The Tavistock and Portman
NHS Foundation Trust

Risk Management Policy and Strategy

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Bodies consulted:	Directors and Managers responsible for risk
Approved by:	EMT
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Lead Manager:	Associate Director of Quality and Governance
Lead Director:	Deputy Chief Executive
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Risk Management Policy and Strategy

1 Introduction

The Tavistock and Portman Foundation NHS Trust (the Trust) is a healthcare and also education and training provider. The healthcare provision is regulated by NHS Improvement, specialist school provision by OFSTED and training and education, delivered within a range of sectors, by the Quality Assurance Agency (QAA).

The Trust recognises that all its activities associated with caring for patients, training and educating students, employing staff, providing premises, managing finances and operating in a commercial environment are, by their very nature undertakings which involve a degree of risk.

The Trust is committed to managing all strategic, and operational risks and working within the appropriate regulatory and legislative frameworks.

At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall approach to helping the Trust successfully deliver the organisational objectives. All staff have a role to play in managing operational risks. Risk management and internal control is central to the effective running of any organisation. It is through this system of internal control and accountability the Chief Executive fulfils his responsibility as accountable office and the Board its responsibility of stewardship.

The Trust places the delivery of *high quality care* at the centre of our objectives, which are underpinned by a range of more specific objectives and work programmes to ensure delivery.

Key systems will be fully embedded at every level of the organisation to ensure compliance with current and future risk management related standards and legislation. Assurances will be provided to the Board of Directors so that members are able to make judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. The Board Assurance Framework will contribute to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Report and it is through this process we monitor adherence to the standards

and regulatory requirements of the Care Quality Commission and other regulators.

Subject to constraints within which the Trust operates, the Trust is committed to the following:

- ensuring effective frameworks, structures and accountabilities are in place for the effective management of risk at all levels throughout the Trust, achieving a clear line of sight of risks from service delivery to the board.
- managing identified risks in an integrated way and not in silos
- ensuring sufficient resources including people, training, finances, work processes and systems of work are in place to successfully implement the risk management policy and strategy and reducing the exposure of risk to an acceptable level.
- ensuring staff feel empowered to report risk and have the systems and tools to formally assess and escalate risk where necessary.
- ensuring risk is managed in a positive, sensible and proportionate way to maximise opportunities to achieve objectives and deliver services
- Ensuring that when risks materialise, despite proactive control actions, there are plans and arrangements to respond and recover, particularly in regards to patient care
- Focusing on experience and learning to eliminate or reduce all risk to an acceptable level

2 Purpose

The purpose of having a risk management framework is to:

- Identify and control risks which may adversely affect the Trust's ability to deliver on strategic and operational objectives at every level in the organisation
- Reduce risks to our service users, staff, visitors and public to an acceptable level
- Ensure high levels of regulatory and best practice compliance

- Protect our assets, interests, reputation and financial sustainability
- Provide a systematic and proactive approach to prioritising and managing risk

The risk management framework is outlined as follows:

3 Scope

This Policy and Strategy and separate Risk Management Procedure applies to all Trust employed staff, including contractors, volunteers, students, bank and agency staff and staff employed on honorary contract.

4 Definitions

Effective risk management can be described as:

- the systematic application of principles, approaches and processes to the task of identifying, analysing, assessing and controlling risks

It has the following attributes: is proportionate, aligned to Trust objectives, organisational-wide and embedded in the business cycle.

Action owner(s)	The action owner or owners will be responsible for taking the actions to control the risk on behalf of or as delegated by the Risk Owner.
Assurance(s)	Provides information on the adequacy and effectiveness of the controls in place
Board Assurance Framework (BAF)	Provides the Trust Board with a simple but comprehensive method for the effective and focused management of the principle risks to meeting strategic objectives.
Control(s)	Arrangements and systems that are intended to mitigate / control the likelihood and consequence of a risk. An effective control will reduce to an agreed level (target risks score), either the likelihood of a risk occurring, and/or the consequence. If this is not the case, then the control is not fully effective and needs to be reconsidered.
Current risk score	This is the risk score with current completed controls in place. The first current score will also be the same as the initial score. It is expected that the current risk score will move towards the target risk score as treatment plans are developed and implemented. However, the current score can increase due to changes in circumstances (maybe external changes) or to controls being changed or removed. The current risk score will be used to demonstrate the effectiveness of the treatment plan in mitigating the risk. It will be used to formally report the risk profile of the Trust and be used for the aggregation and escalation of risks.
Gaps in assurance	Exist where there is a lack of evidence that the controls are effective
Gaps in control	Exist where adequate controls are not in place or where they are not sufficiently effective
Initial risk score	This is the score when the risk is first identified with pre-existing controls in place. This score will not change for the lifetime of the risk and will therefore be used as the benchmark against which risk management actions will be measured.
Monitoring Group	Only one risk monitoring group is allowed per risk. The

	monitoring group is responsible for reviewing risks identified for their attention, ensuring timely actions are being taken by the Operational Lead to reduce the level of risk and escalating the risk to the Risk Owner should the level increase to 9 or greater, for further attention.
Operational Lead	All risks must have a single named Operational Lead who manages the risk on a day to day basis, providing assurances to the Risk Owner and Monitoring Group. Responsible for: · monitoring the risk throughout the lifetime of the risk. · reporting on the status of the risk to the Monitoring Group and Risk Owner. · ensuring the appropriate actions are taken to control the risk
Operational risks	Risks associated with the delivery of operational objectives including the delivery of patient care, in a safe environment.
Project risks	Project risks are those risks to the objectives of a project and as such should be recorded on that projects risk register.
Risk	Risk is an uncertain event which, should it occur, could have an impact upon the achievement of objectives. Note: Risks are things that might happen and are differentiated from Incidents which are things that have happened and issues which are things that either will happen or are already happening.
Risk Appetite	The levels and types of risk the Trust is prepared to accept, and not accept, in pursuance of its objectives.
Risk Assessment	A systematic process to measure and establish risk levels to help prioritise actions at all levels within the Trust.
Risk Owner	All risks must have a single named owner. The owner will usually be the individual who owns the objective to which the risk relates. There are four responsibilities: to monitor the risk throughout the lifetime of the risk; to report on the status of the risk whenever required; to ensure the appropriate actions are taken to control the risk; to ensure all requirements of the risk management policy, strategy, and procedure are met when managing the risk.
Risk Reduction	The process by which the risk is managed to reduce the consequence and/or likelihood of the occurrence of the

	event.
Risk Register	A management tool that allows the various levels of the organisation to capture and understand its comprehensive risk profile. It is a repository of risk information linking risk, control, action and assurance for the whole organisation in a risk priority order. It is a source of reporting to support decision making and provide assurance.
Strategic risk	Risk that **directly** impacts on the ability of the Trust to fulfil its strategic objectives
Target risk score	The level of risk which the Trust is willing to accept after all necessary measures have been applied.

5 Organisational Roles and Responsibilities

5.1 The Board of Directors

The Board of Directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board is responsible for maintaining continuous oversight of the effectiveness of the trust's risk management and internal control systems. The Board formally meets six times a year and considers reports from the Board level committees in order to verify that risks are being managed appropriately and that the organisation can deliver its objectives. The Board of Directors will:

- Provide leadership on the management of risk
- Ensure risk management systems within the Trust are effective and fully operational across the whole organisation
- Direct the reduction, elimination and exploitation of risk in order to increase resilience and achieve objectives
- Review and agree the risk appetite statement and levels of risk to be accepted by the Trust annually
- Ensure a consistent approach to the application of the risk management strategy
- Ensure that the Trust is able to manage all types of risk faced, and at an appropriate level

- Review and requesting assurances to demonstrate that risks have been identified, assessed and all reasonable steps have been taken to manage them effectively and appropriately
- Receive assurance that resources are available to support the risk management system and to manage risk within the agreed risk appetite
- Protect the reputation of the Trust and correctly scoring risks to the achievement of the Trust's strategic objectives, via the Board Assurance Framework, through regular reviews
- Ensure all members of the Board of Directors attend Board development and awareness training in relation to risk management in line with the Training Needs Analysis.

5.2 Audit Committee

The Audit Committee is responsible for providing assurance to the Board of Directors that an effective system of integrated governance, internal control and risk management is maintained within the organisation. It will receive bi-annual reports from the Medical Director for the Integrated Governance Committee, including key risks. The Audit Committee also has a specific remit to review and provide verification on the systems in place for risk management as part of its assurance for the Annual Governance Statement.

5.3 Integrated Governance Committee (IGC)

This committee, comprising executive directors, non-Executive directors, and governors will seek assurance that the Trust is managing risks to operational objectives and will provide a quarterly assurance report to the Board and the Audit Committee.

The IGC will receive assurance reports from the following sub-committees to an agreed reporting schedule:

- Data Security and Protection
- Risk and Safety
- Patient Experience and Quality Care
- Estates and Facilities Compliance
- Organisational Development and People

- Research and Development

Additionally, the Joint Operational Management and Education and Training Executive will report to the IGC in respect of education and training risks.

The IGC will report quarterly to the Audit Committee to provide assurance that the process for managing risks is sufficient to meet the requirements of the regulatory bodies, and needs of the Trust.

The IGC will also provide a quarterly report to the Board for discussion and highlight any issues that require disclosure or executive actions including where unmitigated risks are identified and assurance that plans are in place. The chair of the IGC will advise the Board of any new significant operational risks on an exceptional basis between IGC reports.

The Board will receive the operational risk register three times a year for risks rates 15 or greater, for noting and review highlighted risks by exception.

5.4 Executive Management Team (EMT)

The EMT is formed of the Trust's Executive Directors. EMT are responsible for reviewing and approving operational risks graded 9, monitoring risks to the strategic objectives via the Board Assurance Framework, and all financial risks.

5.5 Education and Training Committee (ETC)

This is a board level assurance committee chaired by the Chief Executive. The ETC will monitor education and training risks, receiving reports from the Education and Training Executive Meeting who will operationally manage the risks.

The IGC DET representative will provide the IGC with quarterly reports on DET operational risks rated 9+.so that all operational risks are reported to the Board via the same route.

6 Individual Roles and Responsibilities

6.1 Chief Executive

The Chief Executive is accountable to the Trust Chair and Board of Directors for ensuring that there is an effective system of risk management and internal control in place and for meeting all statutory, regulatory and corporate governance requirements.

Responsibility for the maintenance of the system of internal control is delegated to the Trust's executive directors as follows:

- Deputy Chief Executive for risks to the Trust's strategy and for non-clinical risk
- Medical Director for clinical risk
- Director of Education and Training / Dean of Postgraduate Studies for education and training risk
- All directors for risks in their directorate

The Deputy Chief Executive is responsible for the following:

- supporting the Chief Executive in their role – acting as the overall lead for Risk Management, with responsibility for coordinating the implementation of this strategy;
- ensuring that processes are in place to identify risks to strategic objectives and that these are recorded in the Board Assurance Framework (BAF), monitored, and reported to the Executive Management Team and the Board of Directors;
- presenting the updated BAF following approval of the annual plan. This will be updated and represented at a frequency agreed by the Board during the year but at least quarterly;
- non-clinical risk management throughout the Trust;
- the management of information risks and contingency plans.

6.3 Director of Finance

The Director of Finance, on behalf of the Chief Executive has responsibility for ensuring a sound system of internal financial control and providing adequate financial information. They are the key contact

for the auditors and is responsible for providing assurances to the Board. The Director of Finance will have ultimate responsibility for any financial implications of plans to control risk and the method used to incorporate such into the business planning process.

6.4 Senior Information Risk Owner (SIRO)

The SIRO will be responsible for ensuring that risk relating to information is managed in accordance with the Data Security and Protection Toolkit. This Framework is monitored by the Data Security and Protection sub-committee reporting to the Integrated Governance Committee.

6.5 Medical Director

The Medical Director, on behalf of the Chief Executive, is responsible for the management of clinical risk throughout the Trust. The Medical Director is responsible for informing the Trust Board of the key risks emanating from clinical activity throughout the Trust and for ensuring the Trust has effective systems for managing these risks. The Medical Director is responsible for providing written advice to the Chief Executive on the content of the Annual Governance Statement in regards to the management of these risks.

In fulfilling this duty the Medical Director will:

- have overall responsibility for clinical governance and management of clinical risk;
- ensure the development, review and publishing of appropriate Trust policies and procedures for the management of clinical risks;
- oversee the provision of internal clinical advice in relation to clinical risk management;
- ensure that the responsibilities for the provision of adequate arrangements for clinical risk management are assigned, accepted and implemented at all levels within the organisation;
- ensure the Trust has robust incident management systems
- bring to the attention of the Chief Executive details of incident trends, levels of performance, clinical claims trends, and matters of clinical risk concern requiring attention, as advised by the Risk and Safety sub-committee lead;

- advise the Chief Executive on investigations into serious clinical incidents;
- report to the Executive Management Committee and Board of Directors on serious clinical risks;
- develop, implement and sustain the Trust's clinical quality, assurance and safety agendas;act as Lead Director for Emergency preparedness and Major Incident planning;
- be responsible for the management of risks within those areas of operational responsibility.

The Medical Director will be supported by the Associate Medical Director in delivering on these responsibilities.

6.6 Divisional/Directorate directors

The directors are responsible for managing risk across their division/directorate. They must ensure the following:

- that local risk management activities, including risk assessments, are carried out to support Trust-wide learning from risks;
- staff in the division/directorate are aware of their roles and responsibilities where appropriate in relation to reducing the consequence and/or likelihood of risks;

6.7 Non-Executive Directors

Non-Executive Directors have a duty to review the Trust's risk management arrangements and be assured that these are robust and defensible. In particular, as members of the Audit and Integrated Governance (IGC) Committees, Non-Executive Directors will review the adequacy of the risk management strategy, and receive regular monitoring information against the management of risks level 9+.

6.9 Associate Director Quality and Governance

The Associate Director Quality and Governance is responsible for developing and overseeing the risk management framework and procedures. They are responsible for providing expert advice and support on risk management and for providing training for all levels of

staff on risk assessment, risk management and risk processes (except for IG risks, see 6.10). In the event that a member of the Board of Directors or Executive Management Team is unable to attend the annual risk update on request they will provide a one to one session using the same materials.

They will ensure that regular reports are available for the sub-committees reporting to the Integrated Governance Committee (IGC) and ensure risk information and reports are compiled to inform the organisation, including the Board Assurance Framework and Operational Risk Register.

6.10 Director of Information Management and Technology

The Director of Information Management & Technology is the Information Governance Lead, acts as the Deputy SIRO and is responsible for:

- working with the SIRO, taking the lead in ensuring compliance with mandatory IG standards;
- ensuring the data and information asset risks are identified and controlled appropriately;
- ensuring that information incidents and risk management activity are reported to and considered by the Data Security and Protection Sub-Committee of the Integrated Governance Committee;
- ensuring the Trust is kept up to date with the latest information on cyber risk by liaising with NHS Digital, IG Alliance and others as necessary.

6.10 Data Protection Officer

- statutory role responsible for Trust compliance with data protection laws.
- provides expert advice on information governance and cyber risk management

6.11 Clinical Governance and Quality Manager

The manager will provide advice and support on safeguarding, ~~PREVENT,~~ revalidation, clinical audit and related clinical governance matters. They are also responsible for the operational management of the Integrated Governance Committee.

6.12 Director of Estates, Facilities and Capital Projects

The Director of Estates, Facilities and Capital Projects is the custodian of the estate and responsible for:

- ensuring that statutory and mandatory building compliance is maintained and transparent across the organisation.

6.13 Health and Safety Manager

The Health and Safety Manager is responsible for:

- fulfilling the requirements of Health and Safety Advisor to the Trust;
- undertaking health and safety risk assessments and safety audits including annual site risk assessments for staff and service provision;
- promoting the use and understanding of risk assessment throughout the Trust;
- arranging, in conjunction with the Associate Director Quality and Governance, training onrisk assessments (as part of the electronic risk management system);
- acting as an enabler/ facilitator for managers logging new risks and managing / updating risks;
- providing regular reports to the sub committees reporting to the Integrated Governance Committee (IGC) as required;
- acting as the Emergency Planning Liaison Officer (EPLO) for Emergency Planning – supporting services in risk management and local business continuity plans.

6.14 Managers

All Managers are responsible **for ensuring that risks in the area under their management** are identified, monitored and controlled in line with

the Trust's risk management strategy. They are responsible for:

- ensuring risk assessments are conducted as appropriate for their area of responsibility and that identified risks are added to the electronic risk management system to be managed;
- ensuring actions are taken to mitigate risks;
- undertaking 'horizon scanning' to identify future issues that may threaten delivery of operational or strategic objectives. These should be relevant to their service area.

6.15 Authorising Engineer

An Authorising Engineer is engaged under contract to provide expert advice, review and assurance.

As there are a few specialist disciplines, an appointing authorising engineer will be required for:

- fire
- water
- gas
- electrical
- asbestos
- and preparing quarterly reports for the Estates and Facilities Compliance sub committee.

6.16 Human Resources and Corporate Governance Director

The HR and Corporate Governance Director is responsible for ensuring that the Trust appointed Occupational Health and Wellbeing Service undertakes appropriate risk assessments and implements appropriate control measures associated with the maintenance of employee health, including providing advice on the management of any uncontrolled risk as it relates to staff.

6.17 All Staff (permanent, temporary, voluntary, contract) and students

All staff and students have a key role in identifying and reporting risks promptly thereby allowing risks to be managed and where necessary add

to the local risk registers. All staff and students are accountable, through their terms and conditions of employment or study for meeting professional requirements where applicable, especially those associated with clinical governance. This will achieved through the Trust new student record system developments. Staff and students who see patients in the Trust are required to comply with all Trust policies and procedures, particularly those relating to the statutory requirements for health, safety and welfare.

In particular staff and students must:

- take steps to avoid injury and risk to patients (where relevant), staff and visitors;
- be alert to, identify and report risks especially those relating to patient care(where relevant), safety and welfare;
- being aware of any emergency procedures relevant to their role and place of work or study;
- manage risk within their sphere of responsibility. It is a statutory duty to take reasonable care of their own safety and the safety of others who may be affected by their acts or omissions.

7 Risk Management Strategy

7.1 Overview of the Process

The management of risks has a well-established approach. All staff must be competent at identifying risks in their own areas. Risks identified in an area other than where the person who identifies it works should be escalated to the relevant service line manager.

The risk process is designed to provide continuous identification, assessment, control, communication and monitoring of risk via defined timescales, reporting and escalation processes and supporting tools. It should be used to inform decision making.

Each division/ directorate will maintain a risk register on the electronic risk management system and have overall responsibility for keeping it up to date.

Together, all operational risks on the system form the Trust Operational Risk Register.

Project risks are those risks to the objectives of a project and as such should be recorded on that projects risk register. Should delivery of the project or any aspect of the project delivery e.g. running overtime, budget, not fulfilling full scope, not meeting expected levels of quality and not enabling expected benefits adversely impact on delivery of operational or strategic objectives then a risk should also be included on the electronic risk management system as an Operational, or Strategic risk, as agreed by the relevant director or Management Team.

The risk assessment approach below as described by the former National Patient Safety Agency has been adopted by the Trust.

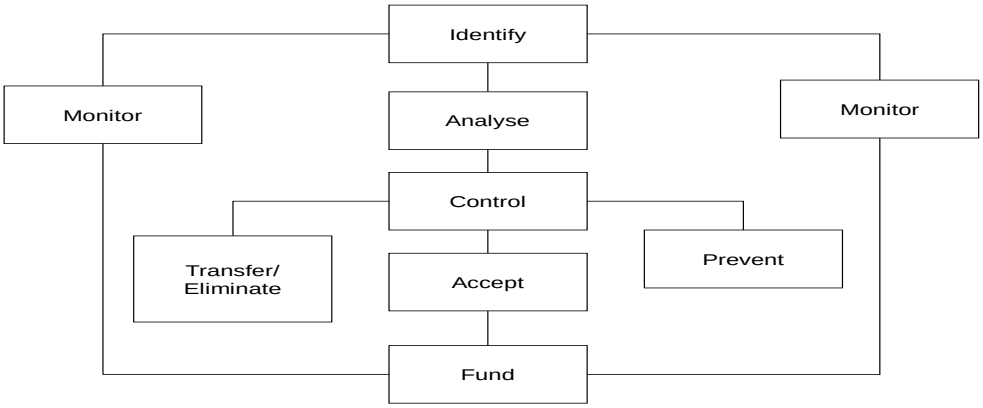

Figure 1: Risk Management Process

7.2 Using the Trust Risk Matrix

The Trust has developed a risk matrix to enable it to consider risks of all sorts against a common framework. The matrix enables a risk score to be ascribed to each identified risk and this score is used to determine the level of action and escalation for review that the risk should undergo. The Trust Risk Matrix is shown below and guidance on how this matrix is to be used is detailed within the 'Risk Management Procedure' and on the electronic risk management system.

Likelihood							
	Almost certain to occur	5	5	10	15	20	25
	Likely to occur	4	4	8	12	16	20
	Could occur	3	3	6	9	12	15
	Unlikely to occur	2	2	4	6	8	10
	Very unlikely to occur	1	1	2	3	4	5
			1	2	3	4	5
			Negligible	Minor	Moderate	Severe	Extreme
			Consequence				

Fig 2 Risk Matrix

7.3 The Risk Register

The Trust uses an electronic risk management system to record all identified risks relating to an objective (or set of objectives), with the exception of project risks It should be useful as a day-to-day tool to help managers achieve their objectives and drive and evidence risk management activities. It should also act as a source of information in risk reporting at all levels.

The single system allows for the capture, updating and and monitoring of risks and includes reports for both operational and strategic risks:

Operational Risks : these are risks to operational objectives. As new risks are identified they are added. Division, directorate. service and team risk reports can be obtained from the system. Risks of a level 9-25 are reviewed quarterly by the IGC via sub-committee reports. The operational risk register goes three times a year to the Board for noting, for risks with a current score of 15 – 25, and for review of individual risks by exception.

Strategic Risks: these are risks which threaten successful delivery of the Trust's strategic objectives. It is the main tool used by the Board to monitor and evaluate the risks. It is reviewed at four times as yearby the Board via the Board Assurance Framework (BAF) report where it will be considered alongside other key management tools, such as performance and quality dashboards and financial reports to give the Board a comprehensive picture of the organisational risk profile.

The electronic risk management system is used to record all current risks and enables them to be quantified and ranked. Information held against each risk helps both in the analysis of risks and in decisions about whether or how those risks should be treated. All risks are managed on a day to day basis by an identified Operational Lead and monitored via a Monitoring Groups.

7.4 Risk Ownership

See definition section 4.0 for details on Risk Owners, Operational Leads and Action Owners.

7.5 Treating and Escalating Risks

The risk score is used for prioritising risks and determining where awareness, monitoring and decision-making should be escalated. The Trust has a scheme of escalation (shown at Figure 3 below). This scheme of delegation applies to an individual identified risk. Those risks which have been identified but with a low risk (level 1-4) that cannot be eliminated should be added to the Trust electronic risk register

Before a risk is logged on the electronic risk register it should be discussed and agreed by the relevant accountable individual (see below).

Figure 3 Escalation levels and monitoring arrangements

Risk level	Authority / Ownership	Action	Escalation level
Low Risk 1-4	Individuals and Team /DET Managers	Managed through normal local control measures with annual monitoring at Team level to ensure the risks do not increase.	Consider for entry onto the Risk Register by Service/DET Manager.
Moderate Risk	Service /DET Managers	Review control measures through formal risk assessment, ensuring	Risk to be raised with relevant Director and considered at

5-8		that any further actions to reduce the risk are taken. Monitor six monthly at directorate level.	Divisional / Directorate level meeting for risk moderation. Record on Risk Register.
High Risk 9-12	Relevant Director	As above plus: Action required to be taken. Monitored by IGC sub committees and reported to IGC three monthly. Report annually to Board.	Risk to be raised with relevant Director and considered at Divisional / Directorate level meeting for risk moderation. Record on Risk Register.
Extreme Risk 15-25	Executive director	As above plus: Highly likely to be an intolerable level of risk **Immediate action** must be taken and the risk escalated to the relevant Director. EMT to review the risk and consider if it should be on the BAF. Board of Directors informed and receive assurance on progress on mitigating actions from the IGC.	As above plus: Raise the risk with relevant Director and record on the Risk Register.

Risk registers will include actions plans with dates to mitigate the risk. Risk controls will be mapped against at least one source of assurance and assurances defined as positive, negativeor neutral Meetings where risks are monitored will be asked to consider whether they have sufficient assurance that the risks are being adequately managed.

7.6 How are the entries on the register reviewed?

Operational Risk Owners are required to review and update information for their risks(s) on the electronic risk system (form 4) in advance of Monitoring Group reviews. . See the Risk Management Procedure. In addition, Operational risks will be reviewed via IGC sub committees for risks level 9 – 25 and reported to the IGC. The Executive Management Committee will receive updates on operational risks level 15-25 prior to taking to Board, and will monitor all strategic risks.

The Board of Directors will receive the risks 15+ on the ~~full~~ Operational Risk Register for review and comment annually three times a year and the BAF quarterly. ~~They will also review all strategic risks 15+ on a monthly basis.~~

As risks should relate directly to objectives they should only exist during the lifetime of the related objective. Thus, if the objective is to be achieved over a

two-year period, all risks relating to that objective should ordinarily be closed at the end of that two year period (sooner if the objective is achieved ahead of time, later if there is a delay in achieving the objective).

For business-as-usual objectives, which essentially continue year after year, they should be revisited each year as part of the planning process and re-set. At the same time, the risks relating to that objective should be reviewed and updated/closed accordingly.

7.7 Risk Management Support

The Associate Director of Quality and Governance, Associate Medical Director (Patient Safety), Health and Safety Manager and Director of Information Management and Technology are available to provide help and support on risk matters to individuals; teams and departments.

8 Training Requirements

8.1 Training

The Trust recognises that training of staff is an essential element of any successful risk management strategy. It has conducted a training needs analysis and full details of this are published in the Trust's Staff Training Policy.

The following table summarises the key training provided in relation to the Risk Strategy.

Target group	Training activity	Training aim	Frequency
Board of Directors and Executive Management Team	Overview of development of risk management systems and assurance framework , plus corporate risk assessment / review This course is tailored annually to needs of trust	Improve strategic management and understanding of risks to Trust,	Annual Delivered by: Risk expert (internal or external)

Target group	Training activity	Training aim	Frequency
Trust Managers	Electronic risk management system training	To ensure that managers are able to report, update and manage risks on the electronic system	Once – via training session or self learning using risk system training slides and videos on Trust intranet
All staff	Risk update including risk assessment and incident reporting	To maintain risk awareness and activity throughout the organisation	All staff risk dashboard for visibility of approved risks
All new staff, including students	Introduction to risk management and incident reporting	To raise awareness of Trust approach to risk management, policies and procedures	Once at induction via ESR online module and Trust Risk Introduction slides as part of Local Induction requirements.

Fig 4: Summary of Risk Management Training from TNA

8.2 Managing attendance at mandatory risk training

- Management of attendance and following up non-attenders of staff at induction and additional risk training will be managed under the Staff Training and Development Procedure

Divisional directors and service managers are sent monthly reports showing statutory and mandatory training compliance for their areas. Team managers and line managers are responsible for following up with those staff who are non compliant.In the event that a member of the Board of Directors or Executive Management Committee is unable to attend the annual risk update on request the Associate Director of Quality and Governance will provide a one to one session using the same materials

8.3 On-going information to staff on risk management

The Trust will provide information on risk management and risk reduction to its staff throughout the year through a variety of different ways which will include:

- Hazard notice circulation with obligatory feedback

- Policies and procedures on the intranet
- Health and Safety Information available by internet/intranet
- Updating at mandatory INSET days
- Provision of specific training on different aspects of risk management, published in the Staff Training and Development Procedure
- Provision of feedback to those who report/ are involved in specific incidents.
- Shared lessons learned from incidents and risks via Quality Portal 'Lessons Learned' summary; learning lessons incident sharing forum meetings, Quality Dashboards and various service and trust staff 'newsletter' updates
- For students, risk management information is included on the digital learning platform (Moodle).

9 Process for monitoring compliance with this policy

The Trust will monitor the key components of this policy and strategy in the following way:

Key process for which compliance is being monitored	Monitoring method	Job title of person responsible for monitoring	Frequency of the monitoring activity	Workstream or Committee responsible for receiving the monitoring results	Committees responsible for ensuring that action plans are completed
Review of the Board Assurance Framework (BAF) by high level committee	Receive the BAF for review	Director of Finance	Quarterly	Board of Directors Executive Management Committee	IGC and reporting to the Board of Directors Training and Education Committee reporting to the Board of Directors
Review of the Operational risk register (risks 15+) by high level committee	Receive operational register for noting / review	Director of Finance	Three times a year	Board of Directors	IGC and reporting to the Board of Directors Training and Education Committee reporting to

Key process for which compliance is being monitored	Monitoring method	Job title of person responsible for monitoring	Frequency of the monitoring activity	Workstream or Committee responsible for receiving the monitoring results	Committees responsible for ensuring that action plans are completed
					the Board of Directors
Review of key operational risks	Receive IGC report by Medical Director	Medical Director	Bi-annually	Audit Committee	IGC and reporting to the Board of Directors

10 References[1]

- Data Protection Act 2018
- The General Data Protection Regulation (GDPR) (Regulation (EU_ 2016/679)
- Code of Governance. NHS Improvement
- NHS Foundation Trust Annual Reporting Manual. NH Improvement.
- Health and Safety Executive (HSE). (2010). Leading Health and Safety at Work: Leadership Actions for Directors and Board Members. London: HSE. Available at: www.hse.gov.uk
- Health and Safety at Work Act 1974

11 Associated documents[2]

Staff are referred to the following related procedures:

- Health and Safety Policy
- Incident Reporting Procedure and flowchart
- Information Governance Policy
- Information Governance Management Framework
- Complaints Procedure
- Claims Management Procedure

[1] For the current version of Trust policy /procedures listed above, please refer to the intranet.

[2] For the current version of Trust policy /procedures listed above, please refer to the intranet.

- Procedure for learning from incidents, claims and complaints to improve patient safety and reduce risk
- Staff Training and Development Policy and Procedure

12 Equality Analysis

Completed by	**Marion Shipman**
Position	**Associate Director Quality and Governance**
Date	**23 February 2021**

The following questions determine whether analysis is needed	**Yes**	**No**
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?	X	
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.
If the answer to *any* of the questions was yes, then undertake the following analysis:

	Yes	**No**	**Comment**
Do policy outcomes and service take-up differ between people with different protected characteristics?		X	
What are the key findings of any engagement you have undertaken?		X	Consultation with Directors and senior managers responsible for risk management within the Trust
If there is a greater effect on one group, is that consistent with the policy aims?		X	
If the policy has negative		X	

effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?			
Will the policy deliver practical benefits for certain groups?		X	
Does the policy miss opportunities to advance equality of opportunity and foster good relations?		X	
Do other policies need to change to enable this policy to be effective?		X	

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

Board and Council Committee Structure 2020

The Tavistock and Portman NHS Foundation Trust