North West Anglia
NHS Foundation Trust

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VERSION CONTROL SUMMARY

Version:	Page or section:	Description of change:	Date approved:	Date published:
1		Complete Review of the policy	N/A	
1.1		The draft policy has been revised to reflect comments from the Audit Committee held on 1 April 2021 and Hospital Management Committee on 23 April 2021. Final approval by Board on 11 May 2021.	11 May 2021	21 May 2021

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1. INTRODUCTION

1.1 North West Anglia NHS Foundation Trust (the Trust) recognises risk management as an essential activity in the delivery of healthcare that underpins the achievement of its objectives. A proactive and robust approach to risk management can:

- reduce risk exposure through the development of a 'lessons learnt' environment and more effective targeting of resources.
- support informed decision-making to allow for innovation and opportunity.
- ensure compliance with applicable laws, regulations and national guidance.
- Increase stakeholder confidence in corporate governance.
- ensure activities are in line with the Trust's risk appetite.

1.2 Risk is accepted as an inherent part of healthcare. Likewise, uncertainty and change in the evolving healthcare landscape may require innovative approaches that bring with them more risk in the interim. Therefore, it is not practical to aim for a risk-free or risk-averse environment; rather one where risks are considered as a matter of course and identified and managed appropriately.

1.3 This policy has been developed to ensure that risk management is fundamental to all of the Trust's activities and understood as the business of everyone. It forms a key component of the Trust's overarching Board Assurance Framework.

1.4 The policy has adopted the following principles of risk management as set out in ISO 31000:

Principle	Description
Proportionate	Risk management activities must be proportionate to the level of risk faced by the organisation
Aligned	Risk management activities need to be aligned with other activities in the organisation
Comprehensive	In order to be fully effective, the risk management approach must be comprehensive
Embedded	Risk management activities need to be embedded within the organisation
Dynamic	Risk management activities must be dynamic and responsive to emerging risks

1.5 This Policy demonstrates the Trust's commitment to its total risk management function. It sets out the Trust's risk architecture (roles, responsibilities, communication and

reporting arrangements) and describes how risk management is integrated into governance arrangements, key business activities and culture.

1.6 The Trust has a risk appetite statement that has been approved by the Board which details the nature and extent of risks the Trust is willing to take to achieve its strategic objectives; taking into account the need to enable innovation.

2. EXECUTIVE SUMMARY

2.1 The policy provides an overview of:

- how the Trust is structured for and manages risk;
- who is accountable for specific elements of governance and risk management;
- what is an acceptable level of risk;
- the nature and extent of risks that the organisation is exposed to and is willing to take to achieve its objectives; and
- which levels of employees can make decisions on implementing further action or control on identified risks and who the key stakeholders are.

2.2 The management of risk at strategic and operational levels is integrated. Risk management is led by the Board of Directors and embedded in normal working routines and activities of the Trust through management systems.

3. PURPOSE

3.1 This Policy describes the Trust's approach to the management of risk at all levels within the organisation. The purpose of this guidance is to encourage a culture where risk management is viewed as an essential process of the Trust's activities. It provides assurance to the public, patients and partner organisations as well as the regulators that the Trust is committed to managing risk appropriately.

4. SCOPE

4.1 This Policy applies to all employees and appointees of the Trust and any individuals working in a temporary or volunteer capacity (hereafter referred to as 'individuals').

5. DEFINITION of RISK MANAGEMENT TERMS

5.1 This Policy has adopted the definition set out in ISO 31000 in that a risk is the **'effect of uncertainty on objectives'.** The effects can be negative, positive or both. This may include damage to the Trust's reputation, which could undermine public confidence.

5.2 The following terms are used throughout this document:

Term	Definition
Assurance	Evidence that controls are working effectively. Assurance can be **Internal** (e.g. committee oversight) or **external** (e.g. Internal Audit reports).
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. The Board Assurance Framework document is the key source of evidence that links the organisation's strategic objectives to risk, controls and assurances and the main tool a governing body uses in discharging its responsibility for internal control.
Controls	The measures in place to control risks and reduce the likelihood of them occurring.
Corporate Risk Register	A tool for recording identified operational risks and monitoring actions against them.
High Impact (Low Likelihood) Risks	These are risks that potentially have a major impact on the Trust, regardless of the perceived probability.
Inherent risk	The risk before any management action or mitigation.
Initial risk score	The numerical assessment of the risk (consequence vs. likelihood) prior to considering any controls and/or mitigating actions.
Current risk score	The numerical assessment of the risk (consequence vs. likelihood) after taking into consideration existing controls and/or mitigating actions.
Residual risk score	Also known as inherent risk. This is a numerical assessment of the risk (consequence vs. likelihood) as a target score. This is the risk that remains after all possible management and control actions have been taken to manage the risk.
Operational risks	These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.
Residual risk	The risk after the management actions have been considered.

Risk	This Policy has adopted the definition set out in ISO 31000 in that a risk is the **'effect of uncertainty on objectives'.** The effects can be negative, positive or both. It is measured in terms of consequence and likelihood.
Risk assessment	An examination of the possible risks that could occur during an activity.
Risk capacity	The amount of risk an organisation can actually bear. Risk capacity should be fully considered when agreeing risk appetite and risk tolerance levels.
Risk appetite	The nature and extent of risks that the organisation is exposed to and is willing to take to achieve its objectives.
Risk culture	The values, beliefs, knowledge and understanding of risk, shared by everyone across the Trust.
Project Risk Register	A tool for capturing potential risks that could impact on the delivery of a project.
Risk management	The arrangements and activities in place that direct and control the organisation with regard to risk
Risk mitigation	Active steps taken to reduce the impact on the organisation and/or likelihood of their occurrence.
Risk profile	The nature and level of the threats faced by an organisation.
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Strategic risks	Board-level risks that threaten the achievement of the Trust's overall long-term objectives.
Target Risk	The risk level that the risk should be at after all management actions have been taken.

6. ROLES and RESPONSIBILITIES

6.1 The following table outlines overall accountability for risk management.

Roles	Definition
Trust Board	The Trust Board has overall accountability for risk management and, as such, need to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Trust Board determine the Trust's risk appetite and risk tolerance levels and are also responsible for setting the organisations risk culture.
Audit Committee	The Audit Committee provides the Trust Board with independent assurance on the effectiveness of the Board Assurance Framework (BAF) and the robustness of the Trust's risk management systems and processes. The committees' role is not to 'manage risk' but to ensure that the approach to risks is effective and meaningful. They are supported in their role by internal auditors and external auditors.
Board Committees	In particular, the Board Committees support the Trust Board by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging when controls are not working or data is unreliable. This includes oversight of high and significant risks related to their area of responsibility. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Risk Register.
Divisional/Corporate Governance Meetings	All divisional and corporate committees and sub-committees are responsible for monitoring operational risks related to their area of responsibility. This will include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the risk register.
Hospital Management Committee (HMC)	The Hospital Management Committee (HMC) is the principal executive and operational decision-making group in the Trust.

	The HMC will be alerted to, and have oversight of, all urgent major and significant operational risks. It will ensure executive direction to risk owners as necessary and consider and agree additional resources that may be required to mitigate risks appropriately. As individuals, Executive Directors will ensure that robust internal controls are maintained within their areas of responsibility and that this policy is applied consistently within their directorates.
Chief Executive Officer	The Chief Executive Officer has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives.
Chief Nurse	The Chief Nurse has overall responsibility for ensuring robust risk and assurance systems are in place and being consistently complied with. This includes promoting the Trust's risk culture within the Executive team and wider Divisions.
Chief Finance Officer	The Chief Finance Officer has overall responsibility for the management of risk associated with finance. This includes ensuring the adequacy of counter fraud arrangements and the implementation of the Trust's Standing Financial Instructions.
Company Secretary	The Company Secretary has overall responsibility for the Board Assurance Framework and Strategic Risk Management.
Deputy Company Secretary & Head of Risk/ Assistant Chief Nurse	Responsible for risk reporting, advising the organisation on best practice risk management and working in a partnership approach with teams across the Trust to embed effective risk management.
Senior Information Risk Owner	The Senior Information Risk Owner has overall responsibility for the management of information risks.
Risk Owners	Risk owners are responsible for ensuring robust mitigating actions are identified and implemented for their assigned risks.
Individuals	All individuals are responsible for complying with the arrangements set out within this policy.

7. RISK APPETITE

7.1 Good risk management is not about being risk averse, it is about recognising the potential that outcomes may result in opportunities for improvement, as well as possible threats to success.

7.2 A 'risk aware' organisation embraces innovation in order to achieve its strategic objectives and looks to exploit opportunities.

7.3 With this in mind, the Board of Directors have agreed to the risk appetite statement outlined at **Appendix A**. The risk appetite statement details the nature and extent of risks the Trust is willing to take to achieve its strategic objectives.

8. RISK TOLERANCE

8.1 Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted.

8.2 Some risks are unavoidable and outside of the Trust's ability to mitigate to an acceptable level. Where this is the case, the focus should be on what controls are in place to manage the risk and what additional contingencies are in place should the risk materialise.

8.3 Strategic risks are more likely to be influenced by external factors such as regulatory requirements and economic factors etc. This may make them more difficult to manage. Strategic risks which are not deemed as treatable will be specifically highlighted during the Board Assurance Framework (BAF) review process.

8.4 The majority of operational risks should have the ability to reduce in consequence and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level. High or Significant risks that are not deemed as treatable should be highlighted as such as part of routine risk reporting.

9. BOARD ASSURANCE FRAMEWORK (BAF)

9.1 The Board Assurance Framework (BAF) is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.

9.2 The purpose of the BAF is to provide the Trust Board with confidence (assurance) that the organisation has robust systems, policies and processes (controls) in place to ensure the achievement of the Trust's strategic objectives.

9.3 The BAF plays a key role in informing the Trust's Annual Governance Statement (AGS) and is the main tool for ensuring that an effective system of internal control is in place.

9.4 The BAF is updated monthly by Executive Directors. This involves a review of the effectiveness of controls and what evidence (internal or external) is available to demonstrate assurance. Any gaps in controls or assurance are highlighted. The BAF is aligned with the Trust's strategic risk register.

9.5 The Board Committees' receive a summary of the BAF on a monthly basis and the full BAF is presented to the Public Board meeting.

10. CORPORATE RISK REGISTER (CRR)

10.1 Whilst risks are inherent in the Trust's processes, it is important that these are captured centrally to provide a comprehensive log of approved and monitored risks that accurately reflect the Trust's risk profile.

10.2 The Corporate Risk Register is the central repository for all the Trust's operational risks.

10.3 The Corporate Risk Register contains details of the risk, the current controls in place and an overview of the actions undertaken to mitigate the risk to the agreed residual level. A named risk owner is given responsibility for ensuring any actions are completed by the agreed date.

10.4 The Corporate Risk register is presented to the Hospital Management Committee (HMC) on a monthly basis.

10.5 A report outlining those risks categorised as high impact (consequence score of 4 or 5) and low likelihood (likelihood score of 1 or 2) will be presented to the Audit Committee and the relevant Board committee on an annual basis.

10.6 A report outlining those risks that have been opened for longer than 18 months will be presented to HMC and the relevant Board committee on a six monthly basis.

10.7 Relevant extracts of the Corporate Risk register are presented to the Board sub-committees in line with their delegated duties. Reports are provided monthly to those sub-committees where risk exists within their remit.

10.8 A summary report is presented to the Trust Board by the Board sub-committees escalating operational risks that are of concern.

11. STATEMENT OF INTENT

11.1 The Board of Directors is committed to the integrated management of all aspects of governance including risk management through the corporate committee structure and associated systems and processes.

11.2 For risks to be managed successfully risk management has to be fully integrated in all strategic and operational activities, and at all levels throughout the organisation, all employees have responsibility and are accountable for the management of risk.

11.3 It is vital that the Trust complies with legislation, national and local governance requirements, and that employees comply with Trust policies and procedures.

12. STRATEGIC PRIORITIES & OBJECTIVES

12.1 The key organisational priorities are outlined in the Trust's Annual Plan which is approved by the Trust Board at the beginning of each financial year. This document is available on the Trust's intranet.

13. STRATEGIC RISKS

13.1 Strategic risks are defined as risks that impact on the Trusts ability to achieve its overall objectives.

13.2 The strategic risk register is maintained by the Deputy Company Secretary & Head of Risk.

13.3 Strategic risks are agreed by the Board on an annual basis.

13.4 The Executive Team are tasked with maintaining the Strategic Risk Register on behalf of the Board, ensuring that the register is reviewed and updated regularly and reported to the Trust Board via the Public Board meeting.

13.5 Any additions or amendments to agreed strategic risks must be approved by the Trust Board.

13.6 The Strategic Risk Register is aligned to the Trust's Board Assurance Framework.

14. MANAGING RISKS

14.1 The Trust has a localised risk management approach with all risks managed locally and escalated as required in line with this risk management policy and other relevant Trustwide and local procedures. In line with this approach, each individual is

responsible for ensuring that risks are identified, recorded and managed within their local area.

14.2 Sources of information used are Reactive (something that has happened) and Proactive (something that might happen) to identify risks and gaps in assurance. For example, complaints, incident reports; claims; audit; risk assessments; patient experience data; waiting list trends; workforce data; and performance information should be used to identify current and potential risks to the Trust. Individuals and Teams will need to triangulate this information in order to identify risks to the organisation.

14.3 Each Executive Director is accountable for ensuring that the foreseeable risks of not meeting the Trust's strategic objectives are identified, quantified and captured on the Strategic Risk Register and managed according to Trust policy.

14.4 Executive Directors are accountable for all aspects of risk within their own reporting line.

14.5 In managing risks, all individuals should take into account other relevant policies, procedures and guidance including on:

- safeguarding;
- adverse events and near misses;
- health and safety;
- security; and
- information governance.

14.6 Project Risks will be managed in line with the Trusts risk standard management policies and procedures. The will include a project prefix to ensure they are identified as project risks on Datix.

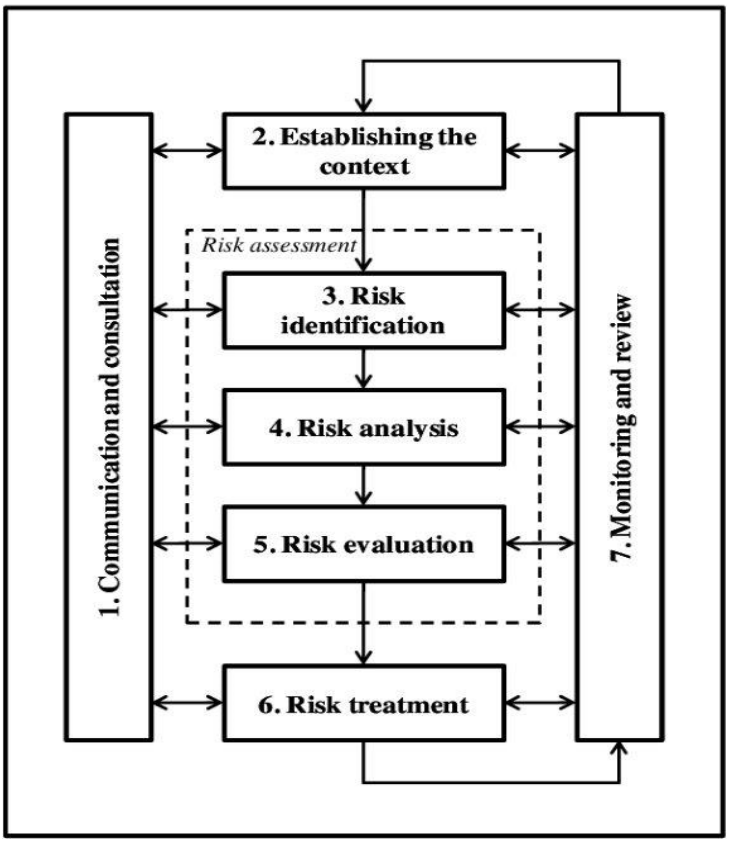
15. RISK ASSESSMENTS and RISK IDENTIFICATION

15.1 Risk assessments can be undertaken at the start of any activity and provide a helpful means of anticipating 'what could go wrong' and deciding on preventative actions.

15.2 Operational risks (those that require adding to the risk register) may be identified through an assortment of means, for example by risk assessments, external assessments, audits, complaints, during meetings and through horizon-scanning.

15.3 Regular meetings are held with Executive Directors and senior managers to discuss new or evolving risks within their respective portfolios/teams. These meetings are defined in relevant local or Trustwide governance documents and structures.

15.4 The diagram below is based on the processes described in ISO 31000 (Risk Management Guidelines) and outlines the risk management process:



16. RISK EVALUATION

16.1 Risk are evaluated by defining qualitative measures of impact and likelihood as shown in the risk scoring matrix in **Appendix C**.

16.2 Risk scores can be subjective, therefore for all high and significant risk, the scores will be subject to review and agreement by senior managers and/or the responsible committee. Each area will have local arrangements for approval of all other risks.

16.3 Members of the Risk Team can also offer support and guidance regarding risk evaluation.

17. RISK TREATMENT

17.1 Risk treatment (also known as risk control) is the process of selecting and implementing measures to mitigate the risk to an acceptable level. Once risks have been evaluated, a decision should be made as to whether they need to be mitigated or managed through the application of controls (as described using the risk treatment model below).

Treatment	Description

Terminate	The most drastic option is to terminate the action and therefore avoid the risk completely. This is often difficult to do in the NHS since most organisations have statutory duties to provide services. For example, the Trust could choose to stop the use of certain clinical procedures which are deemed too high risk.
Transfer	This option transfers the risk, or the management of the risk, to another person or organisation. This maybe because they have specialist skills and knowledge or are more prepared to take the risk. For example, by getting insurance the Trust can transfer a risk of financial loss to the insurance provider.
Tolerate	To tolerate the risk is to deliberately live with the risk, without any further action.
Take	Whilst risk is most commonly thought of as an adverse event and something going wrong, risk is also about opportunity. Therefore one of the options is to take the risk because the potential gains are expected to outweigh the potential losses. For example, the Trust may choose to invest in innovation which will cost more in the short term with the hope that this will reduce costs in the long run if the innovation works.
Treat	To manage the risk through a range of management or mitigation tools.

18. DIVISIONAL MANAGEMENT & REPORTING OF RISKS

18.1 Each Division must establish and maintain a management system and process within their management framework to identify, quantify, record, report on and manage all aspects of risk management. This must include compliance with this Risk Management Policy and other relevant procedures.

18.2 Reporting must include; within the Divisions (to all levels as appropriate), across Directorates to share learning, and outside of the Directorates to corporate committees as described within this Risk Management Policy . In addition, reports must be made to external agencies where legal or contractual compliance is required.

18.3 All risk assessments (High, Significant, Moderate and Low) must be escalated through the local management system to the Divisional Triuvirate (or nominated representative) to be recorded and managed on the Datix risk register.

18.4 There are local processes and guiding documents for the management of risk in specialist areas such as Radiation and Laser protection otherwise risk will be managed in Divisions or CBU's in accordance with this policy and associated policies, procedures and codes of practice.

18.5 The Adverse Event and Near Miss Reporting Policy and Procedure provide detailed guidance on reporting and investigation of adverse events, including those of a serious nature.

18.6 This policy should be considered alongside other relevant risk assessment and risk management procedures and guidance documents.

18.7 Each service, speciality, corporate function or clinical business unit is required to develop a local risk register to be recorded and managed via Datix. These registers will include identified risks related to operational issues that are identified through both proactive risk assessments (i.e. environmental risk assessments) and reactively through incident reporting and other governance activity. These will be escalated to divisional, sub-board and Board level meetings in line with thispolicy.

19. SPECIALIST RISK MANAGEMENT SUPPORT

19.1 General Risk Management

The Risk Management specialists will provide direction and support on more detailed aspects of managing risks.

19.2 Maternity Risk Management

Maternity services/Obstetrics is a specialist risk area. This is described in detail in the Maternity Risk Management Framework. The Maternity Risk Register is an integral part of the Trust wide risk register.

19.3 Other Specialist Support

The Trust has a wealth of specialists who can provide support in all aspects of governance or risk management. If it is not clear who to talk to contact the risk management team who will signpost to the most appropriate specialist. Some of the key officers and their extensions are:

Responsibilities	Responsible Person
Risk Management	Chief Nurse Company Secretary
Corporate Governance, Legal and Commercial Insurance	Company Secretary Deputy Company Secretary and Head of Risk
Risk Register	Deputy Company Secretary and Head of Risk Assistant Chief Nurse

Patient and Public Experience, Complaints, PALS, Chaplains, Adult Safeguarding	Deputy Chief Nurse and Assistant Chief Nurse
Obstetric risks and adverse events, Maternity CNST	Director of Midwifery
Fire Safety	Fire Safety Advisor
Clinical and non-clinical waste	Soft FM Services Manager
Health and Safety and Security	Health and Safety Manager
Moving and Handling	Moving and Handling Specialist Advisor
Clinical negligence, public and employers liability and property claims, and inquests	Legal Services Manager
Clinical Practice, Clinical Mandatory Training, Preceptorship	Practice Development Team
Infection Prevention and Control	Deputy Director of Infection Prevention & Control
Confidentiality breaches patient data	Caldicott Guardian
Compliance with Data Protection Act/Information Governance	Chief Digital Information Officer (SIRO) Information Governance Manager
Day to day running of the hospital	Site Senior Manager
Purchasing and supplies, international purchasing laws	Assistant Director of Procurement
Counter Fraud	Local Counter Fraud Specialist
Child Protection (Safeguarding)	Assistant Director of Nursing - Safeguarding Child Protection (Safeguarding) Team, Named Nurse, Named Doctor

20. CORPORATE AND SUBCOMMITTEE REPORTING STRUCTURE

20.1 On behalf of the Board, the Executive Directors are responsible for ensuring that the Board Assurance Framework is maintained and that strategic risks are aligned where appropriate. This process is supported by the Deputy Company Secretary. An organisation chart at **Appendix D** sets out the reporting structures for Board level committees. Through the integrated governance report and other reports, the

Executive Directors provide the Board of Directors will keep the Board informed of the the key risks to the Trust and advise the Board of Directors on mitigating actions.

20.2 The Hospital Management Committee is the forum by which the Board of Directors get assurance from clinical Divisions on operational management and performance; it reviews all organisation wide High and Significant risks that may compromise the Foundation Trust Terms of Authorisation, CQC Regulations, Strategic Objectives, and contractual issues with the Trust's commissioners. The Board Assurance Framework is also subject to review by the Hospital Management Committee. The Chief Executive will report from this forum to the Board of Directors.

20.3 The Quality Governance Operational Committee receives exception reports from quality or safety committees, or working groups. Where the Quality Governance Operational Committee want further investigation or discussion on particular risks they will defer the risks back to the Divisional management who (if unable to address at the time of the enquiry during the Committee) will then report back at the next Quality Governance Operational Committee.

20.4 Each Board subcommittee will have oversight of relevant high and significant operational risks. The committees will report to the Board through the Committee Assurance Reports including on risk management. Any risks scoring 15 or above will be escalated to Board for information or specified action..

20.5 The Audit Committee will meet its statutory requirements and report independently to the Board of Directors to give assurance on overarching risk management systems and processes. They will be assisted in their role by the internal and external auditors.

21. CHARITABLE FUNDS RISKS

21.1 The Trust acts as the Corporate Trustee for charitable funds. The Trust Board acts on all matters on behalf of the Corporate Trustee.

21.2 Charitable Funds risks are managed in line with the Trusts risk standard management policies and procedures.

21.3 The Charitable Funds Committee will receive regular reports on all high and significant risks and will see a report including all Charitable Funds risks at least once each year.

21.4 All high risks scoring 15 or above will be escalated to the Corporate Trustee meeting.

21.5 To aid with reporting, all Charitable Funds risks should have the pre-fix 'CFC' in the risk title on Datix.

21.6 All new risks will be reviewed by the Chief Finance Officer or Company Secretary or nominated representatives before being submitted for approval to the Hospital Management Committee.

22. COMMUNICATION, MONITORING and REVIEW

22.1 Communication with stakeholders is vitally important to demonstrate the governance systems in operation are effective and efficient. The communication we have and feedback that we receive influences service design, service reconfiguration and any planned service changes. The normal processes in place are through established Board of Director and Board of Governor meetings, through the annual report and the annual general meeting.

22.2 Communication with staff is particularly important. This is mainly implemented through corporate meetings or line management at local meetings and through Team Brief or other Trust communication tools such as the intranet. Divisions are required to establish and maintain robust communication systems so that all employees receive these communications. This policy and its associated documents can be accessed on the Trust intranet.

22.3 The policy will be highlighted to new staff as part of the Trust's induction process and made available to all staff through the Trust's internal communication procedures and internet/intranet sites.

22.4 The Trusts Audit Committee will review the effectiveness of the policy, and its implementation, via the annual risk audit and monthly targeted risk assurance reports.

22.5 The Trust Board will review the risk appetite on an annual basis.

23. STAFF TRAINING

23.1 A training needs analysis has been completed which is available on the Trust Intranet and this highlights the training programmes available to support this strategy. Training courses are advertised regularly on the Trust Intranet and through newsletters such as Factsheet.

23.2 Through the annual staff appraisal and supporting knowledge and skills framework the Trust will ensure that staff have the necessary knowledge, skills and support to meet the aims and objectives.

23.3 A programme of risk training is provided for all employees, as outlined below:

Level of Training	Staff Group	Frequency	Delivery Method	Delivery by Whom

General Risk Awareness	All staff	3 Yearly	TBC	Chief Nurse / Company Secretary
Risk Managers' Training	Risk Owners & Managers	3 Yearly	ESR/Intranet	Chief Nurse / Company Secretary
Senior Managers' Risk Training	Senior Managers	Annually	Workshop	Deputy Company Secretary
Datix Risk Management	Risk Owners	Initial	Face to Face	Deputy Company Secretary
Strategic Risk Management	Trust Board	Annually	Workshop	Chief Nurse / Company Secretary

24. RATIFICATION

24.1 This policy will be approved by the Trust Board having been presented to the Hospital Management Committee and the audit Committee prior to the Board.

25. REFERENCES

25.1 Assurance Frameworks, (2002). HM Treasury.

25.2 A Risk Practitioners Guide to ISO 31000:2018, (2018). The Institute of Risk Management.

25.3 Board Assurance: A toolkit for health sector organisations, (2015). NHS Providers.

25.4 The Orange Book: Management of Risk – Principles and Concepts, (2004).

25.5 Risk Appetite & Tolerance, (2011). The Institute of Risk Management.

25.6 NHS Audit Committee Handbook, (2018). Healthcare Financial Management Association.

25.7 NHS Governance Handbook, (2017). Healthcare Financial Management Association.

25.8 Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking. (2012). The Good Governance Institute.

26. COMPLIANCE MONITORING

Document Section		Control	Checks to be carried out to confirm compliance with the policy	How often the check will be carried out	Responsible for carrying out the check	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting
Page	**Section**	**WHAT?**	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
9	7.0	Risk Appetite Statement	Review of risk appetite statement	Annually	Trust Board	Chief Nurse Company Secretary	Annually
11	10	Corporate risk register	Monthly risk report to Trust Board (IPR)	Monthly	Trust Board	Company Secretary	Monthly
11	10.4	Corporate risk register	Monthly Risk report to HMC	Monthly	HMC	Company Secretary	Monthly
11	10.5	High impact (Low likelihood) risks	Annual report to Audit Committee	Annually	Audit Committee	Chief Nurse	Annually
11	10.6	Aged Risks	Six monthly report to HMC and relevant Board committee	Bi-annually	HMC Trust Board Committee	Chief Nurse	Bi-annually
11	10.7	Corporate risk register	Monthly Risk report to Trust Board Committees	Monthly	Trust Board Committee's	Chief Nurse Company Secretary	Monthly

12	13.3	Strategic risk register	Monthly report to Trust Board	Monthly	Trust Board	Company Secretary	Monthly
18	23.3	Training	Annual report to Audit Committee	Annually	Audit Committee	Chief Nurse	Annually

APPENDIX A: RISK APPETITE STATEMENT

North West Anglia NHS Foundation Trust
Risk Appetite Statement

The aim of North West Anglia NHS Foundation Trust is to provide high quality, effective and safe services which improve the health, wellbeing and independence of the population it serves. The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives.

The Board is responsible for defining and monitoring the risk appetite of the Trust when pursuing its strategic objectives. The Board's approach to and appetite for risk is summarised below.

The Trust recognises its work in a healthcare system where there are quality, service and financial challenges. The Trust's stakeholders extend to not only other health and social care providers, but also to suppliers of services to the Trust, the public, the government and government bodies including regulators.

All processes, procedures and activities carried out by the Trust carry with them a degree of risk. It is necessary for the Trust to agree the level of risk that it is willing to accept, based on what it considers to be justifiable and proportionate to the impact on patients, carers, the public, members of staff and the Trust.

Risk appetite describes the amount and type of risk the Trust is prepared to accept to achieve its financial and strategic objectives. The Trust recognises that its risk appetite may vary on specific elements e.g. safety and care of patients, compliance and regulation and finance etc.

Risk tolerance describes the maximum amount or type 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.

In terms of operational risk, the Trust has determined that all risks rated as significant or high (i.e. score of 12 or above) should be reviewed at Board subcommittee level. In addition, the following matrix shows the Trust's risk appetite against each of the identified domains which will help inform decision making.

Risk Levels ⇨ Domains ⇩	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*
Quality Outcomes	No tolerance for any decisions that could negatively impact on quality or safety of care. Priority for tight management controls and oversight to ensure good quality and safe care.	Tolerance for risk taking limited to those decisions where there is no chance of any significant negative impact on quality or safety of care. Decision making authority held by senior clinicians.	Tolerance for risk taking limited to those events where there is little chance of any significant negative impact on quality or safety of care. Decision making authority generally held by senior clinicians.	Appetite to take decisions with potential to significant negative impact on quality or safety of care. Responsibility for non-critical clinical decisions may be devolved.	Willingness to take decisions that are likely to negatively impact on quality or safety of care. High levels of devolved authority for clinical decisions. Management by trust rather than tight control.	Consistently willing to take decisions that are likely to negatively impact on quality or safety of care. Devolved authority for clinical decisions. Management by trust rather than tight control is standard practice.
Financial/Value for Money (VfM)	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
	In all circumstances, the Trust has no appetite for fraud and/or other financial crime risk					
Staff Experience/ Outcomes	No tolerance for any decisions that could negatively impact on staff experience or outcomes. Priority for tight management controls and oversight to ensure good staff experience and outcomes.	Tolerance for risk taking limited to those decisions where there is no chance of any significant negative impact on staff experience or outcomes. Decision making authority held by senior managers.	Tolerance for risk taking limited to those events where there is little chance of any significant negative impact on staff experience or outcomes. Decision making authority generally held by senior managers.	Appetite to take decisions with potential to significant negative impact on staff experience or outcomes. Responsibility for non-critical decisions may be devolved.	Willingness to take decisions that are likely to negatively impact on staff experience or outcomes. High levels of devolved authority for decisions. Management by trust rather than tight control.	Consistently willing to take decisions that are likely to negatively impact on staff experience or outcomes. Devolved authority for decisions. Management by trust rather than tight control is standard practice.

APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
Risk Levels ⇨ **Domains** ⇩	***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*
Compliance/ Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Continuous Quality Improvement/Innovation	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	
Risk Levels ⇨ **Domains** ⇩	***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*
Estates	No tolerance for any decisions that could negatively impact on the safety of our estate. Priority for tight management controls and oversight to ensure the safety of our estate.	Tolerance for risk taking limited to those decisions where there is no chance of any significant negative impact on the safety of our estate. Decision making authority held by senior managers.	Tolerance for risk taking limited to those events where there is little chance of any significant negative impact on the safety of our estate. Decision making authority generally held by senior managers.	Appetite to take decisions with potential to significant negative impact on the safety of our estate. Responsibility for non-critical decisions may be devolved.	Willingness to take decisions that are likely to negatively impact on the safety of our estate. High levels of devolved authority for decisions. Management by trust rather than tight control.	Consistently willing to take decisions that are likely to negatively impact on the safety of our estate. Devolved authority for decisions. Management by trust rather than tight control is standard practice.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

APPENDIX B: RISK IDENTIFICATION GUIDANCE/ASSESSMENT

GENERAL RISK ASSESSMENT

Ward/Department: **Date of Assessment: / /**
Review Date: / /

Location of Assessment: **Assessor's Name:**

Assessor's Signature:

Completed Risk Assessments are required to be recorded on the Trust Risk Register

<table>
<tr><td colspan="2">Description of Activity</td><td colspan="2">Significant Hazards</td></tr>
<tr><td colspan="2"></td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Frequency:</td><td>Duration:</td></tr>
<tr><td colspan="2">Adverse Effects</td><td colspan="2">People at Risk</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">Number of People Affected:</td></tr>
<tr><td colspan="4">What Precautions exist to Control the Risk:</td></tr>
<tr><td>Likelihood:</td><td>Severity:</td><td>Risk Rate:</td><td>L M S H</td></tr>
<tr><td colspan="4">Are these arrangements satisfactory: Yes / No, If No, What further measures are required to reduce the risk?</td></tr>
<tr><td colspan="4">Re-evaluated Risk Rate:</td></tr>
<tr><td>Likelihood:</td><td>Severity:</td><td>Risk Rate:</td><td>Nil L M S H</td></tr>
<tr><td colspan="4">Person to action Work
……</td></tr>
</table>

Date Action required by ……..

Date Completed ……..

Manager's Signature ……

Manager's Name……..

Review Date of Assessment	Re-assessed on	Signature of Assessor

Additional Information:

APPENDIX C: CATEGORIES of RISK/RISK SCORING MATRIX

RATE	LIKELIHOOD	DESCRIPTION
0	**Impossible**	The event cannot happen under any circumstances.
1	**Rare**	The event may occur only in exceptional circumstances.
2	**Unlikely**	The event could occur at some time.
3	**Possible**	The event will occur or re-occur at some time.
4	**Likely**	The event is likely to occur or re-occur in most circumstances.
5	**Almost Certain**	The event is expected to occur or re-occur in most circumstances.

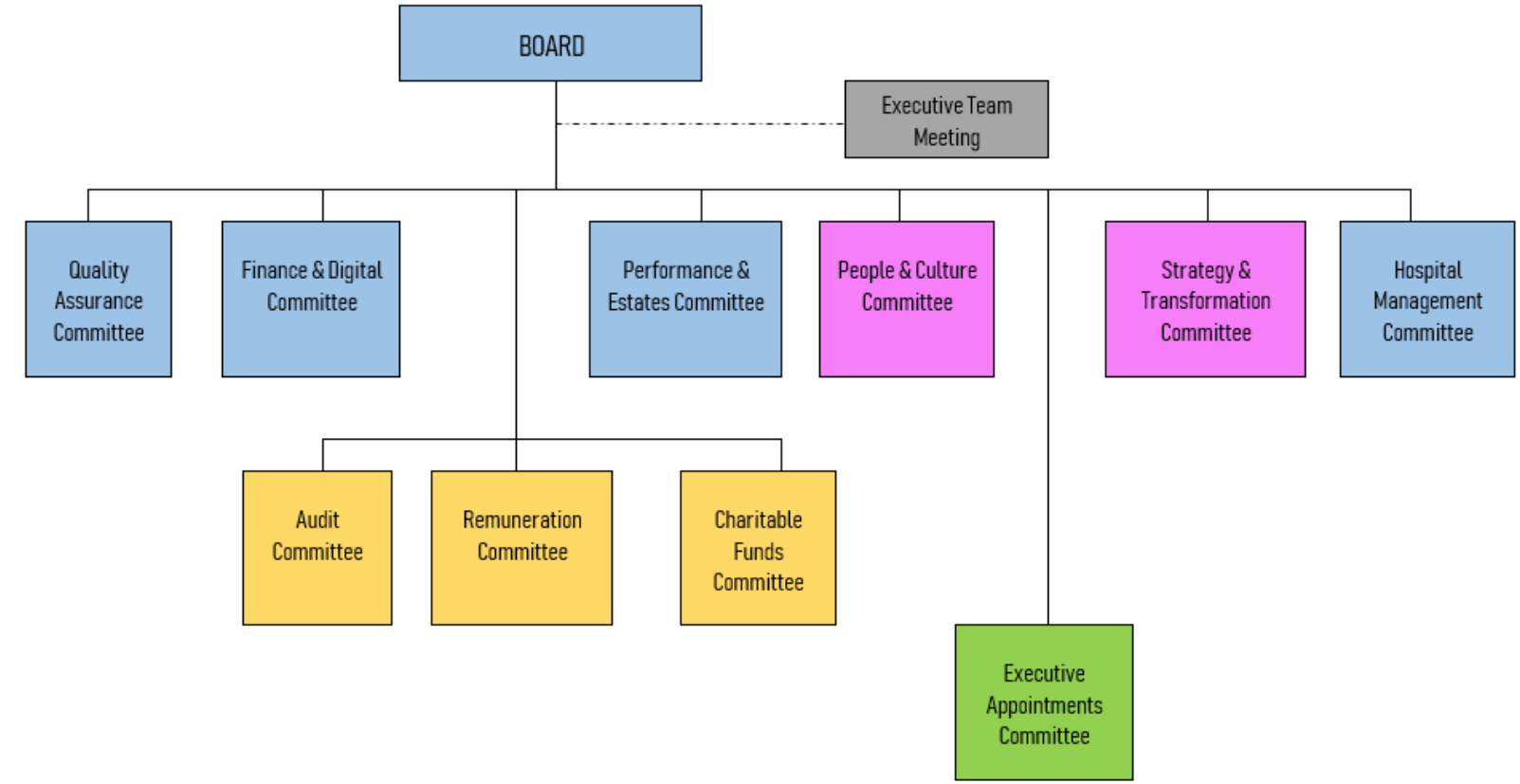
Likelihood of an Incident Occurring					
Level	**1**	**2**	**3**	**4**	**5**
Likelihood	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Description	may occur in exceptional circumstances	could occur at some time	will occur or reoccur at some time	likely to occur or re-occur in most circumstances	expected to occur or re-occur in most circumstances
Percentage of likelihood	<10%	11 – 20	21 – 60%	61 – 89%	>90%

CONSEQUENCES/ SEVERITY	**LIKELIHOOD**					
	Impossible 0	**Rare 1**	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost Certain 5**
No adverse outcome – 0	0	0	0	0	0	0
Insignificant – 1	0	1	2	3	4	5
Minor – 2	0	2	4	6	8	10
Moderate – 3	0	3	6	9	12	15
Major- 4	0	4	8	12	16	20
Catastrophic - 5	0	5	10	15	20	25

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury/Impact on the Person (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment. ►No lost time	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi permanent harm ►Increase in length of hospital stay by 1-3 days ►Affects 1-2 people	►Moderate injury or illness requiring professional intervention to resolve the issue ►RIDDOR / Agency reportable incident (4-14 days lost) or inability to undertake full range of duties ►Adverse event which impacts on a small number of patients ►Extended medical treatment up to 6 months ►Increased length of hospital stay by 4 – 15 days ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. permanent loss of sight) ►>14 days off work ►increased length of hospital stay >15 days ►Extended medical treatment up to 12 months ►Affects 16 – 50 people	►Incident leading to death or permanent vegetative state ►Multiple permanent injuries or irreversible health effects ►Extended medical treatment over 12 months ►An event affecting >50 people
Buildings/ Engineering/ Environmental Impact	►Potential for onsite release of substance ►Minimal or no impact on the environment ► Loss/interruption of services of approx 1 hour	►Onsite release of substance but contained ►Minor impact on the environment ►Minor damage to Trust property – easily remedied <£10K ►Loss/interruption of services approx 8 hours	►On site release of substance ►Moderate impact on the environment ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K ►Loss/interruption of services approx 24 hours	►Offsite release of substance ►Major impact on the environment ►Major damage to Trust property – external organisations required to remedy associated costs >£50K ►Loss/interruption of services approx >24 hours	►Onsite /offsite release with catastrophic effects ►Catastrophic impact on the environment/services or buildings ►Loss of significant part or all of a hospital building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day	►On-going low staffing level - minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ► 75 % staff attendance at mandatory / key training	►Ongoing low staffing resulting in moderate reduction in the quality of patient care ►Late delivery of key objective / service due to lack of staff ►Error due to ineffective training / competency ►50% - 75% staff attendance at mandatory / key training	►Unsafe staffing level leading to a temporary service closure <5 days ►Uncertain delivery of key objective / service due to lack of staff ►Serious error due to ineffective training and / or competency ►25%-50% staff attendance at mandatory / key training	►Loss of several significant service critical staff leading to a service closure >5 days ►Non-delivery of key objective / service due to lack of staff ►Critical error leading to fatality due to lack of staff or insufficient training and / or competency ►Less than 25% attendance at mandatory / key training on an on-going basis
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint ►Minor implications for patient safety ►Claim <£10K	►Justified complaint involving lack of appropriate care ►Moderate implications for patient safety ►Claim(s) between £10K - £100K	►Multiple justified complaints ►Findings of Inquest suggesting poor treatment or care ►Non-compliance with national standards implying significant risk to patient safety ►Claim(s) between £100K - £1M	►Multiple justified complaints ►Ombudsman inquiry ►Totally unsatisfactory level or quality of treatment / service ► Single major claim >£1M
Inspection/ Regulatory	►Small number of recommendations which focus on minor quality improvement issues	►Single failure to meet standards ►No audit trail to demonstrate that	►Challenging recommendations which can be addressed with	►Enforcement action ►Multiple breaches of statutory duty or Registration requirements	►Multiple breaches of statutory duty ►Prosecution

Compliance/ Statutory Duty	►No or Minimal breach of guidance / statutory duty ►Minor non-compliance with external standards	objectives are being met (NICE; HSE; NSF etc.)	appropriate action plans ►Single breach of statutory duty or of Registration requirements ►Non-compliance with > one external standard	►Improvement Notice ►Trust rating poor in National performance rating ►Major non compliance with external standards	►Severely critical report on compliance with national standards ►Zero performance rating ►Complete systems change required
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined ►Use of services affected	►National / International adverse publicity >3 days. ►MP concerned (questions in the House) ►Total loss of public confidence
Fire Safety/General Security	►Minor short term (<1day) shortfall in fire safety system. ►Security incident with no adverse outcome	►Temporary (<1 month) shortfall in fire safety system / single detector etc (non patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	►Fire code non-compliance / lack of single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	►Significant failure of critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety ►Loss of vulnerable adult resulting in major injury or harm ► Major controlled drug incident	►Failure of multiple critical components of fire safety system (high risk patient area) ►Infant / young person abduction ►Loss of vulnerable adult resulting in death
Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Information Governance/ IT	► Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < half a day ►Health records / documentation incident – no adverse outcome	►Minor Breach with potential for investigation ►Unplanned loss of IT facilities < 1 day ►Health records incident / documentation incident – readily resolvable	►Moderate breach of confidentiality – potential for complaint 1 – 5 persons affected ►Health records documentation incident – patient care affected with short term consequence	►Serious breach of confidentiality – more than 5 person or Very sensitive information ►Unplanned loss of IT facilities >1 day but less than one week ►Health records / documentation incident – patient care affected with major consequence	►Serious breach of confidentiality – large numbers ►Unplanned loss of IT facilities >1 week ►Health records / documentation incident – catastrophic consequence
Projects	►Insignificant cost increase ►Insignificant impact on value and/or time to realise declared benefits against profile	►<5% over project budget ►<5% variance on value and/or time to realise declared benefits against profile	►5 - 10% over project budget ►5 - 10% variance on value and/or time to realise declared benefits against profile	►10 - 25% over project budget ►10 - 25% variance on value and/or time to realise declared benefits against profile	►> 25% over budget ►> 25% variance on value and/or time to realise declared benefits against profile
Financial (Loss of contract / revenue / default payment)	►Small Financial loss < £1K ►Theft or damage of personal property <£50	►Loss <£1k - £50K (up to 0.5% of budget) ►Theft or loss of personal property <£750	►Loss of £50K - £200K (between .5% and 1% of budget) ►Theft or loss of personal property >£750 - £10K	►Loss of £200K - £500K (between 1 – 2.5% of budget) ►Theft or loss of personal property £10K - £50K	► Significant financial loss (over 2.5% of total budget) Theft/loss >£500K Failure to achieve EBITDA target for any quarter. ► Theft or loss of personal property > £50K

APPENDIX D: BOARD COMMITTEE STRUCTURE



Key
Weekly
Monthly
Bi-Monthly
Quarterly
Other

** The Board meets monthly. However, Public meetings are held every 2 months. The other time is spent on confidential business in private and on strategy and development sessions.

APPENDIX E: EQUALITY IMPACT ASSESSMENT STAGE 1

Indicate in the table below what kind of impact this policy will have upon the protected groups or how it is likely to influence the Trust's ability to comply with the Public Sector Equality Duty, which is to;

a) Eliminate discrimination, victimisation, harassment or other unlawful conduct that is prohibited under the Equality Act 2010 and/or;
b) Advance equality of opportunity between people who share a characteristic and those who do not and/or;
c) Foster good relations between people who share a relevant protected characteristic and those who do not.

Consider this in the context of the whole policy being updated. The easiest means of approaching this is to consider the following questions;

- **Would the adaptation meet my needs or ensure I had equal opportunities if I had any of the protected characteristics?**
- **Is there anything about the policy that would have a detrimental impact on me if I had one of the protected characteristics?**
- **Does it affect our ability to comply with the Public Sector Equality Duty?**

Please check the appropriate boxes relating to the impact of the policy or adaption:

Age	○ Positive	◉ None	○ Negative	○ Unknown
Disability	○ Positive	◉ None	○ Negative	○ Unknown
Gender Reassignment	○ Positive	◉ None	○ Negative	○ Unknown
Marriage/Civil Partnership	○ Positive	◉ None	○ Negative	○ Unknown
Pregnancy and Maternity	○ Positive	◉ None	○ Negative	○ Unknown
Race	○ Positive	◉ None	○ Negative	○ Unknown
Religion or Belief	○ Positive	◉ None	○ Negative	○ Unknown
Sex (Gender)	○ Positive	◉ None	○ Negative	○ Unknown
Sexual Orientation	○ Positive	◉ None	○ Negative	○ Unknown

If any boxes are checked as Negative, please escalate to a stage 2 assessment by emailing nwangliaft.qualitygovernance@nhs.net or nwangliaft.corporategovernance@nhs.net

If any boxes are checked as Unknown, please contact nwangliaft.edi@nhs.net

Agreement by	**Signature**	**Date**
Ratifying Panel Chair (if required)		
Equality, Diversity and Inclusion Lead (if required)		
Approving Panel Chair		

APPENDIX F: QUALITY ASSURANCE CHECKLIST

COMPLIANCE OFFICER'S USE ONLY

		Y/N/ n/a	COMMENTS (to author for any amendments)
1	**Title of the document**		
	Is the title clear and unambiguous	Y	
2	**Type of document (e.g. policy, guidance)**		
	Is it clear whether the document is a policy, guideline, procedure?	Y	
3	**Introduction**		
	Are reasons for the development of the document clearly stated?	Y	
4	**Content**		
	Is the standard model template used?	Y	
	Is the document in the correct format? **Please refer to Trust-Wide Writing Style Guide**	Y	
	• Paragraphs numbered consecutively	Y	
	• Headers: only on front page to contain logo	Y	
	• Footers: on every page except front page	Y	
	Are the Version Control numbers correct in the panel and the footer	Y	
	Is the introduction of the document clear?	Y	
	Are the objectives/aims clearly stated?	Y	
	Are the duties, roles and responsibilities clearly explained? **(policies only)**	Y	
	Are the definitions of terms clearly explained?	Y	
	Have recommendations from Counter Fraud/Internal Audit been included? **(policies only)**	N/A	
	Does this document concern the handling, moving or storage of personal identifiable or commercially sensitive information? If yes, has a Summary Privacy Impact Assessment been completed?	N/A	
5	**Evidence Base**		
	Is the type of evidence to support the document explicitly identified?	Y	
	Are associated documents referenced?	Y	
6	**Approval Route**		
	Does the document identify which committee/group will approve it?	Y	
7	**Review Date**		
	Is the review date identified?	Y	
8	**Equality and Diversity (policies only)**		
	Is a completed Equality Impact Assessment attached?	Y	
9	**Monitoring Compliance and Effectiveness (policies only)**		
	Has section 'Compliance Monitoring' been completed?	Y	

If answers to any of the above questions is 'no', then this document is not ready for approval, it needs further review.

COMPLIANCE TEAM:		
1.	Date Comments returned to author by Compliance Lead	
2.	Date of Compliance Team approval	16 April 2021
3.	Name of Compliance Lead	Carly Goddard

OPTIONAL LOCAL LEVEL SIGN-OFF: *Enter name of committee/group*			
If the committee/group is happy to approve this document would the chair please sign below and send the document and the minutes from the approval committee to the author. To aid distribution all documentation should be sent electronically wherever possible.			
Chair		**Date**	
Signature/print name			

APPROVAL COMMITTEE: Hospital Management Committee			
If the committee/group is happy to approve this document would the chair please sign below and send the document and the minutes from the approval committee to the author. To aid distribution all documentation should be sent electronically wherever possible.			
Chair	Caroline Walker	**Date**	23rd April 2021
Signature/print name	Caroline Walker		

SECOND LEVEL APPROVAL COMMITTEE: Trust Board			
If the committee/group is happy to approve this document would the chair please sign below and send the document and the minutes from the approval committee to the author. To aid distribution all documentation should be sent electronically wherever possible.			
Chair	Rob Hughes	**Date**	11th May 2021
Signature/print name	Rob Hughes		