect of PPI consultation schemes.

1.17 The PCC may undertake research and conduct investigations into the best methods and practices for involving the public and provide advice on these to HSC organisations.

[1] Health and social care bodies are defined at Section 1 (5) of the Reform Act. However, the particular Health and social care bodies to which sections 18 and 19 apply are defined at Section 17 (8).

1.18 The PCC also has an important challenge role for those HSC bodies prescribed in the Reform Act in respect of PPI, and will accordingly be expected to comment upon and scrutinise the actions and decisions of these bodies as they relate to PPI. In addition it will provide independent assurance to the Department on the effectiveness of PPI Policy.

Regulation and Quality Improvement Authority

1.19 RQIA will continue to provide independent assurance to the Department, of the effectiveness of PPI structures by continuing to monitor these as part of its review of clinical and social care governance arrangements in HSC organisations.

Other HSC organisations

1.20 There are a number of HSC organisations to whom the statutory duty of involvement and consultation does not apply - namely the Northern Ireland Social Care Council, the Northern Ireland Practice and Education Council and the Business Services Organisation. Although these organisations are not required by statute to establish appropriate governance arrangements to involve and consult with service users, their carers and the PCC in the discharge of their business, the Department considers that effective involvement is a key component in the delivery of a quality service across all members of the HSC family.

1.21 The Department therefore encourages these organisations to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by the views of those who use their services. These organisations should consider establishing arrangements to gather views from their service users and carers and use these to inform decisions on their service provision.

1.22 To assist them in achieving this, each of these organisations should consider undertaking the self evaluation processes set out in the 2007 guidance circular to develop and strengthen their arrangements for gathering user feedback, and using this information to improve their organisational decision making and service delivery processes.

SECTION 2: Reporting and Monitoring arrangements

Reporting Arrangements

2.1 Organisations will be expected to include an up-date on progress against action plans for PPI in their published organisational Annual Reports and /or Annual Quality Reports to be developed as part of Quality 2020. Thereafter, they will be expected to devote a specific section in subsequent Annual Reports, giving a full account of their PPI work related

to clinical and social care governance, what has been achieved and what is planned for subsequent years.

2.2 In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine updates to their board on progress and outcomes from PPI work in the organisation.

2.3 PPI reports should answer three broad sets of questions:

- *What have we done?* – overview of PPI activities with feedback and learning from the process.
- *What difference has it made?* – a summary analysis of the outcomes and particular benefits, identified from effective involvement of people (users, carers, communities or the general public) in decisions and planning to improve the quality of services.
- *What do we need to do next?* – action planning for following year and beyond.

Monitoring Performance

2.4 Monitoring of PPI will take several forms:

(a) **Internal monitoring**. Each organisation should monitor the impact of PPI work through their clinical and social care governance arrangements with routine updates to its board and the inclusion of PPI and its impact in its Annual Report.

(b) **Regional monitoring**. From an operational perspective, the PHA through the PPI Forum will monitor PPI activity across all HSC commissioning and provider organisations seeking to ensure best practice is applied and assess effectiveness. From a policy perspective, the Department will monitor the impact of PPI with the support of the PHA and through both the existing formal accountability mechanisms for HSC bodies and Quality 2020 programme management arrangements.

(c) **Independent monitoring**. The Regulation and Quality Improvement Authority (RQIA), in partnership with the Patient Client Council (PCC), will monitor PPI as part of its review of clinical and social care governance arrangements. The principles contained in this guidance will contribute to the framework for PPI monitoring /or a thematic review of the specific requirements for public and service user involvement as outlined in the Quality Standards. The principles set out here are designed to complement those set out in the Quality Standards.

Further Guidance

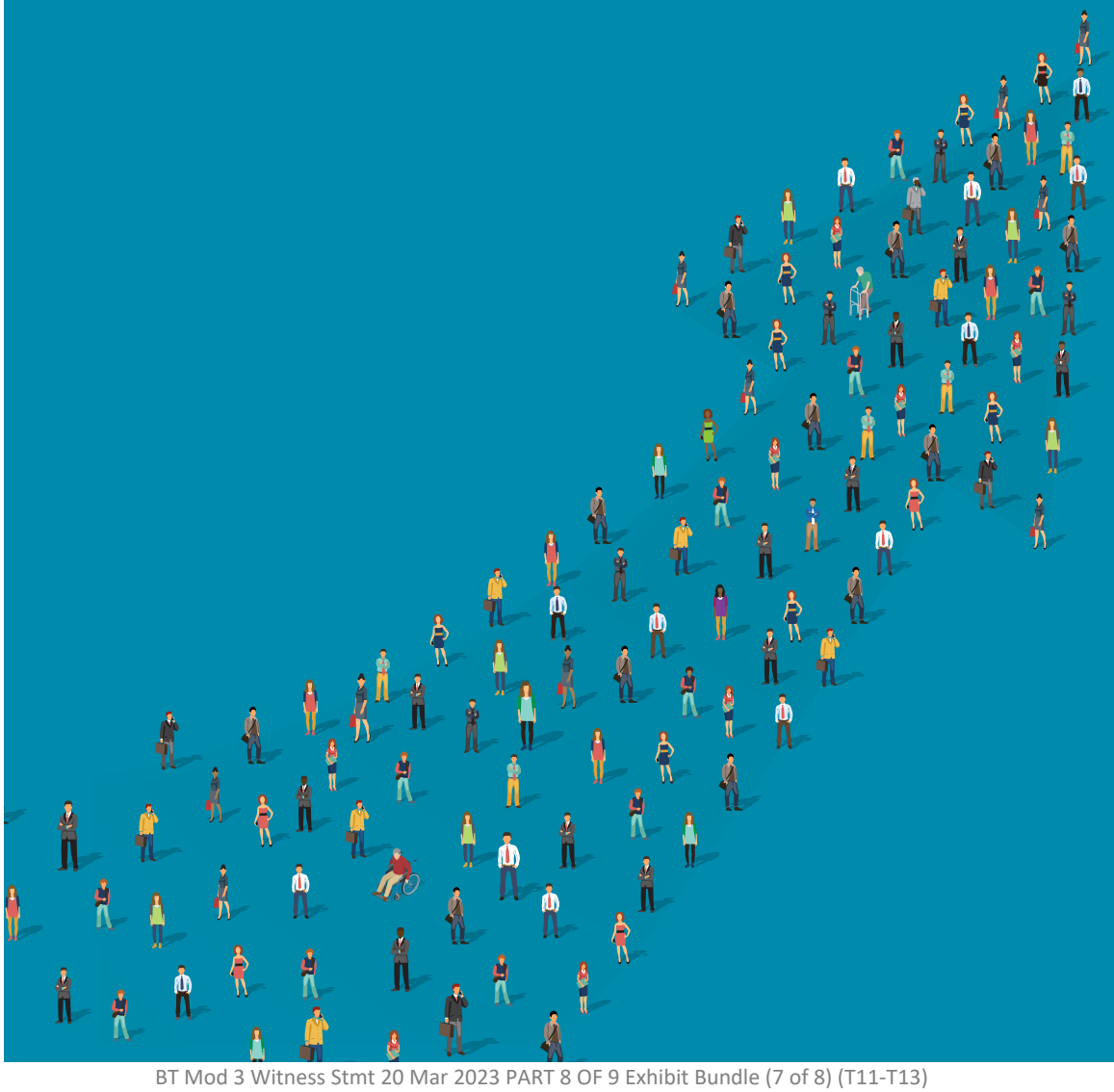
2.5 This circular will be supplemented by further guidance as necessary.

Safety, Quality & Standards Directorate, DHSSPS

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Co-production Guide

Connecting and Realising Value Through People



Contents

Section 1:

What do we want to achieve?

1.1 Our Task

The **Delivering Together** Transformation Implementation Group (TIG) asked for the development of a practical guide to support the application of co-production across our health and social care (HSC) system. This guide has been developed using the principles of co-production in partnership with people who have experience in using health and social care services, Carers, HSC staff, Managers, Personal Public Involvement (PPI) leads, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Patient Client Council (PCC). They were partnered by community and voluntary sector representatives, local government representatives and policy makers from the Department of Health (DoH). Together they have brought their extensive knowledge and experience of co-producing to inform this guide. It is this system wide partnership approach that has given the guide its genuine authoritative footing in providing direction on how co-production can be an enabler of transformational change.

Transformational change in this guide means harnessing the collective efforts of policy makers, people who use services, carers, staff, staff representatives and local communities who all ***work together in partnership to improve health and wellbeing outcomes*** for the people of Northern Ireland. It places **people** at the centre of decision making and aims to connect people together in representative networks so that they can meaningfully influence, shape and participate as real partners in the commissioning, planning, delivery and evaluation of services.

Recognising that co-production is a developmental and incremental process the guide acknowledges that it will take time to fully embed and reflect the principles of co-production in HSC systems. The guide however sets out an ambitious mandate and outlines the key steps required for the adoption and implementation of co-production across all HSC organisations. It represents an opportunity to co-ordinate and integrate all the work undertaken through PPI, patient experience, service user feedback, peer networks, expert patients, peer advocacy, public consultation and community development, into an integrated approach.

The guide requires all HSC organisations to review the extent of partnership working across its services and to develop an integrated plan in order to strengthen co-production between people who use services, staff, their representatives, local communities and multi-agency partners.

1.2 Co-Production Parameters

Uniquely the DoH and its 'Arm's Length Bodies' are the only public bodies in Northern Ireland which have a statutory duty to involve and consult its stakeholders, therefore the guide augments and builds on the requirements set out in current PPI policy[1].

Our goal is to support transformational change through a co-productive approach and promote the opportunity for all sections of the Northern Ireland community to partner with health and social care staff in improving health and social care outcomes. This will be done within existing statutory requirements. The extent to which decisions will be co-produced will be dependent on Executive and Ministerial priorities, adherence to legal and regulatory requirements, professional standards, and HSC organisational financial accountabilities.

It is also important to note that patient and public safety is paramount and there are a range of circumstances where Health and Social Care services within its statutory and legal duties may not co-produce decisions in order to safeguard people and families who are physically, psychologically and socially vulnerable. In this context it is incumbent in line with legislation, statutory, policy and professional requirements that HSC services and professionals are open and transparent about why this is so, and provide information on how people(s) best interest will be reflected and protected throughout decision making processes which impact their lives.

1.3 Our Purpose

To meet the challenges of a 21st century population, we need to be ambitious in how we plan to transform our services to meet the needs of our population, in a safe and sustainable way, so they can ***enjoy long, healthy, active lives*** and to enable those with long term and life limiting conditions to live as well as possible.

Delivering Together 2026 Section Four 'the Approach' identifies partnership working as one of the five enablers in the delivery of HSC transformation. Figure 1 sets out the core requirements and the guide has been developed in recognition that' *"Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all"*

1 https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi
2 Delivering together The Approach Section Four https://www.health-ni.gov.uk/sites/default/files/publications/health/health-andwellbeing-2026-delivering-together.pdf

Figure 1

Co-production will empower patients, service users and staff to:

• **design the system** as a whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;

• work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;

• be partners in **the care they receive** with a focus on increased self management and choice, especially for those with long-term conditions.

Delivering together commits health and social care to:

- Adopt the co-production and co-design model for development of new and reconfiguration services.
- Maximise the lived experience (patient & carer) voice across the system.
- Engage staff particularly staff who are closest to those who use our services in co-design and in the co-delivery of services.
- Build and strengthen partnerships working with other providers of care, including those in the community and voluntary sector and in other government sectors in support of Programme for Government (PfG) priorities.

1.4 Let's Talk About Language

Some of the language and concepts of coproduction are often misunderstood and interchangeably used. It is therefore necessary to set out a number of key definitions of terms used through this guide in order to support understanding.

Definitions used in this document have been developed to reflect and expand on The Executive Office of the Northern Ireland Civil Service (NICS) Policy Champion's Network Guides, *'A Practical Guide to Policy Making in Northern Ireland'* published in 2016 and *'The Good Practice Guidelines for Effective Stakeholder Engagement (2nd edition)'*.

The language and definitions also align with the strategic direction of ***Delivering Together***.

When we talk about co-production, we are referring to a concept that requires the complete application of the six principles and the key implementation steps outlined in Section 3 in addition to the core concepts of co-design, co-delivery and co-creation. A number of terms used throughout the guide to describe the full range of actions associated with ***co-production*** have been defined in order to assist understanding.

Definitions

People

The term **'People'** used throughout this guide refers to citizens across all lifespan groups who use services, their families, carers policy makers, HSC staff, Trade Union Side, local communities, communities of interest, communities of practice, multi-agency and community and voluntary sector partners.

Co-production

A highly **person centred approach** which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. It is deeply rooted in connecting and empowering people and is predicated on valuing and utilising the contribution of all involved. It seeks to combine people's strengths, knowledge, expertise and resources in order to collaboratively improve personal, family and community health and wellbeing outcomes. Co-production is not just a word, it is not just a concept, it is a genuine partnership approach which brings people together to find **shared solutions**, In practice co-production involves partnering with people from the start to the end of any change that affects them. It works best when people **are *empowered*** to influence decision making and care delivery processes.

Co-design

A **partnership approach** which seeks to establish a *representative co-design team* of people, who come together to **design care pathways, develop new and revise existing services models**. The work of co-design teams is governed by person centred values, a shared ambition and commitment to generate solutions in line with the quadruple aim outlined in Delivering Together 2026.

Co-delivery

A partnership approach which aims to **empower multidisciplinary** teams to deliver **integrated care** solutions for their population. It also involves developing and integrating expert patient, peer and community led services into the delivery of health and social care.

Citizen Powered Health and Wellbeing

This is a population health approach which seeks to create the conditions in which people can be empowered, to take a more active role in their own health and social wellbeing. It crucially involves addressing the wider determinants of health and social wellbeing and requires a shared understanding of need. Based on population need stratification, it requires targeted resources in support of prevention, early intervention, recovery and personalised support for those with long term and life limiting conditions.

Lived and Learned Experience

Throughout the guide the terms 'lived experience' and 'learned experience' are used. **Lived Experience** is used to describe the direct experiences, perspectives and views of patients, clients, service users, peer advocates, and carers of their own health and social care needs and that of the services they received. **Learned experience** includes all those staff who are directly involved in leading, managing and providing health and social care.

Being Representative

One of the key objectives of co-production is to avoid unrepresentative perspectives and opinions and to create from the outset equal opportunities for people to influence and shape the design and delivery of health and social care. This means ensuring a representative balance of the people who use services, carers, staff, trade union staff and as appropriate other partners in co-design and co-delivery teams. It is also important in line with Section 75 responsibilities that particular attention is paid to including under representative/hard to reach groups.

Shared Decision Making to Enable Partnership Working

Decision making in HSC is governed by a wide range of legal, professional and policy mandates. In the case of HSC organisations the specific responsibilities of their Chairs, Boards and Chief Executives as well as of the sponsoring Department are set out in the management statements between the Department of Health and each of these HSC organisations. Set within PPI legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes. This requires a commitment to create opportunities for shared decision making to enable partnership working which involves sharing information and developing collective evidenced based solutions. The principle of shared decision making is deeply rooted in prompting equality of opportunity for people who use services and those who provide them to **influence decisions about health and wellbeing**. As co-production develops shared decision making should become the accepted approach in the design of services. Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to **empower partners** to take **shared ownership** for the delivery of health and social care outcomes. This does not remove or dilute statutory accountability, however leaders act as catalysts in facilitating transformation by empowering people to work together to generate improvements in care outcomes.

Section 2:

Why Co-production is Important

2.1 The Co-production Ambition for 2026

As outlined in the draft PfG, our ambition is to enable people to ***enjoy long, healthy, active lives*** and one of the critical building blocks in achieving this aim is to move towards the creation of a 'Citizen Powered Health and Social Care System'. This requires the mobilisation of people into representative networks. **We want a system that partners and organises health and wellbeing with people, for people, and by people.** Therefore the only way to understand what matters to people is to work as partners with them. This requires a commitment to create (through genuine partnership) working opportunities for people to influence the decisions and shape the direction of health and social care.

A citizen powered health and social care system helps to support the building of people's social capital and recognises that the infinite talents and resources of people who use public services are often overlooked and sometimes diminished by the predominance of professional structures. There is a tendency to see **what's wrong, not what's strong,** alongside the unconscious willingness of people to slip into a passive role as recipients of services. **Therefore building social capital methods into the design and delivery of care is a critical aspect of co-production**.

It involves strengthening the commitment and connections between people and their respective social and community networks. Doing this not only addresses the immediate needs of people, but also enables collective action in tackling the wider determinants of health and wellbeing at both strategic and local levels. Inevitably this requires a commitment to embed community development and social enterprising approaches as we implement co-production. This is essential in generating new and innovative solutions with people.

As a system we will:

- **Value** and embed co-design and co-delivery as a core practice in improving health and wellbeing;
- **Value** the contribution and experience of people who use services by creating the conditions for them to ***enjoy long, healthy, active lives*** through the provision of personalised, evidenced based care and support.
- **Value** the outcomes that matter to people, families and their communities.
- **Value** evidence, quality improvement and innovation in achieving sustainable person, family and community centered outcomes.
- **Value** our staff and the wider workforce in the co-design and co-delivery of care systems.

Co-production enables us to genuinely create a system which enables people to play an active role and become invested in improving personal and collective health and wellbeing outcomes. To achieve success, a whole system approach is required. In the next ten years we will work to have a system which will have:

1. **Connected people together as part of the care system.** People working through representative groups and networks and it is usual practice for people to co-design and co-deliver innovative health and social care solutions. Participation has balanced representation and co-design teams routinely consist of people who use services, staff who provide care and as appropriate other partners. Health and social care leaders at all levels are champions of co-production and have created the conditions for partnership working.

2. **Embedded a population health and wellbeing approach**. Population health data, and predictive technologies will be used to anticipate need. This approach enables the development of a shared understanding of need and how actions can change health and social care outcomes for individuals and communities.

3. **Built social capital** as evidenced by more people designing their own health and social care wellbeing solutions. Personalised budgeting, community development peer, expert patient, and social enterprising approaches have demonstrated how improvements can be delivered in health and social care.

4. **Empowered and enabled integrated multi-disciplinary team working.** Teams are self-managing and take responsibility for quality improvement and care outcomes for their respective area of practice and localities.

5. **Utilised enabling technologies.** People are enabled to personalise their health and wellbeing goals, track and analyse their own health data. Enabling technologies support the personalisation of knowledge, self-management and the interactions between people and their health and social care team.

6. **Enabled people to provide real time feedback** on their experiences of health and social care. People's feedback (staff, service users and carers) is utilised to identify areas of excellence and also for service improvement by putting things right when their experiences have not met agreed standards.

7. **Quality assurance systems** fully reflect the principles and practice of co-production. People become partners in the quality assurance process across health and social care services.

2.2 The Benefits of Co-Production

Much has been written locally, nationally and internationally about the benefits of co-production for society, communities and for individual people. As detailed in **figure 2** adopting a co-productive approach is at the heart of improving people's experience of care. Co-production, done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

Figure 2

The Heart of Experience

Co-production demonstrably improves people's experience of care. This is achieved through relationship building, valuing people's contribution, partnering with people in making decisions about their lives, and creating the conditions for co-design/co-delivery of health and social care services.

Think Outcomes

Co-production creates the conditions for people to be empowered to take active responsibility for their health and wellbeing. It gives equal weight to the biological, psychological and social models in the design and delivery of care. Co-production recognises that outcomes are significantly improved when people are enabled to contribute to and work in partnership in order to ***enjoy long, healthy, active lives***.

Optomising Resources

Co-production is a strengths based approach which aims to harness the expertise of people and creates opportunities for partners to pool their resources, their talents and expertise. Services can become more efficient, innovative and cost effective.

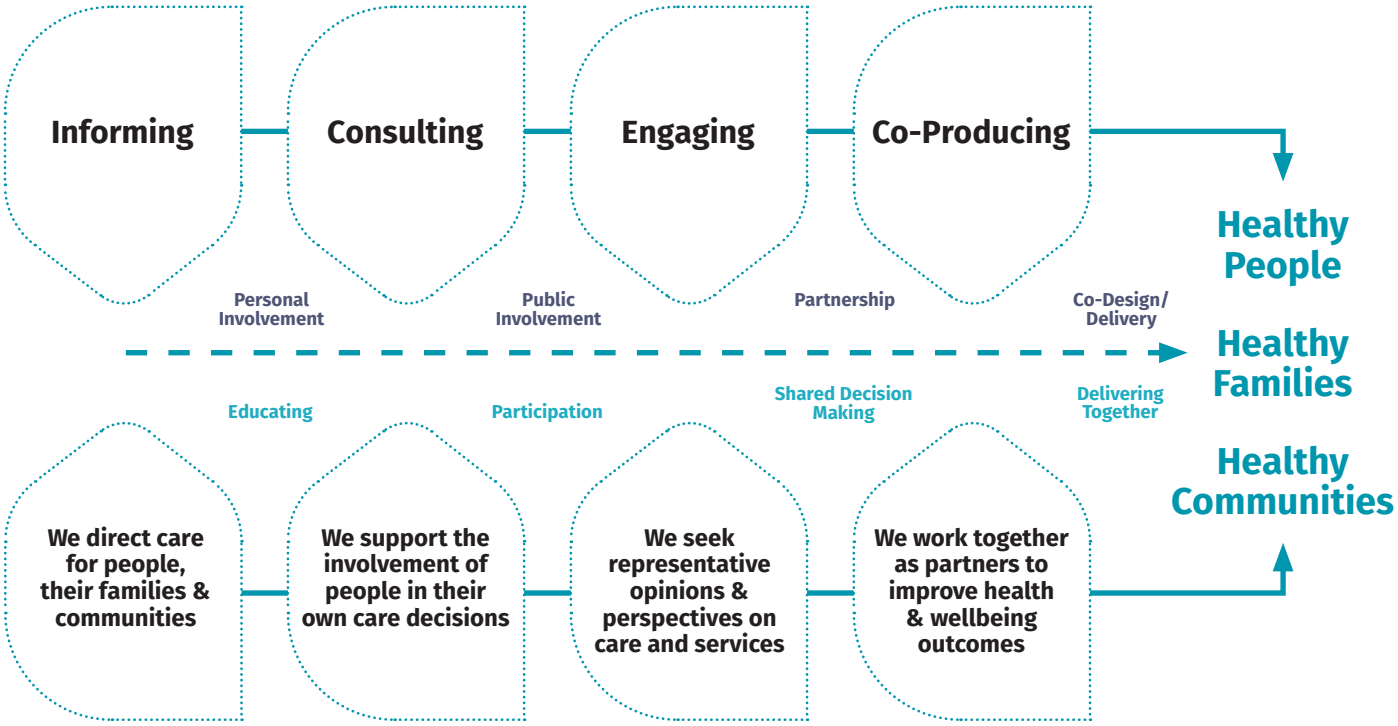
Staff Experience

Co-production is only possible when the staff who provide services are proactively involved as partners in the development and design of health and social care solutions. The evidence shows that when staff are empowered by their organisations and take responsibility the outcomes of care improve.

2.3 The Co-Production Pathway

Co-production has become an increasingly popular methodology in policy making, public health, services delivery organizations and in community sectors. It is important to **recognise** that the evolution of engagement and involvement to co-production in health and social care holds the promise of improving outcomes, it is not always clear what counts as or what is meant by "co-production", what it entails in practice, or what is actually being co-produced. This is because involvement, engagement and co-production approaches are all part of a continuum as outlined in the co-production pathway figure 3. This ranges from involvement, to co-design and co-delivery. The other reason why there is so much variation in approaches is often influenced by the context, culture and beliefs about when co-production is appropriate.

Figure 3



Whilst co-production may challenge conventional forms of engagement and involvement; common to all these approaches is a **desire to improve the interaction between people who use services and staff who provide care**. The real value of co-production is its ability to **create the space** to bring together different and representative perspectives in order to co-design innovative solutions which improve outcomes for people, their families and communities.

Locally, nationally and internationally 'co-production' is seen in current policy agendas both as the next logical step to personal and public involvement by offering a new way of incorporating people's expertise in more substantive and meaningful ways into the design and delivery of health and social care services.

One of its distinctive features involves bringing people into the decision-making process by working across organisational boundaries. This helps to reduce knowledge gaps and addresses power imbalances between different participants. Blurring boundaries erases artificial distinctions between 'recipients' and 'providers' of services. The process of co-production must take into account the participant's understanding of involvement and co-production; the differences between involvement and co-production; and how the power disperses between partners can be equalized through the process of co-design and co-delivery.

The power of co-production is best understood through the shared narrative that evolves when people find ways of working together to generate better outcomes and recognises the ***'sum is greater than all of its parts'.***

Figure 4

What co-production is and is not

✓ Co-production IS:	✗ Co-production is NOT:
Partners respecting each other and valuing each others perspective and contribution	Just giving people a chance to speak but not using the information.
Working together from the very start to identify and achieve an end result that is collaboratively agreed on.	Confrontation and 'winning and losing'.
Listening to each other and understanding where everyone is coming from and the particular challenges they face.	A quick fix.
At times deferring to the other on grounds of practicality, economics, ethics, equality of civic rights, requirements under section 75.	Consultation i.e. having a plan and then going out to tell people about it OR even having a plan, asking people's thoughts and about it and incorporating these thoughts into a revised plan.
Valuing, learning from and building on the different skills, assets, experience and expertise that different people bring to the process.	One partner simply trying to persuade another to come around to their way of thinking.
Working in ways that best meet the needs of all partners.	Listing problems and expecting someone else to solve them.
Sharing ownership for developing solutions that are evidence based, work and are deliverable.	A new way to get your personal agenda on the table at the expense of someone else's.
Breaking down barriers between professionals/ providers and people using public services.	A new forum for public service staff to tell people what is going to happen, or for people to lobby the public sector.
Committing jointly to support and develop the capacity and understanding of all people involved in the process.	
Trust, support and information sharing.	
Taking shared ownership when solutions don't work first time and taking a joint problem solving approach to move forward.	
Talking with and not to.	

Section 3:

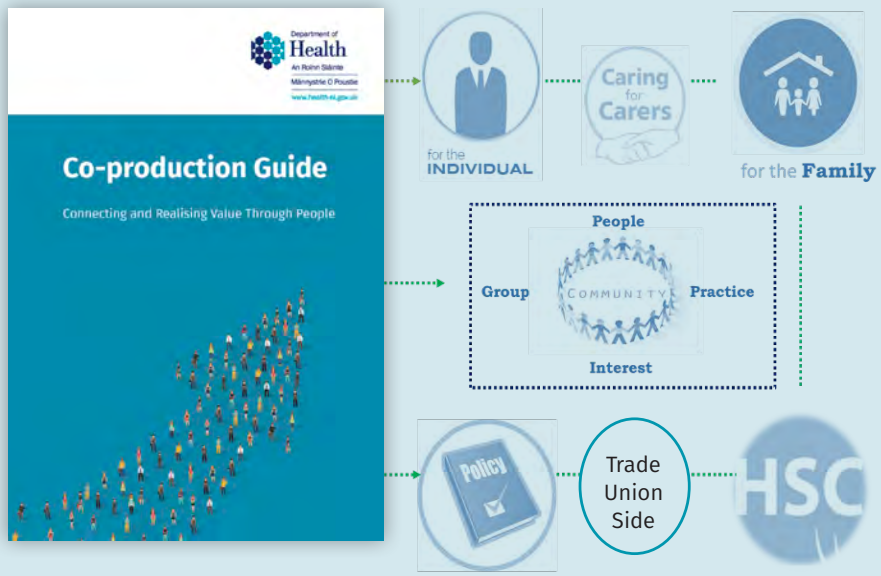
Guide on ‘How To’ Co-produce

3.1 Who can use this Co-Production Guide?

As outlined in figure 5 the Guide has been developed for all those involved in the design and delivery of health and social care specifically with:

1. people who use services their families and/or Carers,
2. local communities, community groups, communities of practice and community of interest.
3. Policy Makers, system Leaders, staff who deliver care and TUS.

Figure 5



It aims to provide guidance on the core principles and practice which underpin co-production and should be of specific use to:

The co-production principles outlined in this guide have been tailored in section 3 to support the embedding of co-production into policy making, strategic planning and care delivery. The Guide is specifically intended to complement existing PPI policy and other key areas of transformation identified in ***Delivering Together***, which includes but is not limited to:

- HSC Leadership Framework;
- Improvement Institute;
- HSC Community Development Framework;
- e-Health Strategy.

- HSC Organisations
- HSC Board Members and Executives
- PPI staff and forums

- Carers
- Primary Care Services
- Local communities
- Communities of Interest
- Community and Voluntary Organisations

- Patient Client Council
- Policy makers and transformation work-stream leads
- People with lived expereince and peer networks

- Staff at the point of care delivery
- TUS
- Operational Managers, Team and Clinical Leads

3.2 The six principles of co-production

The following six principles will enable the implementation of co-production across all HSC organisations. Building on existing PPI infrastructure and using practical steps outlined in this guide each HSC organisation will embed co-production in its strategic, and operational planning.

Valuing People

Co–production is a person centred process which is dependent on building reciprocal relationships between people. It is based on developing mutual respect, openness and accepting collective ownership for outcomes. It recognises that people possess a wealth of different knowledge and expertise about needs, what matters, and what has to change in order to deliver better outcomes. This means we will:

- acknowledge that everyone on the co-production team is an asset with individual skills, strengths and experiences to contribute;
- find ways to use and develop these assets; value everyone's contribution; and build on citizen's ability to participate; and
- work together to develop confidence and strengthen capacity, making sure the voices of everyone co-producing on a project is heard and understood.

Building Representative People Networks

A core principle of co-production is to move towards balanced meaningful participation, engagement and shared ownership. It is about developing effective collaborative partnerships in order to co-design and co-deliver services. It is dependent on developing representative and sustainable networks, with people from all sectors including those who have been marginalised and are hard to reach. The ***principle of representative*** means that co-design and co-delivery groups should reflect a balance of people who use services, staff who provide services and as appropriate other external partners. This requires detailed stakeholder mapping using the **'ARE IN'** principles:

- **A**uthority: People with the ability to act to influence change and enable it to happen when a solution has been developed by the group.
- **R**esources: People who know what we have capacity to do/not do (e.g. finance/HR/access/influence).
- **E**xpertise: In the topic (social, economic, technical, professional etc.)
- **I**nformation: That others need (data etc)
- **N**eed: Service users, carers, staff and others who will be affected by the outcome

Mapping stakeholders in this way will help strengthen existing networks; enable the development of new networks; and to bridge networks where gaps exist. It also creates a real opportunity to maximise social capital through the development of peer led/community networks.

Building People's Capacity

Co-production is dependent on creating the circumstances for shared decision making and power from boardroom to point of care services. This requires investment in:

- building people's knowledge;
- training people in PPI, co-production, quality improvement, population health and community development approaches; and
- harnessing the efforts and work of: local PPI forums; co-production teams; peer networks; Integrated Care Partnerships (ICPs); thematic/communities of interest; quality improvement teams; and other community networks into a logical representative approach.

Reciprocal Recognition

HSC organisations will need to dedicate resource to support co-production, invest in building the capacity within their organisation, mentor/coach/ support people with lived experience and release their staff to become involved in the co-design and in the co-delivery of services. Co-production requires the contribution of all participants to be valued and a commitment to learn together, and resolve different perspectives with respect. As appropriate co-design and co-delivery contributions may include non-monetary and/or monetary rewards.

Cross Boundary Working

Co-production also creates the conditions for a multi-agency approach to the improvement of outcomes for local communities. This is about mobilising all the assets of the community, voluntary sector, and all relevant government organisations. This creates opportunities to pool resources and assets in working towards shared goals and better health and social care outcomes.

Enabling and Facilitating

Co-production requires staff, leaders and managers to become facilitators and enablers of change. Effective facilitation is established by empowering all involved to have solution focused approaches and promotes joint responsibility for achieving positive outcomes. This means we also focus on outcomes and review by considering '*how much did we do, how well did we do it and is anyone better off?*' The system facilitates change and empowers people to have the confidence and opportunity to live their lives in the way they want to and to take control of their own future health and wellbeing.

3.3 Practical Guide for Policy Makers

This section is to help policy makers think about their role in enabling co-production in their organisations. Policy makers have a crucial role to play in creating the conditions for shared decision making to become a reality. This requires cultural change, commitment and collective leadership in order to engage people from the start in policy making processes and in the co-production of strategy.

'People with lived experience have said 'if you want us to step up, you have to learn to step down a bit'

Using the six principles:

Valuing People

People value the opportunity to be involved in shaping the key policies that affect their lives. For this to be meaningful policy makers should work to maximise the opportunities across the system for early involvement and engagement of people in the formulation of HSC policy. Make time for partnership working at all levels and facilitating the necessary background work order in to ensure people's voices and contribution are representative, valued, understood and reflected in the policy making process.

Building Representative Network

Policy makers will enable the active development of representative networks to support the drafting, design and evaluation of policy and strategy. This will include drawing representatives from these networks including unrepresented groups into the policy and strategy formulation process. Policy makers will proactively develop relationships within, across and outside their own department, in order to generate evidence based solutions.

Building People's Capacity

Through sharing knowledge and attending training programmes, policy makers will strengthen people's capacity to participate in the co-design of policy, strategy, and service improvement. There must be opportunities for reflecting and integrating people's experience and evidence into the development of new ways of working. This includes all partners understanding legal and statutory decision making processes as part of the progression towards shared decision making.

Reciprocal Recognition

Recognising and rewarding people's contribution particularly the lived experience and communities' contribution is a fundamental principle of co-production. In line with the reciprocity guidance, secure ring-fenced funding and/or other opportunities for reward to support the time people give to being involved in co-production work.

Cross Boundary Working

The draft PfG requires the wider public sector to work together to deliver better population outcomes. Policy makers should consider opportunities to collaborate and co-design policy widely to address need and ways to pool resources to deliver on agreed programmes of intervention.

Enabling and Facilitating

Policy makers have a critical leadership and enabler role in creating the condition for whole system collaboration (co-design). Policy makers can act as facilitators in the shaping of policy and in enabling collective agreement on the strategic shape and direction of services. Occasionally it may be important to source an independent person to facilitate the process of co-design.

Key Outcome

Community is more actively engaged in health and social care services design and delivery.

3.4 Practical Guide for Board Members and Executives

This section outlines the roles and responsibilities for HSC Boards and Executives (Non Executives, Chief Executives and Directors) leading the development of people powered health and wellbeing approaches through co-production, both within and across their respective organisations. For co-production to be successful it requires Boards, senior executive leaders to lead and have co-production embedded in the organisation's core business and its culture.

Valuing People

In creating the strategic and organisational conditions to enhance the role and contribution of people in the planning, development, delivery and evaluation of all the organisations activities and services. This involves leading from the front and valuing people's contribution by progressively sharing decision making and promoting co-design and co-delivery.

Building Representative Network

Through supporting the development of representative networks across all programmes of care. This includes investing time and resources in building relationships with local communities and groups of people who use services. It also involves investing in peer support, expert patient services and progressively creating self-managing teams who are empowered to co-produce with those who use services.

Building People's Capacity

Building the capabilities and capacity of the workforce to co-produce at all levels. Consider re-energising the role of the Board to overseeing the development of PPI/co-production in the organisation. This involves investing in co-production training across all parts of the organisation. It also involves open and transparent sharing of information in order to facilitate effective co-design and co-delivery with all relevant partners.

Reciprocal Recognition

Ring-fencing funding to enable the development of co-production across the organisation. This includes establishing systems that reward and recognise the contributions people make. It also involves learning from the experience of people who use services and staff who provide care by formally recognising how their contribution has changed the delivery of services.

Cross Boundary Working

As part of transitioning HSC systems of care, Boards and Executives will need to strengthen the organisation's community development role in addressing population health needs. Reach out and invest in multi-agency and community sector partnerships in order to deliver of better outcomes.

Enabling and Facilitating

Facilitating a change in organisational culture which embeds co-production at the heart of the organisation's strategic planning processes. This involves leaders providing oversight and enabling all those involved in service planning, development and improvement to reflect the principles of co-production in their practice.

Key Outcome

People are active participants in co-design and co-delivery of services. There are measureable and objective improvements in people and staff experience, care outcomes and there is evidence of increased productivity across all services.

3.5 Practical Guide for People with Lived Experience & Peer Networks

This section outlines the roles and responsibilities of people with lived experience in participating in service development and in leading co-production. Lived experience includes: direct experience of a health and social care need, carers, advocates and all peer support networks. Fundamentally co-production is a ***deeply person centred approach*** and is based on ***'No decision about me without me'***. It recognises the knowledge of people with lived experience **is of equal value** to staff experience and knowledge. Individuals and peer led/support groups therefore have a fundamental partnership role in formulating their own needs, developing their own personalised support plan, shaping and influencing policies, strategies, and in the co-design and co-delivery of services.

Valuing People

Recognise the value placed on their personal experience and knowledge and will value the worked experience of staff and in partnership with them and other partners work to break down barriers, create mutual understanding of needs, develop shared goals and improve outcomes for all.

Building Representative Network

Have a lead role in developing and building representative peer networks, and in working with other partners who participate in delivering, advocating or enabling better health and social care outcomes. This also involves working in partnership with others and representing lived experience on regional and local co-design/co-delivery working groups.

Building People's Capacity

Avails of training and development opportunities alongside staff in co-production on how HSC systems works. Will also co-deliver training and development for staff, and other partners in seeking to create understanding of the personal, psychological, and social economic needs. People with lived experience will have a leadership role in supporting the development of peer led and expert patient models and services.

Reciprocal Recognition

As a basic principle recognise that everyone has expertise, skills and strengths. Share ownership and accept responsibility with others for shared decisions. This will include advocating for positive change in service delivery models with peers across HSC systems. As outlined in the recognition section of this guide the contribution of people with lived experience will also be recognised, valued, and, where appropriate, remunerated.

Cross Boundary Working

Work with others and across organisational boundaries and through their representative networks influence other government departments, local government and all communities in working together to deliver better outcomes.

Enabling and Facilitating

Be leaders and facilitators of change and an advocate for co-production, supporting and enabling HSC staff and peers to work together to solve problems. Develop with others new and creative solutions which deliver evidence based outcomes.

Key Outcome

The experience of the health and social care system is more person centred, your contribution has enabled change and as a result health and wellbeing outcomes have improved.

3.6 Practical Guide for Operational Managers, Team and Clinical Leads

This section outlines the role and responsibilities of Operational Managers, Team and Clinical Leads in developing and leading co-production within and across their respective organisations. Operational Managers, Team and Clinical Leads have a key role in translating co-production into operational practice and showing leadership by facilitating their staff and people with lived experience to work in partnership to deliver improvements in personalised care and to design solutions which enables better outcomes for people who use their services.

Valuing People

Will champion co-production and demonstrate their organisations commitment by building lived and learned experience into the design of care pathways, service development and in the auditing and evaluation of services. Organisations will need to be accessible and visible in supporting, mentoring and in acknowledging the value of people's contribution.

Building Representative Network

Support the strengthening and development of partnerships working between staff, people with lived experience and their respective communities. Scope partners, map assets and enable the development of peer/lived experience networks. Create the conditions to support networks in the decision making process.

Building People's Capacity

Create time for staff to participate in co-design/co-delivery programmes. Develop training needs analysis, facilitate training in PPI and co-production methodologies. Embed co-production principles in team meetings, supervision, revalidation and continuing professional development processes. Create opportunities for people with lived experience to become involved in the development of care pathways and services. Ensure all participants are given the information they need to meaningfully contribute.

Reciprocal Recognition

Value and learn from the contribution of others, recognise and reward people in line with the principles in this guide. Link all co-design and delivery work to enable better outcomes.

Cross Boundary Working

Lead and build the necessary cross-government or multi-sector partnerships in generating solutions for improving people and communities outcomes. Proactively build connections and contacts beyond 'usual' boundaries, invest in and pool resources with others in outcome focused solutions.

Enabling and Facilitating

Develop/strengthen facilitation skills, and through effective compassionate leadership enable people with lived experience, point of care staff, and communities to solve problems together.

Key Outcome

Teams feel empowered; staff and people with lived experience feel valued; and health and wellbeing outcomes for people with lived experience have positively improved.

3.7 Practical Guide for Communities

This section helps communities as they embark on a transformational co-production process. Communities can be geographical or communities of interest. Geographical communities may reflect a location like a housing estate or a town. Communities of interest may be groups of people who come together from a shared experience or circumstance i.e. Tenants group or Men's shed. Co-production provides the opportunity for health and social care, other public services and the community and voluntary sector involved in health and social care provision to work with communities to design and produce services that are relevant to them. This transformational co-production process enables a different and deeper level of interaction and engagement of all those involved, from HSC organisations to other parts of the public sector through to local communities.

Valuing People

Proactively engage and build on the experience and knowledge of the people who use services and the experience of people and organisations that make up the local community.

Building Representative Network

Find and develop the peer supports that are available at community level. This may mean working in partnership with a number of new people or organisations, finding areas of common interest, or identifying gaps that others in your community can support or help in.

Build People's Capacity

Engage in activities and experiences which strengthen the levels of trust within communities and those community based organisations which are working to improve and sustain health and wellbeing. This includes HSC as well as other organisations i.e. councils, police etc. Refer to and use the knowledge known to the community to help determine what is relevant to their situation and circumstances.

Reciprocal Recognition

Value people's contribution in whatever form it takes. Be willing to use new ways to recognise people for their involvement through the use of schemes like time credits and time banking. Move towards working in a way which is reciprocal and uses the experience and knowledge communities have, and which introduces new communities to the process where they see positive benefits.

Cross Boundary Working

Traditional roles are re-examined and those best placed to address an issue with skills, knowledge, expertise and where necessary reallocation of finance are supported to do so. This is best done through established trusting relationships. These are built over time and will not happen overnight.

Enabling and Facilitating

As a community we are willing to learn and change alongside those within the HSC organisations and other public bodies. Move towards working more collaboratively investing our time into building relationships and shared solutions to overcome complex problems.

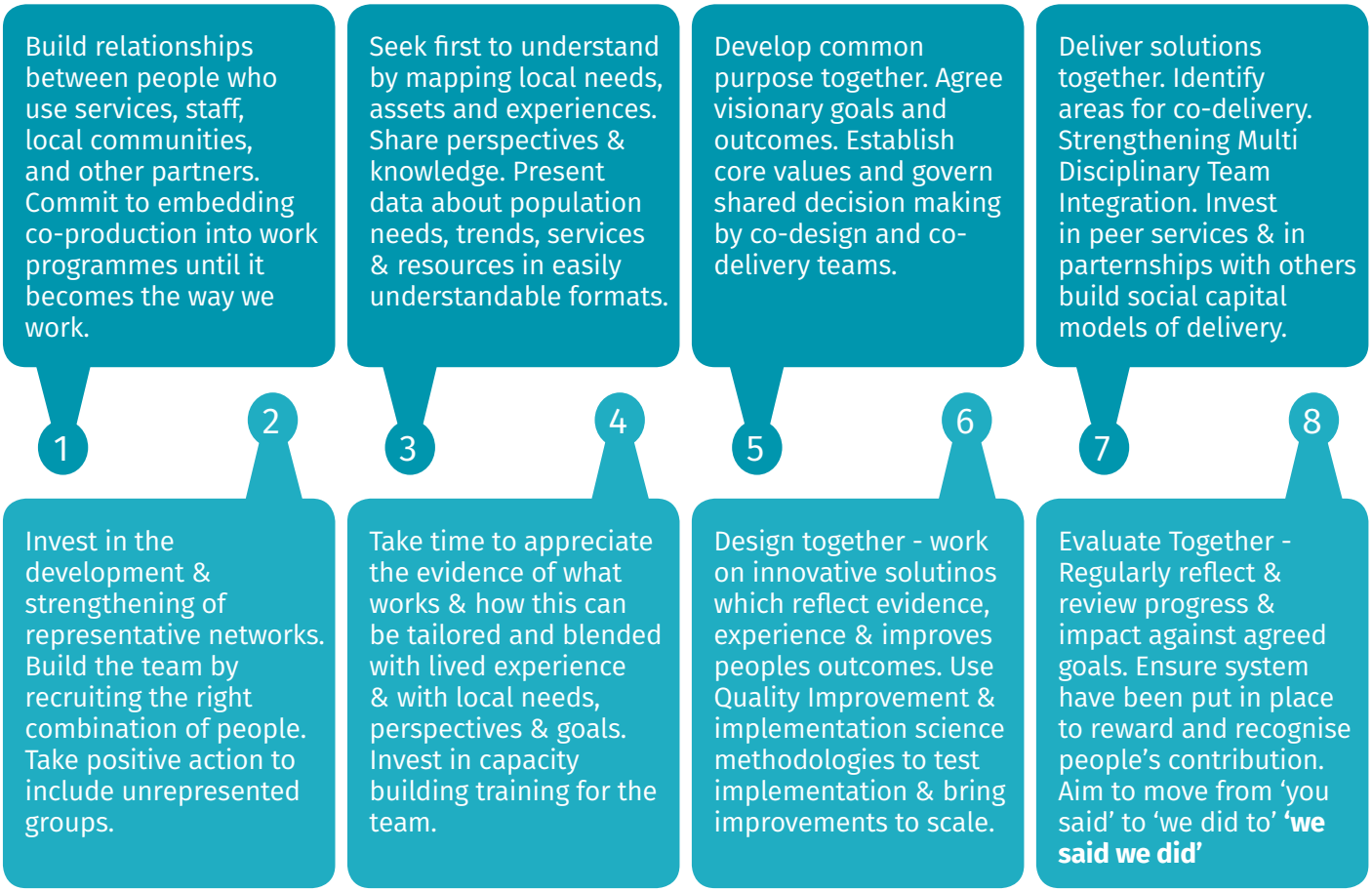
Key Outcome

Community is more actively engaged in supporting health and social care services design and delivery.

3.8 Key Implementation Steps to Effective Co-Production

To translate these prinicples outlined in section 3, figure 6 below, outlines eight key implementation steps which will enable the effective use of co-production within and across each health and social care organisation.

Figure 6



3.9 Collective Leadership

Co-production requires collective leadership at all levels. It reflects the need for distributed leadership and distributed ownership of policy, strategy and delivery within and across systems. It means system leaders:

- are accessible and visible to people who use services and the staff who provide them;
- adopt a facilitation role 'clearing the way' to enable shared decision making and real partnership working to occur, until it becomes the 'way we do things'; and
- exemplify the values and principles of co-production by ensuring they maximise the opportunities of partnership working in order to improve outcomes for all.

3.10 Reciprocal Recognition

At the heart of co-production is a commitment to value, reward and recognise the contribution of all partners, particularly people with lived experience. All the core literature on co-production recognises the principle of **reciprocity** which is defined as ensuring that people receive something back for putting something in, and builds on the premise of recognising and valuing people's contribution.

Examples of Reciprocity include mutual respect, equality of opportunity, joint learning, recognition, flexible rewards, and remunerating people for their role and contribution. This can also include benefits in kind, such as 'out of pocket' expenses, and meeting training and development costs. Depending on role or task being undertaken, rewards should be flexible and provide choice. The importance of choice cannot be overstated.

Recognise that there may be personal reasons why people do not want or are unable to accept payment for commissioned work and therefore rewards for people's time should be flexibly applied.

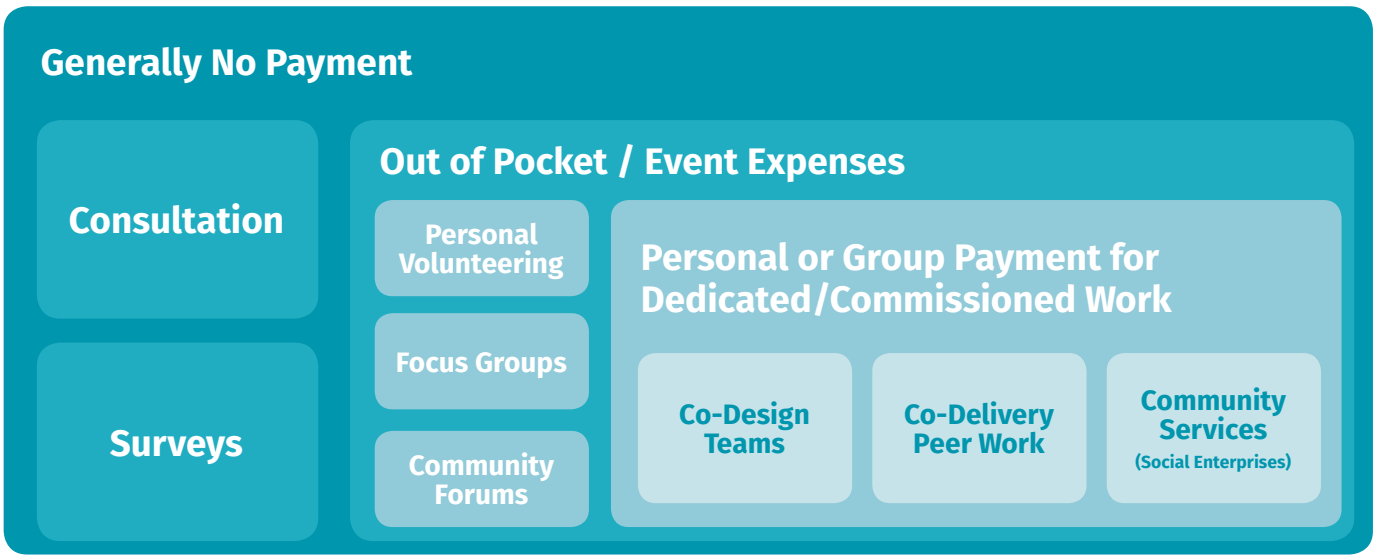
HSC organisations should plan and budget for co-production activities on an annual basis.

In the spirit of co-production, monetary and non-monetary rewards should be appropriate to the function and role required. In the same way that professional services are increasingly required to demonstrate outcomes, all peer led activities should be effectively planned and linked to outcomes.

All sessional peer led activities will be supported by a role specification which will outline the level of responsibility, skill, expertise, and experience required. It is important to note we must not substitute the important value that is associated with volunteering and good will, but aim to achieve a balance between the value of maximising personal involvement, enabling peer networking, and repaying the contribution of people with lived experience involved in co-production.

The table below is intended as a guide to reflect the principles of co-production set out in section 3. Payments should be in line with the existing HSC/NICS expenses, role specification, services commissioning, and recruitment processes.

Figure 7 (illustrative only)



3.11 Conclusion

Co-production is fundamentally an investment in relationships, which when successful leads to improved outcomes for our population. It is a crucial foundation for enabling people and communities to influence their own health and wellbeing by contributing to the co-design, co-delivery and improvement of HSC services. Recognising and harnessing the mutual strengths, capabilities and potential of people, staff and communities provides a real opportunity to achieve positive change.

Success will require a sustained commitment from leadership at all level, a willingness to inspire innovation and share:

- decision making;
- knowledge; and
- resources

to achieve transformational change. Co-production is about ***'realising value through people'***. It can move us from a culture of 'you said, we did' to 'we said, we did it together'.

3.12 With special thanks to the Co-production Working Group

This Guide has been co-produced by a group of people with a vast range of knowledge and experience in using co-production approaches and PPI standards within health and social care services. They worked professionally, tirelessly and enthusiastically as a team to reflect their learning and experiences in how coproduction can be used to improve people's health and social care outcomes.

In the months that we journeyed together working on this project, we have built strong relationships and trust with each other. We communicated well together working through issues to focus on the practical solutions to using co-production as a method of involvement for transformational change.

Their contributions have been exceptional – THANK YOU ALL

Section 4:

Essential Reading

4.1 Department of Health - Policy and Strategic Frameworks

- ☆ **Health and Well Being 2026 - Delivering Together**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

- ☆ **Systems not Structures**

  https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

- ☆ **Personal and Public Involvement Legislation**

  https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi

- ☆ **Department of Health – Personal and Public Involvement Consultation Scheme**

  https://www.healthni.gov.uk/sites/default/files/publications/dhssps/DHSSPS%20Personal%20Public%20Involvement%20Consultation%20Scheme.pdf

4.2 Supporting Literature

- ☆ **SCIE – Guide to co-production in social care**

  https://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/

- ☆ **British Medical Journal – from tokenism to empowerment**

  http://qualitysafety.bmj.com/content/qhc/early/2016/03/18/bmjqs-2015-004839.full.pdf

- ☆ **Health Foundation Improving Outcomes by Helping People Take**

  Control – The Theory and Practices of Co-Creating Health.

  Improving Outcomes by Helping People Take Control The theory and practice of Co-creating Health. - ppt download.

- ☆ **Welsh Government Co-producing services – Co-creating Health.** http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%288%29%20Co-production.pdf

- ☆ ***Scottish NHS Co-Production – Health and Wellbeing*** http://www.govint.org/fileadmin/user_upload/publications/Co-Production_of_Health_and_Wellbeing_in_Scotland.pdf

- ☆ ***Scottish Joint Improvement Team – Co-Production OPM Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care*** http://www.healthissuescentre.org.au/images/uploads/resources/Coproduction-health-wellbeing-outcomes.pdf

- ☆ **Scottish Recovery Network People Powered Health and Wellbeing – Shifting the Balance - How people with lived experience and people who work in services can have good conversations and build connections to co-produce wellbeing** http://www.coproductionscotland.org.uk/files/8014/2788/6655/4._People_Powered_Health_and_Wellbeing.pdf

4.3 Organisations and Networks with Expertise in Co-Produciton

- ☆ **Co-production Wales: Co-production Network for Wales**
  https://coproductionnetworkwales.wordpress.com/
- ☆ **Co-production Scotland – Scottish Co-production Network**
  http://www.coproductionscotland.org.uk/
- ☆ **Co-Production Northern Ireland – Community Development Health Network**
  https://www.cdhn.org/co-production
- ☆ **Kings Fund**
  https://www.kingsfund.org.uk/
- ☆ **Nesta**
  https://www.nesta.org.uk/
- ☆ **New Economics Foundation**
  http://neweconomics.org/
- ☆ **SCIE**
  https://www.scie.org.uk/co-production/

Annex A:

Examples

CO-DESIGN WITH COMMUNITIES
Daisy Hill Hospital (DHH) Pathfinder Project

CONTEXT

A need to develop plans for urgent and emergency care services in the Newry and Mourne area was identified against a background of significant public concern about challenges facing the Emergency Department (ED).

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Trust Directors***
Resources:	***Trust assigned Project Manager, PHA medical consultants, Trust Directors, Trust Head of Communications***
Expertise:	***Clinician and Managerial staff, GPs, Service and Professional Managers, PHA Medical & Nursing staff, NIAS, Commissioners (HSCB and SLCG representatives)***
Information:	***PHA, SHSCT, HSCB***
Need:	***Representatives from the local community, TU representative (UNISON)***

A Daisy Hill Hospital Pathfinder group (DHHPG) was formed to take forward the required development plans. The Trust Board approved adopting a co-production approach for this project. Membership of the group was wide ranging as noted above and of significance included 5 people from the local community. The latter members were selected via an open recruitment process which was facilitated by the Confederation of Community Groups, Newry and District. Essential criteria for selection included access to a local community 'network' that could be utilised to consider and provide feedback on proposals as the project progressed. The professional and managerial staff also had access to networks from their respective fields. The professional staff, while unsure as to how it would progress, embraced this new way of working with the local community. To meet the needs of the local community group members, the Project Lead met with them as required in advance of DHHPG meetings to talk through any issues, unfamiliar concepts, training needs and ideas. Tailored briefings were also provided for these members to enable everyone to be at the same starting point with regards to information and understanding – this ensured power was balanced in meetings.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

A stakeholder mapping exercise was completed to identify what was available in the local area. To facilitate as many people as possible meeting with the Project Lead individually or in a small group, engagement meetings were arranged in several community settings and promoted using a variety of methods including an internet Invite Video. These meetings provided an opportunity

for people to raise concerns directly with the Project Lead and share information about local networks. All considered the meetings as positive and that many stated that they felt their views had been heard and valued. An early step was the production of additional supporting information collated through a comprehensive Health Needs Assessment (HNA). This included a range of relevant local and regional statistical data and information gained through clinical audits and a literature review. This was developed by and shared with all members of the DHHPG for consideration.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People's Capacity, Building People Networks and Cross Boundary Working

Recognising the need for wider staff engagement, an interactive workshop attended by 100 staff and GPs was undertaken to identify their issues, concerns and potential solutions. Collectively the DHHPG considered the output from the workshop alongside information from the Health Needs Assessment, the clinical audits and the literature review to identify priorities. One was the development of a Direct Assessment Unit (DAU) at DHH as an alternative pathway to ED for stable patients. The DHHPG recognised the value of learning from others and arranged a visit to Antrim Area Hospital (NHSCT) where a DAU had been operating for several years. A delegation representing a cross section of all stakeholders from the DHHPG met with medical and nursing staff and explored a number of areas including flow between the primary, acute and community services. The visit helped to create a vision of how a DAU might operate in DHH and highlighted the significant benefits to patients.

The SHSCT was proactive in recognising the need to communicate the continued progress of the Project's work and designated a communications officer to work alongside the team. A communication strategy was developed with a monthly on-line E-Zine that all members of the DHHPG were responsible for sharing in a suitable format within their respective networks and bringing feedback back to the group to aid the wider development process.

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

The information from the Health Needs Assessment paper confirmed for members the need for an ED on a 24/7 basis and the group's focus then shifted to how best they could achieve this. To progress this vision the group agreed priority workstreams and established specialist subgroups to consider:

- ED Workforce;
- Improving Patient Flow, including Rapid Assessment/Short Stay Service; and
- Strengthening Services for the Sickest Patients.

Each subgroup contained members from the community; a range of clinical and non-clinical staff from primary, acute and community settings; and staff side representatives. They worked together, using their collective knowledge, data and networks to develop the proposed new service model, alongside the DHHPG. A final report was published in December 2017 ***http://www.southerntrust.hscni.net/pdf/DHHPG%20Final%20Report.pdf***

Step 5 – Co-delivery

This example primarily focusses on co-design but with a view to developing co-delivery as part of implementation of the model.

Step 6 – Co-evaluate

At the time of writing the co-design phase of this project has just been completed. Regarding implementation and evaluation of the proposed model, the final report commits to continuing the wider partnership approach to successfully co-deliver and co-evaluate this project. The situation regarding Daisy Hill hospital was a contentious, high profile, emotive issue. The co-production approach enabled all parties to effectively outline their positions, consider these in the context of clear evidence and information and then develop solutions in partnership.

Michael McKeown, President of Newry Chamber of Commerce, captured the impact of the process. "I have been privileged to sit on the DHHPG as a community representative. Remarkable change is taking place. Now is the time to... remove the negative. Replace the word 'save' with the word 'support'. Support Daisy Hill."

CO-DELIVERY IN MENTAL HEALTH

'You in Mind' Mental Health Care Pathway and Recovery Colleges

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority: PHA HSCB Trust Directors

Resources: PHA Nursing Facilitated Regional group, Trust MH service improvement officers, Trust service user and carer networks.MH Operational managers, AD Mental health.

Expertise: External ImRoc facilitators, PHA, Trust clinical staff, service user and carer/ families,Service improvement managers.

Information: All Trusts, PHA,HSCB

Need: TU Representation

When the group was formed, members outlined their initial anxieties in order to build trust – people with lived experience expressed concern about dominant professional perspectives, whilst the professional anxiety was that coproduction might undermine professional expertise. Overcoming these anxieties required all to have an agreed understanding of our values and our vision of recovery orientated practice and its practical application. This involved true partnership working and mutual respect for each other's point of view to develop relationships.

Each of the 5 areas agreed to either use existing or if required to create a new network outside of the group that could be used to engage with and inform the process as it evolved – in line with PPI statutory requirements.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People's Capacity and Reciprocal Recognition

Taking a strengths based approach, the various partners outlined the value of the different knowledge bases and networks available to them during the process and this enabled them to identify training gaps. They used the results of a regional survey of the experiences of people using or caring for someone who uses mental health services – which clearly outlined the need for 'good communication', 'shared care', 'timely information' and the importance of respectful and dignified care.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

The consensus view on our vision was to work in a co-productive way in order to transform people's lives and make it part of the way we work on a daily basis. By doing this we wanted to create a culture where the values of hope, control and opportunity became the norm. Working in equal partnership to put co-production at the heart of mental health care by co-producing a NI Mental Health Services Framework that incorporated the 'You in Mind' mental health care pathway and the development of Recovery Colleges.

Step 4 – Co-design the Solution

Principles demonstrated - Cross Boundary Working and Enabling and Facilitating

Giving equal weight to people's lived experience with professional expertise was fundamental to promoting co-production. This influenced practice, reform of services and was instrumental in the revision of the Northern Ireland Mental Health Services Framework. The establishment of an expert by experience writing group ensured the pathway remained grounded and real for everyone involved. The group helped translate a complex range of evidence and co-production concepts into an easily understood practical guide.

The vehicle used to facilitate the establishment of Recovery Colleges was through the *'Implementing Recovery through Organisational Change Programme'* (IMROC). The Recovery Colleges have been designed using a 'hub and spoke' model and programmes are delivered within local communities through a wide range of community and voluntary sector venues and public buildings. A wide range of co-produced courses have since been developed in partnership with people with lived experience and with the active involvement of voluntary and community sector professionals.

Step 5 – Co-delivery

Principles demonstrated - Valuing People, Building People Networks, Building People's Capacity, Reciprocal Recognition, Cross Boundary Working and Enabling and Facilitating

The establishment of Recovery Colleges created a robust network of people with lived experience who are now actively involved in the design and delivery of a wide range of co-education programmes across Northern Ireland.

The 'You in Mind' care pathway and the Recovery Colleges have helped to mainstream and embed co-production, whilst also initiating a culture shift across mental health care. The co-delivery of this work has led to the establishment of peer support worker posts, five Recovery College Hubs and the appointment of Recovery College peer educators.

Step 6 – Co-evaluate

Principles demonstrated - Valuing People, Building People's Capacity, Cross Boundary Working and Enabling and Facilitating

The approach to evaluating the difference Recovery Colleges have made to people's lives is being carried out using an outcomes based accountability approach.

We consider how much we do regarding numbers of attendees and co-produced courses; how well we do it - using the 8 criteria identified by IMROC for developing a Recovery College; and finally if anyone is better off?

We consider feedback on:

- improved knowledge;
- self-reporting on improved confidence and wellbeing;
- improved connections with others in the community; and
- wanting and having opportunities to give back.

CO-DESIGN WITH COMMUNITIES
Primary Care Multi-Disciplinary Teams

CONTEXT

Delivering Together: Health and Wellbeing 2026 identifies enhancing support in primary care as a key priority. It sets out a vision for a primary care service focussed equally on mental, physical and social wellbeing which is able to intervene early to support self-management and independence. In order to deliver this, a broader primary care team is needed with a genuinely multi-disciplinary team wrapped around GP Practices.

Step 1 – Build the initial team - develop relationships, trust and networks

Principles demonstrated - Building People Networks and Cross Boundary Working

Group Membership

Authority:	***Department of Health, HSCB and PHA reps***
Resources:	***Department of Health, Trust, HSCB, PHA and GPs reps***
Expertise:	***DoF and HSCB analysts, health and care professionals***
Information:	***Department of Health, HSCB and PHA reps***
Need:	***Patient representatives, Trust, GP, HSCB and PHA reps***

A working group was formed to develop an approach to rolling out the new primary care model set out in Delivering Together. Given the very wide scope of primary care it was not possible to include all interested groups and parties round the table – instead a smaller group including a user representative, Trust and GP representatives was formed with membership from different regional agencies and from different professional backgrounds and expertise. Members of the group were expected to communicate back to their own professional networks, regional groups and organisations. The group discussed approaches to user engagement and agreed to expand the number of user representatives on the working group and create a separate service user and carer reference group to feed in a wider range of views.

Members of the service user and carer reference group were recruited from existing networks and have been meeting monthly. The group is chaired by a service user and they have been considering the principles that should underpin primary care MDT working from a user perspective.

Step 2 – Identify what can we do, what do we know, what are our strengths?

Principles demonstrated - Valuing People, Building People Networks, Reciprocal Recognition and Cross Boundary Working

A stakeholder mapping exercise was completed and a stakeholder engagement plan developed which is reviewed monthly by the working group.

An evidence base was developed through reviewing quantitative data about existing demand and service performance, commissioning a survey giving us new insight into the case mix presenting to GPs and through work to review best practice locally, across the UK and internationally. This information was reviewed and discussed collectively with all partners on the team to inform the next steps. Different members of the group have also led presentations on key elements – such as the role of social workers, or the proposed neighbourhood nursing model, or paediatric care. In addition, the working group has had presentations from others in the systems on topics which are relevant – such as primary care infrastructure or mental health.

To further enhance what we knew about the current models in place, a local best practice workshop was held. The approach to co-production was discussed and each of the 5 Trusts presented on their current multi-disciplinary approaches to working in primary care. Discussions on the key learning points, questions and issues were held in small, mixed groups of those in attendance – this included Trust staff; GPs; patient and service user representatives; and community and voluntary sector representatives.

Alongside this, a significant number of meetings were held with groupings of community and voluntary sector organisations and key professional groups to explain our approach to the work and seek their early input.

Members of the servicer user and carer reference group all completed a short profile which allowed us to assess the spread of skills, experiences and interests which were represented in that group and consider whether there were any gaps that needed to be addressed or additional training. Having drawn membership from existing groups such as ICPs, representatives had already received training in core skills. Members of the group have been provided with time to engage informally over lunch in order to help build relationships within the group.

We drew on existing regional guidance to ensure service users and carers and professionals attending workshops (such as GPs) were able to claim back travel and other costs in line with regional guidance.

Step 3 – Co-create the Vision

What do we want to do; where do we want to be; who can help us out?

Principles demonstrated - Valuing People, Building People Networks, Cross Boundary Working, and Enabling and Facilitating.

In the next stage we wanted to develop our proposals. To do this we needed to involve a wider range of perspectives into our discussions. We scheduled a series of regional facilitated workshops to do this. These are seeking to:

(i) Share what we know so far

(ii) Take views on what the future should look like

(iii) Gather suggestions for the principles that should underpin the approach to primary MDT working; and

(iv) Seeks views on the best approach to rolling out an MDT approach.

So far 3 workshops have been completed with a further 2 planned. The workshops have been held in daytime and in evenings to help ensure accessibility and have been at venues across Northern Ireland. Invitees included frontline Trust staff (doctors, nurses, social workers, AHPs and managers), ICP chairs and members, council representatives working on community planning, representatives from Trust PPI groups and from our own service and user reference group who were users of primary care services, GPs and practice or federation staff, Ambulance Service representatives, community and voluntary sector representatives, independent sector representatives, community pharmacy representatives and commissioners (LCG chairs).

Step 4 – Co-design the Solution

Principles demonstrated - Enabling and Facilitating, Cross Boundary Working, Valuing People and Building People Networks

To date the workshops have gathered views on the approach to roll-out and what elements should part of the initial model we seek to implement. Once the workshops have been completed, the working group will use this input in conjunction with the evidence collated in step 2 to make a recommendation to TIG about:

- a set of principles to underpin the work; and
- about how we should seek to roll the model out.

The exact design of the model will require further active engagement from a wide range of local partners in the areas that seek to test the model in.

Step 5 – Co-delivery

We intend to form a strong partnership with GPs, Trusts, community and voluntary sector, those with lived experience of using primary care services and staff involved in the delivery of the new model in each local area to ensure that practice on the ground can be adjusted, barriers removed and learning shared. Throughout the roll-out period it is intended that the service user and carer reference group will continue to play an active role in shaping the model we use as the 'network' for the service user reps on the Project Team.

Step 6 – Co-evaluate

DoF analysts are currently discussing the approach to evaluation with our service user and carer reference group, who are keen to shape the approach and help develop the questions we use. Proposals will then be brought back to the working group for consideration as part of our overall approach to measuring success.

We intend to co-create a continuous feedback loop that will allow us to learn from initial roll out, re-design the model with input from partners and users and support further roll-out and evaluation of the service.

Annex B

GLOSSARY OF ACROYNMS IN USE ACROSS HEALTH AND SOCIAL CARE

AHP	Allied Health Professional
ALB	Arms Length Bodies
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CAMHS	Child and Adolescent Mental Health Services
CEC	Clinical Education Centre
CHD	Coronary Heart Disease
CMP	Condition Management Programme
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COPD	Chronic obstructive pulmonary disease
CPD	Commissioning Plan Direction
CPO	Chief Pharmaceutical Officer
CSP	Chartered Society of Physiotherapy
DOH	Department of Health
DE	Department of Education
ED	Emergency Department
ELCOS	End of Life Care Operation System
FPS	Family Practitioner Service
FSH	Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
GPSI	General Practitioner with Specialist Interest
HIA	Health Impact Assessment
HLC Alliance	Health Living Centre Alliance
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSE	Health and Safety Executive
ICP	Integrated Care Partnership
IP	Inpatient
IPH	Institute of Public Health in Ireland
LCG	Local Commissioning Group
LD	Learning Disability
LGB&T	Lesbian, Gay, Bisexual and Transgender
LEP	Local Engagement Partnership

LTC	Long Term Condition – Chronic ailment from which there is no cure but will require long term treatment or monitoring
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIAS	NI Ambulance Service
NIASW	NI Association of Social Workers
NIBTS	Northern Ireland Blood Transfusion Service
NICE	National Institute for Health and Clinical Excellence
NICVA	Northern Ireland Council for Voluntary Action
NIFRS	NI Fire and Rescue Service
NIMDTA	NI Medical and Dental Training Agency
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NIPSA	Northern Ireland Public Service Alliance
NISAT	Northern Ireland Single Assessment Tool - for use when planning home care for older people
NISCC	NI Social Care Council
NMTG	Nursing and Midwifery Task Group
OSS	Office of Social Services
PCC	Patient and Client Council
PD	Physical Disability
PfG	Programme for Government
PHA	Public Health Agency
PPI	Personal and Public Involvement
QOF	Quality and Outcomes Framework
RQIA	Regulation and Quality Improvement Authority
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SCIE	Social Care Institute for Excellence
SEHSCT	South Eastern Health and Social Care Trust
SET	South Eastern Trust
SHSCT	Southern Health and Social Care Trust
TDP	Trust Delivery Plan
Trust	Provider of Health and Social Care Services to a particular population
TYC	Transforming Your Care
UU	Ulster University
WHSCT	Western Health and Social Care Trust

HSC Health and Social Care

Setting the standards

Personal and Public Involvement (PPI)

Involving you, improving care

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers and the public in Health and Social Care (HSC) services.

People have a right to be involved in and consulted on decisions that affect their health and social care. We know that when people are meaningfully involved in decision making about their health and social wellbeing, or listened to when they complain or raise concerns, this leads to improved quality and safety.

PPI is a statutory duty for HSC organisations. It is a two-way process and not solely to be used when we want to hear the views of service users and carers on something which we bring to them for their consideration.

Involvement can range from one-to-one clinical or social care interaction with service users and carers, through to larger engagements to assess needs, design services and influence commissioning priorities and policy development.

To help embed PPI into HSC culture and practice, a set of standards has been developed which set out what is expected of HSC organisations and staff. These will help standardise practice and support the drive towards a truly person-centred system.

Standard One – Leadership

Health and Social Care (HSC) organisations will have in place, clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- PPI Leadership structure in place across the organisation to include:
  1. named executive and non-executive PPI lead at board level; with clear role descriptions and objectives;
  2. PPI operational lead;
  3. PPI leadership structure throughout the organisation.

Standard Two – Governance

HSC organisations will have in place, clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- Governance and corporate reporting structures are in place for PPI.
- Action plan with defined outcomes developed to demonstrate the impact of PPI.
- Annual report produced, demonstrating evidence of compliance with PPI responsibilities and work undertaken to address challenges in this area.

Standard Three – Opportunities and support for involvement

HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Key Performance Indicators:

- Maintain an up-to-date register of existing and future opportunities for involvement at all levels across the organisation, which is accessible by the public.
- Support the involvement of service users, carers and the public to include:
  1. provision of clarity on roles/responsibilities for those who are participating;
  2. provision of training, support and advocacy if required;

3. use of accessible communications, mechanisms and procedures, eg use of plain English, easy read, jargon-free etc.
4. good meeting etiquette;
5. application of interim service user, carer and stakeholder reimbursement guidelines and procedures for HSC organisations.

- Provide named HSC points of contact for each individual engagement exercise.
- Provide feedback to those involved in each engagement as standard practice.
- As part of your PPI action plan, identify barriers to involvement and develop actions to overcome these.


SKILLS
20mg
SKILLS
RESPONSIBILITY
EXPERIENCE
CREATIVITY
LOYALTY
KNOWLEDGE
ACCURACY
MOTIVATION

Standard Four – Knowledge and skills

HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.

Key Performance Indicators:

- Integrate basic PPI awareness raising into induction arrangements for all new staff.
- Evidence compliance with any annually agreed regional targets for the provision of and access to PPI training.
- Ensure a mechanism is in place to capture information on the uptake of PPI training.
- Demonstrate service user and carer involvement in the design, delivery or evaluation of PPI training.

Standard Five – Measuring outcomes

HSC organisations will measure the impact and evaluate outcome of PPI activity.

Key Performance Indicators:

- Evidence service user and carer involvement in the monitoring and evaluation of PPI activity.
- Demonstrate through the annual report:
  1. how the needs and values of individuals and their families have been taken into account in the development and delivery of care;
  2. the outcomes and impact (positive/neutral/negative) achieved by using PPI approaches in respect of policy, investments, decisions and service delivery across the organisation.

Values underpinning PPI

Dignity and respect

Each person is treated with dignity and respect.

Inclusivity, equity and diversity

The PPI process should facilitate the inclusion of all those who need to be involved and who chose to do so. It must be sensitive to the needs and abilities of each individual.

Collaboration and partnership

The PPI process is based on collaboration and partnership working. Each person has a responsibility to build constructive relationships with others involved in the process.

Transparency and openness

The PPI process should be open and transparent and each person has a responsibility to be open and honest in their interactions and relationships with others.

HSC Public Health Agency

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www.publichealth.hscni.net

Find us on: