NHS Fife

RISK MANAGEMENT FRAMEWORK

RISK PHILOSOPHY

NHS Fife

RISK MANAGEMENT APPROACH

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Approach to Risk Management

RISK MANAGEMENT FRAMEWORK

Date: August 2014

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Author: **NHS Fife Risk Manager on behalf of the NHS Fife Executive Lead for Risk Management**

Approval Record	Date
Strategic Management Team	17 February 2014
NHS Fife Audit and Risk Committee	2 April 2014
Fife NHS Board	26 August 2014

1. PHILOSOPHY

1.1 Risk Management is an essential and integral part of Fife NHS Board's governance arrangements and is embedded within the organisation's business processes and culture. It is the process whereby organisations methodically address the risks attached to their activities (IRM 2010).This includes identifying, assessing, managing and controlling potential events or situations to provide reasonable assurance regarding the achievement of the organisation's objectives.

1.2 Healthcare provision is complex and involves a degree of inherent risk. These risks may be associated with staff, patients or visitors, working practices and operational arrangements as well as the estate, equipment and consumables.

1.3 In NHS Fife we will aim to eliminate risks where reasonably practicable, or reduce these to an acceptable level. Where risks cannot be eliminated, we will put in place contingencies to control and reduce their impact. Such systems will build upon existing good practice and be integral to all our decision making, planning, performance reporting and delivery processes.

2. OBJECTIVES

The objectives of this Framework are to:

- Affirm NHS Fife's commitment to managing risk
- Set out our approach to risk management
- Identify roles and responsibilities in relation to risk management
- Describe key risk management structures
- Enable compliance with national risk management standards/guidance
- Enable compliance with the Code of Corporate Governance

To achieve these objectives we must:

- Identify, record and review the key risks to the organisation, their sources and consequences
- Through regular review, control, reduce, or transfer to an acceptable level, the risks which may impede NHS Fife fulfilling its objectives
- Embed in all planning processes the resources required to identify, manage, control and evaluate risk
- Foster a culture that raises awareness of risks and focuses on assessment and prevention rather than reaction and remedy

NHS Fife is aware of the statutory obligation to accept vicarious liability for the actions of all staff. We also acknowledge that individual officers may be subject to criminal prosecution for breaches of statutory obligations to protect employees and the public, from the actions carried out in the normal course of NHS activities.

3. SCOPE

This Framework applies to the management of all risk in NHS Fife. Its scope includes everyone employed by NHS Fife and includes permanent, temporary, student, locum, contracted, agency and bank staff.

4. CONTEXT

This Framework is a key strand of NHS Fife's aspiration to deliver safe, effective person centred care. As such, it connects to the NHS Scotland Quality Strategy and the Scottish Government's 2020 Vision which provides the strategic narrative and context for taking forward implementation of the Strategy.

The Framework links to the external accountability environment through a range of national policy frameworks and programmes. These include standards set by Scottish Government, NHS Healthcare Improvement Scotland, the Scottish Patient Safety Programme and Audit Scotland.

The Framework will respond to local priorities including the Local Delivery Plan, Getting Better in Fife, and the emerging Strategic Framework and approach to quality improvement.

It will allow for the consideration of risks identified through established internal routes, external intelligence sources, horizon scanning and in response to new initiatives and lessons learned from their implementation.

5. APPROACH TO RISK MANAGEMENT

Risk will be managed as a routine part of day to day business at the operational level closest to the risk. The structural arrangements are illustrated at Appendix A.

- Local level responsibility and coordination (e.g. Directorate / Service / Operational Managers)

- Divisional / CHP Group / Committee Responsibility and Accountability (e.g.CHP Clinical Governance & Risk Management Groups and Acute Services Division (ASD) Risk Management Group and Clinical Governance Committee)

- Board Level Accountability (e.g. Standing Committees and the Board)

5.1 Reporting Arrangements

The governance reporting arrangements for risk management are as follows:

Lead Officers will report twice a year on the management of their corporate risks to SMT and the Standing Committee to which the risks are aligned; this will be done in line with the Programme of Reporting on Corporate Risks to the NHS Fife Standing Committees.

- SMT will report twice a year on the Corporate Risk Register to the Audit and Risk Committee and by extension, Fife NHS Board.

- This will take the form of a Statement of Assurance on the integrity and reliability of NHS Fife's risk management arrangements as measured against tools including Annexe F (Scottish Government Audit Committee Handboook, 2008) and the Risk And Control Evaluations (RACEs). The RACEs tool was developed by Internal Audit to be a guide to support the assessment of controls which mitigate to an acceptable level, key risks and control weaknesses that result in risk exposure. It is a key part of the internal audit fieldwork process. The tool is based heavily on Public Sector Internal Audit Standards (2013), section 2010 - Risk Management.

- Following review by the Audit and Risk Committee, SMT will provide a twice yearly report to Fife NHS Board detailing the Board Assurance Framework (BAF) entries against NHS Fife's strategic objectives.

- Reports on relevant visits by external scrutiny agencies e.g.

    - NHS Healthcare Improvement Scotland
    - Health & Safety Executive
    - HMiE

The Chief Executive's Annual Governance Statement, published as part of the organisation's annual report and accounts, and assembled from assurances gained throughout the year, will detail the organisation's performance, risk management and internal control framework, including responses to actual and emerging risks.

5.2 Workplan

A Programme of Reporting on Corporate Risks to the NHS Fife Standing Committees details the timetable against which each risk on the Corporate Risk Register is to be reported to SMT and the relevant Committee during the year. See Appendix B.

5.3 Roles and Responsibilities

This Framework is designed to support the effective management of all categories of risk. The intention is to embed risk management arrangements into all services and wherever possible and appropriate, to devolve responsibility for the management of risk to the CHPS, the Acute Services Division and the Corporate Directorates.

Within these arrangements, the NHS Fife Executive Leads have delegated responsibility for their respective functions from the Chief Executive. Responsibility for the day-to-day management of risk is devolved to the management teams in the CHPs, the Acute Services Division, and the Corporate Directorates.

Fife NHS Board

Fife NHS Board has corporate responsibility for managing risk. Each Board member must be aware of their obligations to protect the public, patients and staff from risk in the course of normal NHS provision. This is done through the implementation of an effective risk management framework, including the use of appropriate risk management tools, and the regular review of the organisation's risk management systems and processes.

The Standing Committees of the Board

In accordance with the Code of Corporate Governance, each risk on the Corporate Risk Register is mapped to the most appropriate Standing Committee; where applicable, risks are aligned to the Quality Strategy Ambitions and HEAT targets.

Each Committee is responsible for the oversight of corporate risks and relevant and related risks on other risk registers. It must be assured on the adequacy and effectiveness of risk management arrangements within its sphere of responsibility. It shall fulfil this function through receipt and review of a report on the management of these risks at least twice per year. The Committees will also take cognisance of any relevant internal and / or external audit reviews of the risk management system.

The Audit and Risk Committee

The Audit and Risk Committee has the responsibility to provide assurance to Fife NHS Board on the adequacy and effectiveness of its risk management arrangements. To fulfil this role, the Committee shall:

- At each meeting, receive and review a report summarising any significant changes to the Corporate Risk Register, and the plans in place to manage them. The Committee may also elect to request information on risks held on any of the organisation's risk registers.

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required.

- Assess whether the Corporate Risk register is an appropriate reflection of the key risks to the Board, in order to be able to advise the Board on any omissions and highlight the need for action.

- Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system require to be updated.

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements in place throughout the year, and highlighting any material areas of risk.

- Consider the need to commission a 'Deep Dive' exercise into the entire Corporate Risk Register or any risk therein as deemed necessary.

The Clinical Governance Committee

The Clinical Governance Committee shall provide particular oversight to clinical risks and all matters relating to the Board's legal duty to monitor and improve the systems of health care which it provides (Reference S12H of National Health Service (Scotland) Act 1978).

The Committee shall also provide oversight to the Board's responsibilities for Information Governance, through the Information Governance Group.

The Staff Governance Committee

The Staff Governance Committee shall have particular oversight of risks relating to the Board's legal duty in relation to the governance of staff (Reference S121 of National Health Service (Scotland) Act 1978).

The Strategic Management Team (SMT)

The SMT chaired by the Chief Executive, NHS Fife, has delegated responsibility for risk management and ensures executive and corporate integration of the management of risk within the main governance areas in NHS Fife.

The SMT will consider the Corporate Risk Register on a monthly basis. It shall monitor the corporate risk profile and deal with escalated risks. Lead Officers must escalate any moderate or high level risks that are deemed impossible or impractical to manage at an operational level to the SMT, for consideration with a view to inclusion in the Corporate Risk Register or for alternative management action.

To identify and analyse future trends and to determine whether NHS Fife is adequately prepared for potential opportunities and threats, SMT will undertake horizon scanning. This will help ensure that appropriate measures are taken to maintain system resilience.

Through the Lead Officers, and as required, SMT will highlight risk management issues to the relevant Standing Committees. Through the Chief Executive, it will provide assurance to the Audit and Risk Committee and by extension the Board, that these matters are being adequately managed.

The SMT will receive from the Director of Acute Services, the CHP General Managers and Executive Directors, an annual report providing assurance on the management of risks in their respective areas of responsibility; this will include Groups and Committees under their jurisdiction. The evidence will be from minutes of meetings at operational delivery level where risks are discussed. These will demonstrate that risk is a standing agenda item at such meetings and that appropriately detailed discussion takes place on risk management issues.

Divisional and CHP Risk Management Groups

While the Chief Executive has overall accountability for risk management, the Executive Leads, the Corporate Directors, CHP and Divisional Management Teams are responsible for leading the co-ordination, integration, oversight and support of the risk management agenda.

These officers will provide positive assurance to the SMT and the Standing Committees, that risks are being adequately managed and risk management principles are embedded across NHS Fife. They are responsible for implementing local arrangements in accordance with the principles and objectives set out in this Framework.

NHS Fife Chief Executive

The Chief Executive, as the Accountable Officer, has, on behalf of Fife NHS Board, responsibility for maintaining a system of internal control that includes the management of risk throughout the organisation. He is answerable to the Scottish Government for the propriety and regularity of activities under his control through the production of an annual Governance Statement. The Governance Statement proves assurance that risk management processes are embedded in the planning, operational, monitoring and review activities of the Board.

While ultimate responsibility for the management of risk lies with Fife NHS Board, executive responsibility for risk management is delegated strategically to the Director of Nursing who is charged with providing the assurance to the Board on the mechanisms that are in place to produce, implement, manage and monitor effective risk management policies and procedures.

Line Managers

All staff in NHS Fife with a management role have a responsibility to encourage staff to maintain general risk awareness, to manage risks appropriately and to escalate these when necessary. They must ensure their staff have access to relevant risk management education and training.

Employees

All staff have a responsibility to:

- Comply with policies and procedures
- Maintain general risk awareness at all times and, where possible, take reasonable action to identify, eliminate or control risks
- Notify line managers of identified risks
- Report incidents, accidents, and near misses
- Participate in risk management education appropriate to their area of work
- Instigate a risk assessment at the start of any major organisational change, project, and introduction of new equipment

Independent Contractors

NHS Fife aims to ensure that its risk management principles are embedded within the work of all our independent contractors. We will work with independent contractors to clarify their relationship with the systems governing risk management in NHS Fife and establish how this Framework applies to their services. The arrangements for each separate profession need to be formalised. In the meantime, the existing arrangements will remain in place.

General Practitioner links with the Medical Director to the Board are through the GP Sub-committee, the Primary Care Department, and the Medical Director, Primary Care.

5.4 Risk Identification, Assessment, Escalation and Resolution

Guidance on the operational management of risk ie.identification, measurement, recording, management, monitoring, review and escalation of risk is detailed in the NHS Fife Risk Register and Risk Assessment Policy GP/R7; this is available on the intranet.

All risks in NHS Fife are recorded in the Risk Module of the Datix IT Risk Management System. The SMT must approve any risk for inclusion on the Corporate Risk Register.

Where it is felt that a risk should be included on the Corporate Risk Register, the SMT Lead of the service involved, must submit a proposal to SMT detailing the risk and the rationale for its inclusion on the Register.

Where there is uncertainty in relation to any aspect of any risk, this can be raised at the appropriate Divisional or CHP Risk / Clinical Governance / other Group. The Chair of the Group will agree the appropriate course of action and may decide to escalate the issue to the SMT.

5.5 Use of External Intelligence

NHS Fife will use intelligence from multiple sources to inform its approach to risk management and its priorities for action. e.g.

- Healthcare Improvement Scotland
- Health Protection Scotland
- Health & Safety Executive
- Fraud Intelligence Network
- NHS England National Patient Safety Alerting System

5.6 Governance, Monitoring and Review

As part of its strategic and annual work programmes, Internal Audit will review the adequacy of the Board's risk management system and the Board Assurance Framework, identify areas for improvement and provide appropriate recommendations.

In accordance with Section 2120 of the UK Public Sector Internal Audit Standards, internal audit activity must evaluate the effectiveness and contribute to the improvement of risk management processes.

Determining whether risk management processes are effective is a judgment resulting from the internal auditor's assessment that:

- Organisational objectives support and align with the organisation's mission;
- Significant risks are identified and assessed;
- Appropriate risk responses are selected that align risks with the organisation's risk appetite; and
- Relevant risk information is captured and communicated in a timely manner across the organisation, enabling staff, management and the Board to carry out their responsibilities.

The internal audit activity may gather the information to support this assessment during multiple engagements. The results of these when viewed together, provide an understanding of the organisation's risk management processes and their effectiveness.

Risk management processes are monitored through ongoing management activities, separate evaluations, or both.

Each audit report will identify areas for improvement and provide appropriate recommendations. The annual Chief Internal Auditor's Statement will summarise the position and give an overall opinion.

5.7 Arrangements for Working with Partner Organisations

As the organisation develops in accordance with national and local directives, the risks emerging from joint working with other NHS Boards, other care providers, partners and independent contractors will require joint solutions. To ensure the optimal delivery of joint outcomes, each partner should have in place an effective system which allows for the mutual routine monitoring and updating of existing and emergent risks.

NHS Fife is committed to minimising any risk by ensuring:

- An adequate risk management framework is incorporated as part of the governance arrangements for joint management and partnership agreements
- There is a system in place to identify, evaluate, record and monitor joint risks
- Common objectives are agreed with partner agencies, contractors and the voluntary sector
- With regard to the Health & Social Care Partnership (H&SCP), the Partnership Management Group will continue to monitor the efficacy of the existing H&SCP Risk Management Strategy and arrangements, and review these to ensure they comply with any changes made to the partnership arrangements and to accommodate the requirements associated with developments in Health & Social Care Integration.
- Key principles based on NHS and Council Risk Management processes that will form the basis of the future model for management of risks in the Integrated Authority, will be developed for the Integration Scheme.
- The Responsible Officers for the respective elements of the Integrated Authority will provide reports to the Joint Board on risk related issues associated with joint working arrangements.

5.8 Training and Development

Effective risk management depends on all staff having a clear understanding of the reasons for managing risk, how they can contribute and the benefits of doing so for themselves, patients, and the wider organisation.

A range of risk management training is available to all staff. The content of the training is reviewed and updated to ensure that it meet the needs of NHS Fife staff.

Board Development sessions will be recommended at the discretion of the Chief Executive and the Board Chairman, to enable a Board discussion of the most significant risks facing the organisation; this will inform the further development of the BAF.

5.9 Business Continuity

Business Continuity Management is a holistic process that identifies potential impacts that threaten an organisation. It provides a framework for building resilience and the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities.

The NHS Fife Business Continuity Programme operates in accordance with the principles set out in the British Standard BS25999 and NHS Resilience and Business Continuity Management Guidance documents. The identified Executive Lead for Business Continuity provides assurance to the SMT and the Board on the adequacy and effectiveness of associated risk management arrangements.

5.10 Communication

It is widely recognised that good communications are essential for any organisation wishing to achieve high performance standards. Therefore, NHS Fife will share risk management information with staff, the public and other stakeholders. We will:

- Be open with the public about our understanding of the nature of known risks
- Seek patient and public involvement in decision making processes that affect them
- Act proportionately and consistently in dealing with risks to the public

This Framework and other risk management related information will be posted on the NHS Fife intranet. This includes:

- Policy and procedural documents
- Newsletters
- Datix information
- Links to useful websites

Managers are responsible for making staff aware of this Framework.

6.0 FURTHER READING

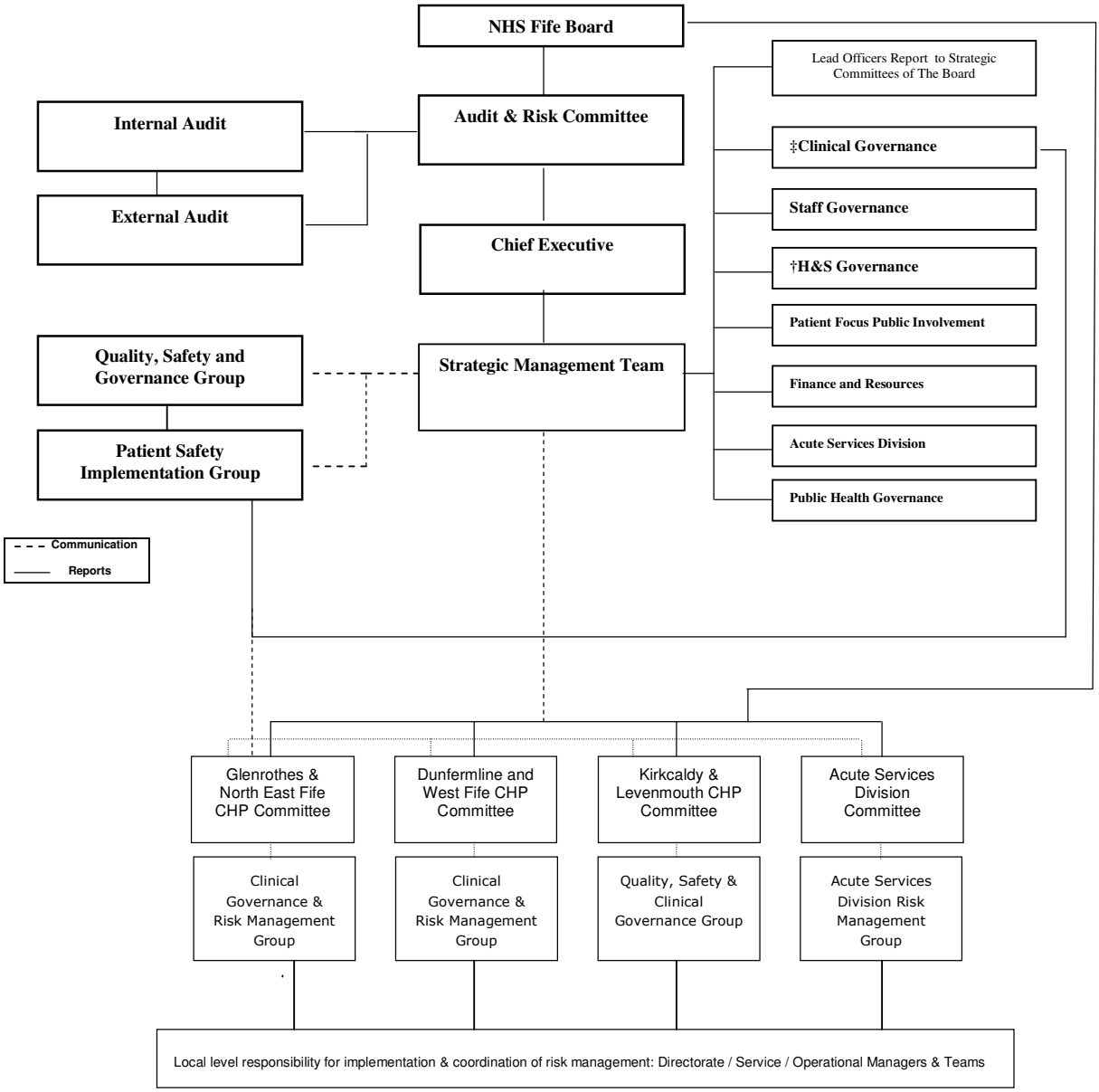
We recommend reading this Framework in conjunction with the following:

- NHS Fife Adverse Events Policy (2013) and Management of Significant Adverse Events and Reviews: Supporting Guidance & Resources (2013)
- NHS Fife Code of Corporate Governance (including Standing Orders and Standing Financial Instructions (February 2014)
- NHS Fife Healthcare Improvement Programme - Getting Better in Fife (2012)
- NHS Fife Risk Register and Risk Assessment Policy (2014)

- NHS Scotland Route Map to the 2020 Vision for Health and Social Care (2013)
- NHS Scotland Quality Strategy (2010)
- Audit and Risk Committee Handbook, HM Treasury (April 2013)
- Public Sector Internal Audit Standards: Applying the IIA international Standards to the UK Public Sector (Section 2120), HM Treasury (2013)
- Risk And Control Evaluations (RACEs). FTF Development Group (2010/11)
- Scottish Government, Audit Committee Handbook - Annex F (July 2008)
- The Patient Rights (Scotland) Act 2011

Appendix A

NHS Fife Risk Management Structure



‡Groups providing assurance to Clinical Governance Committee:

Public Health Governance, CHP and Divisional Committees, Infection Control, Blood Transfusion, Radiation Protection, Area Drug and Therapeutics, R&D, Resuscitation, Information Governance

†Groups providing assurance to H&S Governance:

Management of Health and Safety Group

Appendix B

PROGRAMME OF REPORTING ON CORPORATE RISKS TO THE STANDING COMMIITTEES OF NHS FIFE 2014

Corporate Risk	Risk Owner	SMT *	Committee	Date	Y/N	SMT *	Committee	Date	Y/N
525 (Formerly 2599 (Equality & Diversity)	S McLean	24 Feb 2014	PFPI	5 Mar 2014		25 Aug 2014	PFPI	3 Sept 2014	
518 (Formerly 3039 (Resilience)	E Coyle	3 Mar 2014	Public Health Governance	13 Mar 2014		1 Sept 2014	Public Health Governance	11 Sept 2014	
528 (Formerly 1193 (Pandemic Flu)	E Coyle	3 Mar 2014	Public Health Governance	13 Mar 2014		1 Sept 2014	Public Health Governance	11 Sept 2014	
524 (Formerly 3205 (MMC)	B Montgomery	3 Mar 2014	Staff Governance	30 April 2014		24 Nov 2014	Staff Governance	4 Dec 2014	
527 (Formerly 1890(Staff Governance)	R King	3 Mar 2014	Staff Governance	30 April 2014		24 Nov 2014	Staff Governance	4 Dec 2014	
523 (Formerly 3177 (Policy & Procedural Updates - HR))	R King	3 Mar 2014	Staff Governance	30 April 2014		24 Nov 2014	Staff Governance	4 Dec 2014	
521 (Formerly 3035 (Capacity Planning)	H Knox	10 Mar 2014	Acute Services Division	19 Mar 2014		15 Sept 2014	Acute Services Division	24 Sept 2014	
519 (Formerly 3040 (Health, Safety & Fire)	R King	10 Mar 2014	Health & Safety Governance	16 April 2014		8 Dec 2014	Health & Safety Governance	18 Dec 2014	
526 (Formerly 1280 (Legionella)	J Leiper	10 Mar 2014	Health & Safety Governance	16 April 2014		8 Dec 2014	Health & Safety Governance	18 Dec 2014	
517 (Formerly 3037 (Finance)	C Bowring	17 Mar 2014	Finance & Resources	25 Mar 2014		22 Sept 2014	Finance & Resources	30 Sept 2014	
522 (Formerly 2124 (Prescribing & Meds Management)	C Bowring	17 Mar 2014	Finance & Resources	25 Mar 2014		22 Sept 2014	Finance & Resources	30 Sept 2014	
523 (Formerly 3177 (Policy & Procedural Updates - General)	C Bowring	17 Mar 2014	Finance & Resources	25 Mar 2014		22 Sept 2014	Finance & Resources	30 Sept 2014	
516 (Formerly 3042 (Infection Control)	S McLean	24 Mar 2014	Clinical Governance	9 April 2014		29 Sept 2014	Clinical Governance	8 Oct 2014	

520 (Formerly 922 (Child Protection)	S McLean	24 Mar 2014	Clinical Governance	9 April 2014		29 Sept 2014	Clinical Governance	8 Oct 2014	
529 (Formerly 3036 (Information Governance)	E Coyle	24 Mar 2014	Clinical Governance	9 April 2014		29 Sept 2014	Clinical Governance	8 Oct 2014	
523 (Formerly 3177 (Policy & Procedural Updates - Clinical)	S McLean	21 April 2014	Quality, Safety & Governance (Clinical Governance)	30 April 2014		20 Oct 2014	Quality, Safety & Governance (Clinical Governance)	10 Dec 2014	
(842) In patient Falls New: Added to Register July 2014	M Porter	N/A	N/A	N/A		29 September 2014	Clinical Governance Committee	10 Dec 2014	

* Denotes SMT meeting to which draft paper / verbal report should be submitted preceding relevant Standing Committee

Board Assurance Framework (BAF)

Currently Under Consideration

Policies & Procedures

RISK REGISTER AND RISK ASSESSMENT POLICY

DOCUMENT CONTROL		POLICY NO	GP/R7
Policy Manual/System	General		
Author	Risk Manager	Version No	2.0
Reviewer	Risk Manager	Implementation Date	01/11/2009
Status	Final	Next Review Date	01/06/2015
Approved By Director of Nursing	Director of Nursing	Last Review Date	01/06/2014

General Note

NHS Fife acknowledges and agrees with the importance of regular and timely review of policy statements and aims to review policies within the timescales set out. New policies will be subject to a review date of no more than 1 year from the date of first issue.

Reviewed policies will have a review date set that is relevant to the content (advised by the author) but will be no longer than 3 years.

If a policy is past its review date then the content will remain extant until such time as the policy review is complete and the new version published.

1. FUNCTION

1.1 This policy is part of a suite of policies that enables the delivery of the NHS Fife Risk Management Framework.

1.2 It describes the responsibilities and procedures to be followed in the process of risk identification and assessment and the development and maintenance of risk registers in NHS Fife.

1.3 The Board has a legal duty under the Health and Safety at Work Act 1974, to ensure, as far as is reasonably practicable, the health, safety and welfare of all employees. Compliance with the legislation includes duties towards patients, members of the public, contractors, and other people who use hospital premises. These duties, and the concept of risk management, are implicit in the Act and subsequent UK Health and Safety Regulations and are reflected in NHS Fife Policies.

1.4 We recognise that by their very nature, healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances can be complex and involve a degree of risk. These risks are present on a day-to-day basis throughout the organisation and some risks of these may never be totally eliminated.

1.5 Risks must not be seen merely as threats, but through informed decision making, as potential opportunities for success and innovation. Risks must, however, be properly

managed. If not, they have the potential to cause harm to patients, staff and others and may affect the reputation and assets of the organisation.

1.6 Risk identification and risk assessment can help organisations, teams and individuals set their priorities and improve decision-making to reach an optimal balance of quality and efficiency - risk, benefit and cost. It enables us to:

- Gather facts about activities and services and their associated hazards and risks;
- Highlight the need to eliminate or manage identified hazards and risks, in order to protect the safety and well-being of patients, visitors, staff, and the organisation as a whole
- Assist in the identification of risks that are a threat to the achievement of strategic objectives;
- Take corrective actions when new risks are identified or existing risks are not adequately controlled;
- Assess the likelihood and consequence of risks causing harm or damage;
- Gauge the consequence of non-compliance;
- Consider the consequences of not meeting key objectives.

1.7 NHS Fife is committed to a process of proactive risk assessment and management within its services and activities. The organisation will use risk assessment as part of Corporate, CHP, Divisional, Directorate, Service, business and project planning, in the establishment, restructuring or redesigning of services and in the development of risk registers.

1.8 A risk register is a management tool that provides an organisation with information on its risk profile and is a repository for risk information across all areas of activity. This repository is at the heart of the internal control system and contains details of the risks that threaten NHS Fife's success in achieving its stated aims and objectives.

1.9 In NHS Fife, the registers are populated through the organisation's risk assessment and evaluation process. This process enables risks to be quantified and ranked. It provides a structure for collecting information about risks that will assist both in the analysis of risk, and in decisions about whether or how these risks must be controlled, managed and monitored.

1.10 Risk registers can also support decision making on how resources should be allocated. Ideally, all decisions such as changes in policy, procedures or practices, service developments, enterprises such as new projects and all associated resource commitments should result in reductions to the organisation's highest priority risks. At all levels, proposals to make changes or commit resources must include reference to the effect this may have on the organisation's risk profile.

1.11 In NHS Fife, Risk Registers must be recorded in the Risk Module of the Datix Risk Management Information System*, from this point to be referred to as Datix.

1.12 The appendices attached to this policy cover the following:

Appendix 1	Glossary of Terms
Appendix 2	Examples of Risk Issues
Appendix 3	The Risk Assessment Process
Appendix 4	Record of General Risk Assessment

Appendix 5	Assessing the Level (Grade) of the Risk
Appendix 6	Risk Escalation
Appendix 7	Recommended Risk Register Content

2. LOCATION

2.1 This policy and associated procedures are applicable to all staff and, by agreement, contractors working within NHS Fife. It can also be used by independent GP, Dental, Pharmacy and Orthoptic contractors. The accountability arrangements of these independent contractors differ from those of NHS Fife employees, and therefore this policy should be seen as good practice guidance, and used in conjunction with the requirements of their own professional body.

3. RESPONSIBILITY

3.1 Fife NHS Board

3.1.1 The Board is responsible for ensuring that there is a clear and appropriate management structure that enables risk to be identified and decisions to be taken at an appropriate level.

3.1.2 The Board will be informed of the risks associated with achieving its objectives and will actively re-assess and monitor them.

3.2 The **Chief Executive** is responsible for

- Ensuring that there are arrangements in place for identifying, evaluating and managing risk;
- Providing resources for putting the policy into practice.

3.2.1 In practice, this responsibility is delegated to the Board Director of Nursing who as the Executive Lead for Risk Management, is accountable to the Chief Executive for ensuring that policies and procedures are in place to support the effective management of risk.

3.3 NHS Fife SMT

3.3.1 The NHS Fife SMT is responsible for maintaining the NHS Fife Corporate Risk Register in Datix.

3.3.2 The risk content of the Corporate Risk Register will be informed by the escalation procedures noted in **Appendix 6**, as well as the collective input of the NHS Fife SMT and Fife NHS Board. All corporate risks will be mapped to the Governance Committees of NHS Fife, which will be responsible for oversight and scrutiny of the management of the risks. Where applicable, these risks will also be aligned to HEAT targets and the Quality Ambitions.

3.3.3 The NHS Fife SMT will receive from the Chief Executive, NHS Fife, the Director of Acute Services, CHP General Managers and Executive Directors, an annual report providing assurance on the management of risks in their respective areas of responsibility, including Groups and Committees under their jurisdiction. The evidence will be from minutes of meetings at operational delivery level where risks

are discussed. These will demonstrate that risk is a standing agenda item at such meetings and show that discussion takes place on:

a. high level risks registered on the NHS Fife Corporate Risk Register;
b. action plans associated with these high level risks or a summary of the key actions being taken to manage risks;
c. high or moderate level risks managed within the area of responsibility which it is felt should be brought to the attention of the NHS Fife SMT;
d. confirmation that the Priorities and Risk Framework risks have been identified and managed;
e. any other high and moderate level risks and control measures;
f. adverse events / trends in adverse events that represent a significant risk within the area of responsibility or to NHS Fife and any resultant significant management action;
g. the desired target levels for risks where this is appropriate and an assessment of the progress made by the Committee /CHP/ Division / Directorate / Service in achieving its risk management objectives as well as for example, highlighting any actions/action plans that have reduced risks;
h. key actions required over the next six months.

3.3.4 The NHS Fife SMT will provide twice yearly reports to the NHS Fife Audit and Risk Committee and by extension Fife NHS Board, on the Corporate Risk Register. This will summarise key actions, changes and developments in relation to the risks therein and assure the Board that NHS Fife:

- has complied with all relevant statutory requirements
- has appropriate risk management processes and controls in place

3.4 NHS Fife Clinical Governance Committee

The Committee will:

- Receive 6 monthly reports on the clinical governance risks in the high level risk registers of the CHPs, the Acute Services Division and the Corporate Risk Register, summarising key actions, changes and developments in relation to the risks;
- Monitor the management of clinical governance risks recorded on the Corporate Risk Register.

3.5 Director of Acute Services /CHP General Managers / Executive Directors

3.5.1 Management Teams in the Acute Services Division, the CHPs and Corporate Directorates are responsible for maintaining, regularly reviewing and updating their risk registers in Datix and making these accessible to all staff. Risk registers will be used to help inform local planning, management decisions and priorities.

3.5.2 All risks must be allocated a risk owner who is the lead person assigned the responsibility for ensuring that the risk is adequately controlled and monitored. If allocating risk ownership to another individual, this must be discussed and agreed in advance.

3.5.3 The review of Divisional / CHP/Corporate Directorate Risk Registers will be a standing Management Team agenda item at the Clinical Governance and Risk Management Group meetings in the component parts of the organisation.

3.5.4 Risks will be reviewed to determine the adequacy and effectiveness of risk management arrangements; all actions and changes will be recorded in Datix.

3.5.5 Action must be taken as soon as possible, at the lowest possible level of the organisation, to eliminate, reduce or transfer the risk.

3.5.6 Any risk that cannot be managed at a Division / CHP / Corporate Directorate Management Team level **must** be escalated by the Executive Lead for the area of risk to the NHS Fife SMT to be considered for inclusion on the Corporate Risk Register.

3.6 NHS Fife Risk Management Team

The Risk Manager, NHS Fife is responsible for providing leadership and direction to the NHS Risk Management Team. The Team works across NHS Fife as part of the Clinical Governance Support Team and in partnership with colleagues in the Delivery Units with explicit risk management responsibilities, to support the development and
Implementation of an effective risk management framework. The Team is responsible for the co-ordination and monitoring of organisation - wide risk management activity across NHS Fife. This includes:

- Developing strategy, policy and procedures relating to risk management to ensure the organisation meets its legal and corporate governance requirements
- Communicating the benefits of systematically identifying workplace risks, assessing the associated potential for risk or harm and putting in place measures to control the risk
- Producing composite risk management reports for individuals, groups, Standing Committees and the Board
- Promoting a positive attitude to risk management by sharing good practice, communicating lessons learned and celebrating success
- Delivering training and development to support effective risk management
- Providing advice and support to individuals and teams on risk management including:
    - the development and implementation of risk registers
    - the management of adverse events and Significant Adverse Events and Reviews
- Leading on the development and implementation of the Datix system (incidents, risks, complaints and claims modules) to:
    - improve knowledge and understanding of its use and potential
    - assist in the resolution of Datix user software problems

3.7 Service/Directorate/Departmental Managers

3.7.1 Senior and Line Managers are responsible for:

- identifying, evaluating and managing risk within their areas of control;
- recording risks in the risk module of Datix, developing action plans and monitoring the plans until the risk has been reduced to its lowest reasonably practicable level;
- ensuring that staff are consulted on matters relating to health and safety and other pertinent areas of risk;

- ensuring that there are sufficient trained risk assessors/staff who have attended risk management training in their areas of responsibility;
- allocating sufficient time for risk assessors to attend risk assessor/risk management training and to perform their risk assessment duties;
- ensuring that staff do not carry out any work unless a suitable and sufficient assessment of the risks has been carried out and the necessary steps have been taken to adequately control the risk;
- ensuring that all staff are aware of this policy, understand its content and those of local and associated procedures;
- ensuring that employees are aware of their responsibilities with regard to risk assessment and risk management;
- ensuring that risk assessments are reviewed at least annually, or immediately if in response to e.g. changes in procedures, equipment, location, personnel, legislation or other external requirements, new initiatives, technological developments, strategic change, adverse events, near misses, claims and complaints;
- ensuring that staff groups and individuals identified as being at risk are given relevant information, instruction, training and supervision;
- monitoring the effectiveness of risk control measures through an effective system of reporting, recording and investigating adverse events and near misses.

3.7.2 Managers must put into place systems at a local level to ensure that their Service/Directorate/Departmental risks recorded in Datix are accessible and available to all staff.

3.7.3 Managers at all levels must review action plans to ensure that actions have been implemented within preset timescales and monitor these to ensure that these actions are having the desired effect on the risks they are intended to address.

3.7.4 Service/Directorate/Departmental Management Teams will use Risk Registers to inform priorities for the local implementation and monitoring of agreed risk controls.

3.7.5 Management Teams are responsible for regularly reviewing and updating their Risk Registers in Datix with next review dates being set for all risks. Delays in completing reviews will be reported to the appropriate Divisional/CHP Clinical Governance/Risk Management Group/Management Team for consideration.

3.7.6 Managers must escalate any risk that cannot be managed at a Service/Directorate/Department level to the relevant Divisional/CHP Clinical Governance/Risk Management Group/Management Team for consideration and appropriate action.

3.6.7 Managers at all levels must review risks and monitor action plans at appropriate intervals to ensure that the risks remain current, and that relevant and appropriate actions have been recorded , implemented within timescale and are targeted towards eradicating the risk or effectively reducing the risk to an acceptable level.

3.7.8 Managers are responsible for recording and taking appropriate actions on risks identified through the investigation of adverse events (incidents).

3.8 **All employees are responsible for**:

- taking reasonable care of themselves and others who may be affected by their actions;
- taking part in training and implementing learning to manage risk co-operating by following rules and procedures identified through the risk assessment process, designed to enable working in a manner which controls risk to as low a level as is reasonably practicable;
- reporting all incidents and near misses;
- informing managers/colleagues/risk assessors of any new risks/hazards encountered during the course of their daily work ;and
- informing their managers if they believe that systems in place for the assessment or control of risks are ineffective or inadequate.

4. OPERATIONAL SYSTEM

4.1 A risk assessment must be completed for risks that would prevent NHS Fife from achieving its objectives. This forms part of the Board Assurance process. Such risks will form part of the Corporate Risk Register and will be monitored, maintained and held by NHS Fife SMT and will be subject to review at its meetings. These meetings will provide for discussion about new and emerging risks.

4.2 The Acute Services Division, the CHPs and Corporate Directorates must, in the first instance, undertake baseline risk assessments to identify all their significant risks and develop a Risk Action Plan to manage these risks. Risks which have not been eliminated or satisfactorily reduced will form part of the Divisional/CHP/Directorate Risk Register and will be the responsibility of the Director of Acute Services /CHP General Manager/Executive Director.

4.3 NHS Fife will adopt a measured approach to solving a problem or a perceived risk. This will involve consideration of the impact of the proposed solution on all key stakeholders and/or services. If a comprehensive risk evaluation is carried out before taking action, the best and most cost effective option should emerge.

4.4 The Risk Register will enable NHS Fife to understand:

- The risk (s) that may prevent the organisation from achieving its objectives;
- The highest priority risks;
- The options for managing these risks;
- The most cost effective options;
- How, when, and if these options can be put in place;
- If existing risk action plans (already in place) have been effective;
- If risk action plans are being monitored appropriate to the risk level;
- How the organisation will respond to the new risks

4.5 **Sources of Potential Risks**

4.5.1 Risk is inherent in all aspects of healthcare including:

- treatment and care delivery
- organisational strategy and business planning;
- design of services
- financial planning;

- projects and service developments and ;
- purchasing;

4.5.2 NHS Fife recognises that its Risk Register will be populated with information from a wide range of internal and external sources. These may include the following:

- Adverse Events and Reviews
- Business Cases & Plans
- Business Continuity Plans
- Care Commission Reviews
- Changes in Statute/regulatory guidance
- Claims
- Clinical Audit Reviews
- Complaints
- Confidential Enquiries
- Environmental Health
- External Audit Reports
- External Review e.g. NHS Healthcare Improvement Scotland (HIS) including Healthcare Environment Inspectorate (HEI) / Scottish Public Service Ombudsman (SPSO) Health and Safety Executive (HSE) Reviews / CPA; Mental Welfare Commission
- Failure Modes and Effects Analysis (FMEA)
- Fife Fire Authority
- Fire Safety Reviews
- Guidelines (e.g. SIGN NICE/ NPSA/)
- Health & Safety Reviews
- Horizon Scanning
- Internal Audit Reports
- Losses and Compensation Register
- Patient Feedback
- Performance/Activity Reports
- Professional Bodies
- Recruitment /Retention/Absenteeism data
- Risk Assessment Process (see **Appendices 3 4 and 5**);
- Safety Action Notices/ /Product Recalls
- Scenario-based exercises
- Scottish Environment Protection Agency
- SPSP Senior Leadership Walk Rounds/ other Walk Rounds e.g. HAI
- Staff Surveys
- Training Needs Analyses
- Other legal or regulatory reviews.

4.6 Risks will be identified through the routes highlighted above and by the Division, CHPs, Corporate Directorates, Wards and Departments of the organisation. The risk rating will determine the degree and detail of monitoring within the documented action plan.

4.7 The Risk Register and Risk Action Plans should be flexible enough to allow the organisation to respond to unforeseen risks, serious adverse events, external events or changes in national policy. **Appendix 7** provides guidance to the field names and their description when using Datix to record risks and action plans.

4.8 **Appendix 8** details the Risk Types and Sub-Types for categorising risks in Datix.

5. RISK MANAGEMENT

5.1 Appendices 3, 4, and 5 detail the steps for conducting a risk assessment and formulating risk action plans.

5.2 It is recommended that risk assessments are initially scoped out on the NHS Fife 'Record of Risk Assessment' form (see **Appendix 3**) prior to entering in Datix. The person assessing the risk and the manager or head of department must sign this. Managers are advised to keep a copy of the assessment form in their department.

5.3 The risk rating will determine the level of risk and the degree and detail of monitoring within the documented action plan.

5.4 If the current risk level is assessed as moderate or high, a risk action plan should be developed. The action plan must be implemented and/or escalated as necessary (see **Appendix 6**) and entered into the risk module in Datix (see **Appendix 7**).

5.5 All risk assessments must identify a review date and be regularly reviewed.

5.6 Assessments must be reviewed immediately if:

- there is reason to suspect it has become invalid;
- there has been a significant change in the previously assessed work/task/project/equipment;
- there has been a change in the law or guidance concerning the work/task/project;
- there has been a change in the staff undertaking the task assessed; or
- An adverse event or near miss has been reported and subsequent investigation recommends a review.

5.7 Managers must review plans as necessary to ensure that objectives are current and achievable.

5.8 Managers must review risk action plans regularly to ensure that time-bound objectives identified in the plans have been achieved.

5.9 Reviews/revisions should continue until all objectives identified have been achieved.

5.10 The manager, through a process of consultation, will nominate staff members for appropriate risk management training, dependent on the nature of the work and the location(s) of the work place.

5.11 The manager or supervisor must inform staff:

- of the findings of a risk assessment for any work/task/activity in which they are involved;
- about the dangers and risks to themselves or anyone affected by the activity arising from their work;
- of any precautions to be taken;
- what to do in the event of an emergency; and
- how and when to report adverse events and near misses

5.12 REPORTING OF FAILURES IN RISK CONTROL MEASURES

Managers must ensure all unplanned events that did result in, or could have resulted, in harm, loss or damage are reported in line with the NHS Fife Adverse Events Policy GP/I9.

Managers must report events e.g. release of a dangerous substance, a failure of medical equipment or certain defined injuries or diseases associated with work, to external agencies in line with guidance in the NHS Fife Adverse Events Policy GP/I9.

5.13 RISK MANAGEMENT

This policy is an integral part of NHS Fife's system for managing risk the key principles of which are described in the emerging NHS Fife Risk Management Framework, and the Quality Delivery Plan.

6. RELATED DOCUMENTS

NHS Fife Adverse Events Policy GP/I9 and Management of Significant Adverse Events and Reviews: Supporting Guidance & Resources (2013)

NHS Fife Risk Management Framework (Draft) 2014

7. REFERENCES

Australian/New Zealand Standard: Risk Management (AS/NZS4360:2004) Risk Management Standard), (2004) Standards Australia/Standards New Zealand

Clinical Governance and Risk Management Standards (2005), NHS Quality Improvement Scotland

National Patient Safety Agency (2006) Healthcare risk assessment made easy

NHS Fife Quality Delivery Plan (2013) (currently being updated)

NHS Scotland Quality Strategy (2010)

Priorities and Risks Framework National Audit Planning Tool for Local Government, Audit Scotland

APPENDIX 1

Glossary of Terms

***Adverse Event*:** Any incident / near miss, event or circumstance arising during NHS service provision that could have or did lead to unexpected harm, loss or damage.

***Assurance*:** Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Consequence: Most predictable consequence to the individual or organisation if the circumstances in question were to occur.

Contingency: Emergency plans/alternative arrangements that intervene should the risk become apparent.

Eliminate Risk: Do things differently & thus remove the risk where it is feasible to do so.

FMEA: A failure mode and effects analysis is a procedure for the analysis of potential failure modes within a system for classification by severity or determination of the effect of failures on the system identifying actions to mitigate the failures. A crucial step is anticipating what might go wrong.

***Governance Statement*:** This is a statement by the Accountable Officer which is to be published as part of each organisation's annual report and accounts. It is assembled from assurances gained throughout the year about the organisation's performance, risk management and internal control framework, including responses to actual and emerging risks and its success in managing them.

***Horizon scanning*:** The systematic examination of potential threats, opportunities and likely future developments which are at the margins of current thinking and planning. It may explore novel and unexpected issues as well as persistent problems or trends. Overall it is intended to improve the robustness of policies and evidence base e.g. anticipating, identifying and preparing for new or changing risks, developments, trends or changes in workplaces, including those arising from socio-economic, workplace trends and so on that could have an impact on ability to deliver on objectives.

Internal Control: Corporate governance arrangements designed to manage the risk of failure to meet NHS Fife's objectives.

***Likelihood*:** Probability of an event occurring, wherever possible based upon the frequency of previous occurrences.

Near Miss: Where no harm, loss or damage is caused but could have resulted in harm, loss or damage in other circumstances.

***Partnership*:** Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies which affect their working lives.

***Reduce risk*:** Take action to control the risk either by taking actions which lessen the likelihood of the risk occurring or the consequences of occurrence.

Risk: The chance of something happening that will impact on the organisation's ability to achieve its objectives.

Risk Appetite: The amount and type of risk that an organisation is prepared to seek, accept or tolerate (BS311001 (British Standards, 2008)

***Risk Assessment*:** An overall process to identify risk and evaluate whether acceptable or not taking into account new/ best practice.

***Risk Control Measure*:** An action undertaken to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

Risk Escalation: The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impractical or not reasonably practicable to manage locally.

Risk Evaluation: This involves an estimate of the probability and /or frequency of the risk occurring and the impact or severity if it does***.***

Risk Level: The classification of a risk expressed as a combination of its likelihood and severity of consequence.

Risk Management**:** Incorporates all the activities required to identify and control the exposure to risk which may have an impact on the achievement of an organisations objectives.

Risk Owner: The lead person assigned with responsibility for ensuring that the risk is adequately controlled and monitored.

Risk Register**:** A database of risks always changing to reflect the dynamic nature of the risk and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.

Risk Tolerance: The specific maximum risk that an organization is willing to take regarding each relevant risk

Root Cause Analysis: A systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and the environmental context in which the incident occurred (NPSA, 2004).

Significant Risk**:** Broadly, any risk that could adversely affect achievement of NHS Fife's objectives or present a large loss. A 'significant' risk could be defined as one with a risk grading of 'moderate' (orange) or 'high' (red) determined using the Risk Grading Matrix.

System Failure**:** The most likely cause of an adverse event. Typically due to a flaw or flaws in the design or operation of a system of work rather than an individual's actions or inaction.

Transfer Risk**:** The most common form of risk transfer is insurance.

APPENDIX 2

EXAMPLES OF RISK ISSUES

Policies and Procedures
- Clinical
- Division/CHP
- Departmental Gaps
- Compliance

High Risk Areas
- Surgery & Anaesthetics
- Obstetrics
- A & E
- Pharmacy
- Medicines management
- Medical devices
- Infection control
- Consent issues
- Critical care

Staffing
- Numbers
- Grades/skill mix
- Lone working
- Emergencies e.g. Pandemics

Competence & Staff Training
- Access and availability of training
- Induction
- Supervision
- Volunteers
- Counselling

Record Keeping
- Clinical Records
- Data Collection
- Storage and Retrieval
- Content
- Filing
- Data Protection

Services
- Maintaining services out of hours
- After care/discharge

Organisational Arrangements
- Incident Reporting
- Complaints
- Clinical Audit
- Significant Adverse Events
- Dealing with Emergencies
- Research and Development
- Communications
- Information Provision and Access
- Access to Support and Advice
- Geographical Issues
- Maintenance & Use of Equipment

Health and Safety
- Manual Handling
- Hazardous substances or biological agents
- Workplace environment, ergonomics and welfare
- Violence and Aggression
- Access to Support/Back Up
- Sickness/Absences

APPENDIX 3

THE RISK ASSESSMENT PROCESS

3 Key Principles

- Adopt a collaborative approach to risk identification, involving the right people from the outset.
- Consider the issues/problems/hazards associated with the work environment and the activities undertaken there. Decide who or what might be harmed or damaged and under what circumstances this might occur.
- Evaluate the risk of the hazard or threat causing harm, loss or damage and consider the adequacy of the existing control measures.

What is risk assessment?

The process of risk assessment seeks to answer four simple but related questions:

- What can go wrong?
- How bad could it be?
- How often could it occur?
- Is there a need for action?

Steps to carrying out a risk assessment

To ensure a consistent approach to the assessment of risk, a logical process or series of steps should be followed. The following guide is based on guidance from the Health & Safety Executive and the National Patient Safety Agency.

For each task, group of tasks or environment

Step 1 - Identify the hazard – what can go wrong?

Step 2 - Decide who might be harmed and how.

Step 3 - Evaluate the risk and decide on precautions – is there a need for further action?

Step 4 - Record your findings, proposed action and who will lead on what action.

Step 5 - Review your assessment and update if necessary.

Step 1 Identify the hazard (what can go wrong)

To prevent harm, it is important to understand not only what is likely to go wrong but also how and why it may go wrong.

Consider the activity within the context of the physical and emotional environment, the culture of the organisation and the staff who perform the activity. Take into account things that have gone wrong in the past and near-miss incidents. Learn from the past.

- Where appropriate, tour the work place/clinical area and talk to patients and staff;
- Map or describe the activity to be assessed;
- Consider if the risk assessment requires a multi-disciplinary approach;
- Consult legislation, approved Codes of Practice and Guidance – some hazards will have specific legal requirements pertaining to them;
- Look at 'in house' policies, arrangements, guidance and hazard checklists;
- Look at Incident/Near Miss data and/or use information gathered from Safety Action Notices and other sources;
- To prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong.

Step 2 Decide who/what might be harmed and how (what can go wrong? Who is exposed to the hazard?)

In deciding who/what is at risk, you will need to:

- Recognise that people will make mistakes. It is therefore necessary to anticipate some degree of human error and try to prevent this resulting in harm;
- Consider e.g. the number of people that might be affected over a stated period;
- Consider groups/entities who may be particularly at risk, e.g. vulnerable patients, children, young/inexperienced workers, new and expectant mothers, people with disability, volunteers, students, visitors, members of the public, the organisation;
- Think about the complexity of the task;
- Consider work-related factors e.g. lone workers and workload;
- Consider provision of and/or level of training;
- Consider experience/technical knowledge.

Step 3 Evaluate the risks (how bad/ how often?) and decide on what precautions are needed (is there a need for further action?)

This involves considering the control measures/ management actions currently in place and deciding whether these are adequate to control the risk to an acceptable level.

- Use the NHS Fife risk matrix to determine the level of risk. Consider both consequence (how bad?) and likelihood (how often?). (Remember Risk = Likelihood x Consequence) Is there a need for additional action? Further guidance on risk grading can be found in **Appendix 5**. This may help you prioritise your actions.
- Decide on the precautions/management actions (controls) that will most effectively reduce consequence and/or likelihood.
- Re-evaluate the risks in the light of the precautions (controls) that have been taken.

Step 4 Record your findings, proposed actions and identify lead persons for each action. Record the date of implementation.

Risk assessments and action planning should be reviewed and changed when necessary. This is made more straightforward if the assessment is well-recorded and the logic behind the decisions transparent. An efficient and succinct system of documentation is essential.

- The significant findings of the risk assessment must be recorded on the NHS Fife 'Record of General Risk Assessment' form (see **Appendix 3**). Risk assessments or copies of risk assessments must be available to people working with particular hazards.
- Record significant and outstanding risks in DATIX
- For all significant risks, implement the action plan and/or escalate in line with the process detailed in **Appendix 6**. Where necessary, refer to local escalation procedures.

Step 5 Review your assessment and update if necessary

Good documentation is important because things are always changing and it is vital to keep track of such changes. Research and new developments increase the pace of change and those changes can alter existing and/or introduce new hazards.

Managers must review the risk assessment when it is no longer valid. This may be due to changes within the organisation e.g. changes in work practice/procedures or personnel. It may be due to external changes e.g. new legislation or governance arrangements.

Review your risk assessment:

- When you are planning a change
- Routinely – frequency will be determined by the level of threat posed by the risk
- When there has been a significant change
- Following an incident/near miss event

Implementing Further Controls

The following hierarchy of control measures will help you to identify what additional action you should take to reduce the risk to an acceptable level. It is important to remember that some corrective measures are better than others. The table below shows the preferred hierarchy for controls. Always try to use those higher up in the table before considering the need for those below.

HIERARCHY OF CONTROL MEASURES	
Hazard Elimination	**e.g. use of alternatives, design improvements, change of process**
Substitution	**e.g. replacing a hazardous chemical with one with less risk**
Use of Barriers	**e.g. isolation/segregation**
Use of Procedures	**e.g. safe systems of work**
Use of Warning System	**e.g. signs and labels, audible alarms**
Use of Personal Protective Equipment (PPE)	**Should be used only as a last resort**

Whilst the hazard cannot change, the overall level of risk presented can be altered through management action e.g. the nature of 240V AC/13A electricity does not change but the risk of receiving an electric shock can change depending upon the controls in place.

APPENDIX 4

RECORD OF GENERAL RISK ASSESSMENT

Department	
Manager responsible	
Risk Assessor(s)	

Describe the Task / Procedure/Environment

What are the hazards/ threats? (See Hazard Identification Sheet(s) for examples)

Where in the task/procedure are the hazards / threats present? (e.g. preparation, storage, transportation, during the task, at the end)

Who/what might be harmed by the hazards / threats above and how? (e.g. Nursing / Medical / Technical / Domestic Staff, Porters, Admin & Clerical Staff, Maintenance Contractors, AHPs or vulnerable groups such as staff with disabilities, visitors, young persons, new and expectant mothers, inexperienced staff or people on training experience, lone workers, patients / clients, those with language difficulties or special needs, the organisations reputation, the ability to meet objectives/targets and so on)

What are the current management actions /risk control measures? *(e.g. hoists, local exhaust ventilation, protective equipment, safe systems of work, personal alarms, training and supervision, contingency plans)*

What risks are not adequately controlled? *(i.e. given the control measures currently in place, what risks or hazards remain present and / or are uncontrolled?)*

Consider the likelihood and consequence (Assess if risks are very low / low / moderate / high using the guidance in Appendix 6)

If risk is graded moderate or high, has it been entered on the Datix risk register?

Yes ☐ No ☐ Risk ID No:

What further action(s) is necessary? (Remember to complete an action plan indicating who is going to take action and by when) (Consider emergency situations e.g. major spills, fire, cardiac arrest)

Has the risk assessment been agreed with your line manager?
Who will own this risk?

Yes ☐ No ☐ Manager's Signature and date

Have the findings of this Risk Assessment been communicated to all appropriate staff?	***Methods(s) used?*** *(e.g. safety brief, notice board, memo)*
Yes ☐	
No ☐	

Risk assessment completed by:

Print Name: **Signature:**

Designation:

Date: **How soon should this assessment be reviewed?**
How frequently should review occur?

Review carried out by:

Print Name: **Signature:**
Date:

APPENDIX 5

ASSESSING THE LEVEL (GRADE) OF THE RISK

1. Determine the **Likelihood (L)** of recurrence for the event using **Figure 1** (see below).

   When determining the likelihood you should consider:

   - The frequency of any previous occurrences e.g. when was the last time you were killed in a car crash? Never. Does that mean you can't be killed today or in the future?

   Figure 1: Likelihood of Recurrence definitions

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances (5-10 years)	Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)	May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)	Strong possibility that this could occur – likely to occur (quarterly)	This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)

2. Determine the **Consequence (C) rating** using **Figure 2 (see below)**

   Look at **events** that **could lead** to the consequence, **not the consequence itself**

   e.g. **Event** Hole being punctured in aircraft
   Consequence Bringing aircraft down

   Which consequence do you opt for? NOT worst case scenario
   NOT most likely scenario

   Opt for the "Reasonably foreseeable, worst case scenario" –

   - If you got a phone call to tell you it had happened, you wouldn't be surprised

Figure 2: Consequence Table

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Objectives / Project	Barely noticeable reduction in scope / quality / schedule	Minor reduction in scope / quality / schedule	Reduction in scope or quality, project objectives or schedule	Significant project over-run	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects
Complaints / Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day) Short term low staffing level (>1 day), where there is no disruption to patient care	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training / implementation of training	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training Ongoing problems with staffing levels	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<10k)	Minor organisational / personal financial loss (£10k-100k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£250 k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendation	Recommendations made which can	Challenging recommendation	Enforcement action.	Prosecution.

	s which focus on minor quality improvement issues	be addressed by low level of management action.	s that can be addressed with appropriate action plan.	Low rating Critical report.	Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry

3. Use the risk matrix shown in **Figure 3** below to determine the risk grading for the risk. **L x C =R**

Figure 3: Risk Assessment Matrix

Likelihood	**Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost certain	LR	MR	HR	HR	HR
Likely	LR	MR	MR	HR	HR
Possible	VLR	LR	MR	MR	HR
Unlikely	VLR	LR	LR	MR	MR
Remote	VLR	VLR	VLR	LR	LR

In terms of grading risks, the following grades have been assigned within the matrix.

- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

APPENDIX 6

RISK ESCALATION

The assessed level (grade) of the risk, which is also known as the Risk Rating in Datix, will determine what action is to be taken.

RISK RATING	PRIORITY	RESPONSE	LEVEL OF ACTION
Green **Very Low**	Low	None/ long term	No further action or records required
Yellow Low	Low/ Medium	Medium term	Service/Directorate/ Departmental management action required to reduce risk as low as reasonably practicable
Amber Moderate	Medium/ High	Short term	Division/CHP/Corporate Directorate/Directorate/Service management action required to reduce risk as low as reasonably practicable
Red High	High	Immediate	Strategic NHS Fife SMT action/Board level awareness required

NB:

- To prioritise risk, NHS Fife will use the Generic Risk Assessment Tool at **Appendix 6**.

- **Moderate** and **High** Level Risks which are deemed not reasonably practicable to manage at a Service Directorate/Departmental level must be escalated to the appropriate Divisional /CHP Clinical Governance/ Risk Management Group/ Management Team by the appropriate manager for consideration for inclusion on the Division/ CHP Risk Registers

- **Moderate** and **High** Level Risks which are deemed not reasonably practicable to manage at a Division/CHP/Corporate Directorate Management Team level, must be escalated by the appropriate Executive Lead to the SMT to consider for inclusion in the Corporate Risk Register.

- Risks and their Action Plans must be monitored appropriate to the risk level. Every opportunity must be taken to mitigate the risk.

APPENDIX 7

RECOMMENDED RISK REGISTER CONTENT

Risks identified in NHS Fife should be recorded in the Datix Risks module. The following provides a guide to the field names. A risk register will contain the components listed below.

	Description
ID	Datix generates a number for each new record created within it. This number should be used to identify risk when creating reports from Datix.
Service/Directorate	Indicates the Service or Directorate where the risk originated
Opened	The date that the risk was first identified and registered **not** the date it was entered into Datix
Description	A statement of the nature of the risk, including how that risk might present itself and impact upon the organisation. This should be expressed as follows: "There is a risk that (likelihood)…which will result in…(consequence):e.g. *There is a risk that risk identification and monitoring procedures are insufficient which will result in threats not being identified and managed leading to events that impact adversely on the Board achieving its objectives.*
Risk Level(Initial)	Level of risk based on the combination of initial consequence and likelihood
Current Management Action	Any additional actions necessary to improve the management of the risk. (e.g. processes; policies; practices; devices or other actions to minimise negative risk or enhance positive opportunities.
Risk Level (Current)	Level of risk based on the combination of current consequence and likelihood.
Risk Target	The expected risk assessment after any proposed actions have been instigated. By setting a target, we can determine how effectively the risk is being managed and /or if the management actions need to be reviewed.
Risk Owner	The lead person assigned with responsibility to ensure that the risk is adequately controlled and monitored.
Results of Review	**Summary** of findings following review of risk; this should be recorded in the **Notepad Field** on the main Risk Assessment Screen
Next Review	Date when the risk and any identified actions will be reviewed.
Previous Review	Date the risk was last reviewed.
Position of Risk	This is a **mandatory** field in Datix. It is used to indicate the specific risk register in which any individual risk is currently located. This field must be completed to be sure that a risk is contained within any risk register
Risk Type and Sub Type	The mechanism by which NHS Fife categorises its risks. See **Appendix 8**

Guide to Action Plans and their Components

All risks should have an action plan and this should be recorded in the Datix Risk module. The following provides a guide to the action plans and their components.

Description	Where In Datix
Risk ID Number	Risk Assessment Screen.
Action Summary (used to record a summary of all the actions for the risk)	Enter details into the **"Action Summary"** field on the Action Plan Screen.
Current Risk Level (following implementation of management actions)	**Main Risk Assessment Screen** (providing this has been entered).
Priority assigned to this action	**Action Plan Screen.** Select from the drop-down list (e.g. high, medium or low).
Description of the type of action	**Action Plan Screen**. Select an action type from the drop down list in the **Type** field or enter text in the description field adjacent.
Synopsis of current position	**Details Button** on the Action Plan Screen. Enter as free text, dating each new entry.
Resources required to carry out the action	**Details** Button on the Action Plan Screen. Enter as free text, dating each new entry.
Reporting and Monitoring Requirements	**Details Button** on the Action Plan Screen. Enter as free text, dating each new entry.
Progress with the action	**Details Button** on the Action Plan Screen. Enter as free text, date each new entry.
Action To: Name of person responsible for ensuring completion of the action	**Action Plan** screen. Select the name from the drop-down list. The selected person must have access to Datix.
Date when action is due to be completed	**Action Plan** screen. Enter date as dd/mm/yyyy.
The source of any funding, including approval status	**Action Plan** screen, Cost Type Field. Select from list.
Date when the Risk and Action Plan will next be reviewed	**Risk Assessment** screen – Next Review field.

For further information on how to complete an action plan or run a report from Datix, please refer to the Datix Risk Register Guide. This is available on the Intranet.

DATIX RISK TYPES AND SUB-TYPES FOR CATEGORISING RISKS
APPENDIX 8

Risk Type	Risk Subtype
Clinical	Blood Transfusion
Clinical	Consent
Clinical	Guidelines/Policies/Procedures
Clinical	Healthcare Associated Infection
Clinical	Healthcare Records
Clinical	Infection Control
Clinical	Medication
Clinical	Medical Treatment/Procedure
Clinical	Professional Competency
Clinical	Patient Identification
Clinical	Research
Clinical	Sharps
Clinical	Tissue Viability
Clinical/Health/Safety/Strategic/Operational	Communication
GHMS Project Risks	Non Public Private Partnership
GHMS Project Risks	Public Private Partnership
GHMS Project Risks	General
Health & Non Clinical	Patient Fall
Health & Non Clinical	Slip / Trip /Fall
Health and Safety	Asbestos
Health and Safety	Biological Agents
Health and Safety	Confined Spaces
Health and Safety	Construction Design and Management
Health and Safety	Decontamination
Health and Safety	Display Screen Equipment
Health and Safety	Electricity
Health and Safety	Fire
Health and Safety	Flammable and Explosive Equipment
Health and Safety	Food Safety and Hygiene
Health and Safety	Substances Hazardous to Health
Health and Safety	Working At Height
Health and Safety	Legionella
Health and Safety	Lone Working
Health and Safety	Manual Handling
Health and Safety	Medical Equipment
Health and Safety	Medical Gases
Health and Safety	Noise
Health and Safety	Personal Protective Equipment
Health and Safety	Pressure Equipment
Health and Safety	Radiation
Health and Safety	Sharps
Health and Safety	Workplace Transport

Health and Safety	Waste Management
Health/Safety & Strategic/operational	Environment
Human Resources	Agenda for Change
Human Resources	Establishment
Human Resources	Knowledge & Skills Framework
Human Resources	Recruitment
Human Resources	Retention
Human Resources	Staff Absence
Human Resources	Skill Mix
Human Resources	Staff Governance
Human Resources	Training
Human Resources	Excessive Workload
Multi	Other
Non Clinical	Accommodation
Non Clinical	IT Systems
Non Clinical	Personal Accident
Non Clinical	Projects
Non Clinical	Security
Non Clinical	Vandalism
Non Clinical	Violence & Aggression
Strategic/Operational	Adverse Publicity/Reputation
Strategic/Operational	Business Continuity
Strategic/Operational	Capacity Planning
Strategic/Operational	Child Protection
Strategic/Operational	Clinical Governance
Strategic/Operational	Confidentiality
Strategic/Operational	Emergency Planning
Strategic/Operational	Equipment Failure
Strategic/Operational	Equality & Diversity
Strategic/Operational	Financial
Strategic/Operational	Freedom of Information
Strategic/Operational	Information Governance
Strategic/Operational	Legislation
Strategic/Operational	Major Change
Strategic/Operational	National/Statutory Requirements
Strategic/Operational	Corporate Objectives
Strategic/Operational	Operational Guidelines/Policies/Procedures
Strategic/Operational	Patient Experience
Strategic/Operational	Redesign
Strategic/Operational	Risk Management
Strategic/Operational	Service Delivery
Strategic/Operational	Sustainability
Strategic/Operational	Waiting Times

Audit & Risk Committee Terms of Reference

AUDIT AND RISK COMMITTEE

CONSTITUTION AND TERMS OF REFERENCE

CHAIRPERSON, AUDIT COMMITTEE

Date of Board Approval: 25 February 2014

AUDIT AND RISK COMMITTEE

CONSTITUTION AND TERMS OF REFERENCE

1. PURPOSE

1.1 To provide the Board with the assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee shall be in accordance with the Scottish Government Audit Handbook, dated July 2008.

2. COMPOSITION

2.1 The membership of the Audit and Risk Committee will be:

- Three Non-Executive Members of Fife NHS Board.

2.2 The Chairperson of Fife NHS Board cannot be a member of the Committee.

2.3 In order to avoid any potential conflict of interest, the Chairperson of the Audit and Risk Committee shall not be the Chairperson of any other statutory governance Committee of the Board. Members of the Audit and Risk Committee who are the Chairpersons of other statutory governance Committees should declare this for the minute prior to consideration of any issues relating to these Committees.

2.4 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chairperson will agree with the Lead Officer to the Committee which Directors and other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance
- Chief Internal Auditor or representative
- Executive Lead for Risk Management
- Statutory External Auditor

2.5 The Director of Finance shall serve as the Lead Officer to the Committee.

2.6 The Board shall ensure that the Committee's membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee's responsibilities for financial reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

3. MEETINGS

3.1 The Committee shall meet as necessary to fulfil its remit but not less than four times a year.

3.2 Fife NHS Board shall appoint a Chairperson who shall preside at meetings of the Committee. If the Chairperson is absent from any meeting of the Committee, one of the other Committee Members shall chair the meeting.

3.3 The agenda and supporting papers will be sent out at least five working days before the meeting.

3.4 If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and, if relevant, the External Auditor and/or Chief Internal Auditor.

3.5 If required, the Chairperson of the Audit and Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor and the Accountable Officer.

4. REMIT

4.1 The main objective of the Audit and Risk Committee (the Committee) is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs. This includes:

- Helping the Accountable Officer and Fife NHS Board formulate their assurance needs with regard to risk management, governance and internal control;
- Reviewing and challenging constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board;
- Reviewing the reliability and integrity of those assurances, i.e. considering whether they are founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence;
- Drawing attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed;
- Commissioning future assurance work for areas that are not being subjected to significant review
- Seeking assurance that previously identified areas of weakness are being remedied.

The Committee has no executive authority, and is not charged with making or endorsing any decisions. The only exception to this principle is the approval of the Board's accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who in turn, makes the decision.

4.2 The Committee will keep under review and report to Fife NHS Board on the following:

Internal Control and Corporate Governance

4.3 To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:

- control environment;
- risk management;
- information and communication;
- control procedures;
- monitoring and corrective action.

4.4 To review the system of internal financial control, which includes:

- the safeguarding of assets against unauthorised use and disposition;
- the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.

4.5 To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.

4.6 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

4.7 To review the disclosures included in the Governance Statement on behalf of the Board. In considering the disclosures, the Committee will review as necessary and seek confirmation on the information provided to the Chief Executive in support of the Governance Statement including the following:-

- Annual Statements of Assurance from the main Standing Committees of Governance and the conclusions of the other statutory Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation;
- Details from the Chief Executive on the operation of the framework in place to ensure that he discharges his responsibilities as Accountable Officer as set out in the Accountable Officer Memorandum;
- Confirmation from Executive Directors that there are no known control issues nor breaches of SOs/SFIs other than any disclosed within the Governance Statement;
- Summaries of any relevant significant reports by Health Improvement Scotland (HIS) or other external review bodies.

4.8 To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

Internal Audit

4.9 To review and approve the Internal Audit Strategic and Annual Plans having assessed the appropriateness to give reasonable assurance on the whole of risk control and governance.

4.10 To monitor audit progress and review audit reports.

4.11 To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.

4.12 To consider the Chief Internal Auditor's annual report and assurance statement.

4.13 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

4.14 To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and that the opportunity is given for discussions with the Chief Internal Auditor at least once per year (scheduled within the timetable of business) and, as required, without the presence of the Executive Directors.

4.15 To review the terms of reference and appointment of the Internal Auditors and to examine any reason for the resignation of the Auditors or early termination of contract/service level agreement.

External Audit

4.16 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for Patients' Funds and Endowment Funds.

4.17 To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.

4.18 To consider all statutory audit material, in particular:-

- Audit Reports;
- Annual Reports; and
- Management Letters

relating to the certification of Fife NHS Boards Annual Accounts, Annual Patients' Funds Accounts and Annual Endowment Funds Account.

4.19 To monitor management action taken in response to all External Audit recommendations, including Best Value and Performance Audit Reports.

4.20 To hold meetings with the Statutory Auditor at least once per year and as required, without the presence of the Executive Directors.

4.21 To review the extent of co-operation between External and Internal Audit.

4.22 To appraise annually the performance of the Statutory and External Auditors and to examine any reason for the resignation or dismissal of the External Auditors.

Risk Management

4.23 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. However the Committee shall seek assurance that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risks at all levels of the organisation.
- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management
- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive's approach to risk management is consistent with that appetite.

4.24 In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- At each meeting, receive and review a report summarising any significant changes to the Boards corporate risk register, and what plans are in place to manage them. The Committee may also elect to occasionally request information on significant risks held on any risk registers held in the organisation.
- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board.
- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required.
- Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system requires to be updated.
- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk.
- Whilst the Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions, the Board's Clinical Governance Committee shall provide particular oversight to clinical risks and all matters relating to the Board's legal duty to monitor and improve the systems of health care which it provides (Reference S12H of National Health Service (Scotland) Act 1978),
- The Clinical Governance Committee shall also provide oversight to the Board's responsibilities for Information Governance, through the Information Governance Group.
- The Staff Governance Committee shall have particular oversight of risks relating to the Board's legal duty in relation to the governance of staff (Reference S121 of National Health Service (Scotland) Act 1978).

Standing Orders and Standing Financial Instructions

4.25 To review annually the Standing Orders (including Schemes of Reservation and Delegation) and Standing Financial Instructions of Fife NHS Board and advise the Board of any amendments required.

4.26 To examine the circumstances associated with each occasion when Standing Orders of Fife NHS Board have been waived or suspended.

Annual Accounts

4.27 To review and recommend approval of draft Fife NHS Board Annual Accounts to the Board.

4.28 To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts.

4.29 To review annually (and approve any changes in) the accounting policies of Fife NHS Board.

4.30 To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval.

Other Matters

4.31 The Committee has a duty to review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

4.32 The Committee shall review regularly the sections of the NHS Fife Balanced Scorecard relevant to the Committee's responsibility.

4.33 The Committee has a duty to keep up-to-date by having mechanisms to ensure topical legal and regulatory requirements are brought to Members' attention.

4.34 The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

4.35 The Committee shall review regular reports on Fraud and potential Frauds.

4.36 The Committee should report to the full Board by submission of a copy of the unconfirmed minutes. The Chairperson of the Committee shall also submit an Annual Report of the work of the Committee to the Board following consideration by the Audit and Risk Committee in June.

4.37 The Chairperson of the Committee should be available at Fife NHS Board meetings to answer questions about its work.

4.38 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year.

4.39 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

4.40 The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002.

4.41 The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000_, the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

5. AUTHORITY

5.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in doing so, is authorised to seek any information it requires from any employee or external experts.

5.2 In order to fulfil its remit, the Audit and Risk Committee may obtain whatever professional advice it requires, and may require Directors or other officers of the Board to attend meetings.

5.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5.4 The Committee's authority is included in the Board's Scheme of Delegation and Standing Financial Instructions, and is set out in the Purpose and Remit of the Committee.

6. REPORTING ARRANGEMENTS

6.1 The Audit and Risk Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

6.2 The Audit and Risk Committee will advise the Scottish Government Health and Well Being Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

Reporting Framework to Audit & Risk Committee

REPORT TO THE AUDIT & RISK COMMITTEE ON
THE NHS FIFE CORPORATE RISK REGISTER
DD/MM/YY

1. Purpose of the Report

1.1 The purpose of this report is to provide assurance on the management of risks at a corporate level.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2. Recommendations

The Audit & Risk Committee is recommended to:

2.1 Agree the current updated NHS Fife Corporate Risk Register, highlights of which are contained in section 3.2 and summarised in Appendix 1.

2.2 Note …..

3. Discussion of Key Issues

3.1 This report sets out the position since the last report to the Audit & Risk Committee on ddmmyy

3.2 The SMT has agreed principles for submitting risks on the Corporate Risk Register which are set out below:-

3.2.1 Risks that the Strategic Management Team (SMT) cannot manage

3.2.2 Risks are defined in such a manner that it is clear to the Board what the contributing factors are, and what items require a decision of the Board

3.2.3 Detail of what determines whether or not something is on the Corporate Risk Register. It is likely that this will include items with a higher risk rating.

3.2.4 A review of the current risks on the Corporate Risk Register reported to the Board on dd/mm/yy was undertaken by the SMT against the above principles and following this, xx were confirmed as strategic risks:-

3.2.4.1 xx risks were removed from the Corporate Risk Register through this review and the rationale is set out below, leaving a total at ddmmyy of xx corporate risks.

3.2.5 Additional Changes - Risks on the Corporate Risk Register are updated regularly in line with the stated timescales for review. The SMT considers the Register on a

monthly basis. In addition to changes highlighted above, the following changes have also taken place:-

3.3 Table 1 below provides a summary of the corporate risks and movement in risk level over the last 4 quarters. Appendix 1 provides additional details of each individual risk, updates and the changes set out above.

3.4 This table illustrates the nature of movement in risk level over the last year.

Table 1 - Risk Level up to Quarter x

Datix ID	Risk Title	Initial Risk Level	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014

3.5 Risk Appetite

It is proposed his section will refer to the Board's intentions on risk appetite. This has yet to be agreed.

Risk Appetite Statement e.g.

"NHS Fife operates within a low overall risk appetite range. The Board's lowest risk appetite relates to patient and staff safety, experience and delivery of effective care. The Board tolerates a marginally higher risk appetite towards delivery of corporate objectives including clinical strategies, finance and health improvement."

This risk appetite statement seeks to reflect the Board's appetite and tolerance towards risk and the extent to which it is prepared to tolerate or accept risk in delivering its strategy and associated corporate objectives.

- This overarching appetite reflects the nature of the services NHS Fife provides
- The "Statement of Risk Appetite" aims to set a good overall "tone / sentiment" for how the Board views Risk, which overall is low for delivery of corporate objectives set within a scale of "None, Low, Medium, High".

Once the risk appetite statement is agreed, the next step will be to set targets which represent the Board's Risk Appetite and Tolerance.

4. Key Risks

4.1 The Risk Register process fails to identify, control or escalate risks that could have a significant impact on NHS Fife

5. Risk Register

5.1 Not applicable.

6. Impact on Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates does not have any direct impact on health inequalities, each of the component risk areas within the document contains elements of the processes established to deliver NHS Fife's corporate objectives in this area.

7. Resource Implications

7.1 The resource implications are directly related to the actions required against each risk.

8. Governance

8.1 Staff Governance

Where relevant, the Corporate Risk Register reflects risks relating to reflect NHS Fife's responsibilities under the Staff Governance Standard.

8.2 Clinical Governance

In addition to being considered by SMT, reports on Clinical Governance risks are reported as appropriate to the Clinical Governance Committees of NHS Fife.

8.3 Financial Governance

The Corporate Risk Register highlights any risks relating to finance.

8.4 Equality & Diversity

Any specific equality and diversity issues in relation to individual risks are covered in the associated management actions.

8.5 PFPI

The Corporate Risk Register reflects risks linked to the quality ambitions and the delivery of the local delivery plan and in managing these, takes cognisance of the need for patient and public involvement as appropriate.

9. Risk Management

9.1 The Board is responsible for risk management at a strategic level and is required to have robust systems in place to ensure that it can discharge this responsibility. The development and management of the Corporate, Divisional, CHP, and local risk registers, are essential components of our approach to managing risk.

10. Best Value

10.1 Best Value, pervades all aspects of the Board's operations and governance structures; within our overall Best Value Framework document, the aim is to identify the Committee that is responsible for providing lead governance assurance on the relevant characteristic of Best Value. Through its business and reporting arrangements, SMT addresses the characteristics of 'Sound Governance at a

Strategic and Operational Level' through elements of performance as evidenced by Board and Committee consideration of the Balanced Scorecard and 'Contribution to Sustainable Development' through the elements of Objectives and Plans as evidenced by the Balanced Scorecard.

Signatories

Appendices

This will include a summary of the Corporate Risk Register.

NHS Fife Corporate Risk Register

APPENDIX 1

Risk Appetite & Tolerance

To be agreed

Tools to Assess Ourselves Against

RISK AND CONTROL EVALUATIONS (RACEs) 1

VERSION: 2

RISK

The organisation may not be managing risks appropriately because it does not have a comprehensive risk management framework in place comprising appropriate strategy, structures, policies and procedures

TEST DETAILS *(Testing section of guidance)*

TEST 1.1	Check that a Risk Management Strategy has been produced and approved by the Board following endorsement by the appropriate Standing Committee(s) including the Audit Committee. The Strategy should include:	**Select Yes/No from the Drop Down List**	**Comments**
	• Linkage to the Board's vision		
	• Reference to the Board's corporate objectives		
	• The organisation's risk priorities		
	• Philosophy & risk culture		
	• Objectives of the Risk Management Strategy (including links to relevant legislation and guidance)		
	• Description of how risk management contributes to achieving outcomes		
	• Governance & reporting		
	• Monitoring, Audit and review		
	• Roles and Responsibilities for all Staff		
	• Risk Management Methodology (risk identification assessment and resolution)		
	• Risk Appetite and Risk Tolerance		.

• Arrangements for working with Partner Organisations and management of joint risks		
• Key dependencies and resources required		
• Training and Development		
• Risk Management Structure		
• Risk Escalation Process		
• Business and Continuity Planning		
• Communication of the Strategy		
• KPIs		
• Review date and version control		

TEST 1.2	Determine if responsibility for risk management has been delegated in line with the Risk Management Strategy. Review:	**Select Yes/No from the Drop Down List**	**Comments**
	• Scheme of Delegation		
	• Risk management responsibilities delegated to Standing and other Committees evidenced by remits, workplans and annual reports to check content and frequency of reporting		
	• Chief Executive and Executive Team objectives to ensure risk management is included		
	• Senior Officer responsible for 'Championing' risk		
	• Governance statement for positive conclusion on risk management arrangements		

TEST 1.3	Review adequacy of the Board's risk management arrangements including assessing if:	**Select Yes/No from the Drop Down List**	**Comments**
	• The Board has a strategic overview of risks e.g. a corporate risk profile which is reviewed and reported on a regular basis.		

• The Board has considered how frequently it considers risk and has an agreed timetable for this		
• There is a process to ensure that Committees are aware of and ensure that corporate and significant operational risks associated with their remit are managed appropriately		
• The Board considers risk factors for all key decisions (include review of papers to Board which are for decision making to ensure a risk assessment section is included and has been appropriately populated)		
• The Board considers risk regularly as part of its normal flow of management information about the organisation's activities and links performance management information to risks to the achievement of objectives		
• The Board has a top down approach to risk management which ensures corporate risks and risk appetite is considered at departmental / service level		
• The escalation process ensures key operational risks are considered by the Board /Committees where appropriate		
• Having weighed the identified risks, the Board seeks to distinguish unidentified risks through, for example, horizon scanning to identify emerging trends, problems or opportunities that might change the organisation's working environment.		.
The Board has considered the use of assurance mapping and/or Board assurance framework approaches, particularly for key risks		

TEST 1.4	Check that appropriate assurance on risk is provided to Board including reporting on:	**Select Yes/No from the Drop Down List**	**Comments**
	• Compliance with the Risk Management Strategy for all risks		
	• Adequacy of management of key risks / controls		

	• Effectiveness of controls i.e. the extent to which they are actually being applied		
	• Assurance on adequacy of the above		

		Select Yes/No from the Drop Down List	Comments
TEST 1.5	Risk management responsibilities have been allocated to an appropriate management committee which co-ordinates risk management activity, ensures consistency of application of the Board's Risk Appetite, escalates risks as appropriate and considers the Risk Management Annual Report prior to presentation to the AC		

		Select Yes/No from the Drop Down List	Comments
TEST 1.6	Arrangements are in place to ensure the availability of appropriate competent advice on risks and controls, through an officer with appropriate experience and qualifications		

		Select Yes/No from the Drop Down List	Comments
TEST 1.7	Check if the organisation has appropriate risk management policies and procedures in place and confirm that these are reviewed and updated in line with the organisation's policy approval route in general these will often have been reviewed separately e.g. Resilience, H&S, or though a review of policies and procedures).		

		Select Yes/No from the Drop Down List	Comments
TEST 1.8	Determine whether appropriate governance and reporting arrangements are in place for risk management including obtaining and reviewing:		
	• the organisation chart documenting the reporting arrangements at both operational and strategic level		
	• the annual risk management work plan which should be approved and monitored by a Standing Committee of the Board.		

		Select Yes/No from the Drop Down List	Comments
TEST 1.9	There is a Risk Management Annual Report presented to the Audit Committee which includes positive assurance on the adequacy and effectiveness of Risk management Arrangements and compliance with the Risk Management Strategy, with supporting evidence including performance against KPIs		

RISK AND CONTROL EVALUATION (RACE) 2

RISK

All relevant strategic and operational risks may not be accurately identified, assessed, evaluated, recorded and monitored (PIAS 2020)

TEST DETAILS *(Testing section of guidance)*

Identification

TEST 2.1	Check if Risk Management guidance is available to all relevant staff and includes:	**Select Yes/No from the Drop Down List**	**Comments**
	• definition and explanation of risk management		
	• methodologies for identifying risks e.g. horizon scanning		
	• reference to the organisation's risk register including how to access the risk register		
	• a description of the risk identification, assessment, recording and monitoring process. This includes action plans to mitigate risk to the appropriate tolerance).		
	• How to apply the organisation risk appetite to individual risk tolerance		
	• process for risk escalation		
	• management of joint risks		

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.2	From discussion with a sample of relevant staff, determine whether the risk management guidance note has been appropriately communicated and staff are aware of their responsibilities.		

		Select Yes/No from the Drop Down List	Comments
TEST 2.3	For a sample of risks check that guidance has been appropriately applied.		

TEST 2.4	Determine whether the organisation has in place an appropriate process to identify all risks including:	Select Yes/No from the Drop Down List	Comments
	Board level		
	• Board development events		
	• Horizon Scanning		
	• Review of corporate objectives and risks to achievement of these objectives		
	Management identification of risks associated with operating activities		Identification at Operational, Divisional,CHP,Specialty and Strategic Groups & Committees
	• Complaints & Claims		
	• Losses and Compensation Register		
	• Incident reporting & associated investigation		
	• Internal Audit Reports		
	• External Audit Reports		
	• Internal reviews such as Fire Safety, H&S, Clinical Audit		
	• External reviews such as HSE, HIS, MWC, Care Commission		
	• Other legal or regulatory reviews		

	Select Yes/No from the Drop Down List	Comments

TEST 2.5	Check that where appropriate, departmental risks have been aggregated i.e. where a departmental / site risk has been identified consideration has been given to whether the risk should be applied to the organisation as a whole and recorded in the risk register as such.		

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.6	Confirm that the Clinical Governance Strategy overtly describes the risk management process for Clinical Risks and how they will be comprehensively identified, recorded, managed and monitored.		

Evaluation

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.7	Check that there is a documented scoring mechanism for evaluation of risks across the organisation. Check that the mechanism is:		
	• Based on recognised good practice e.g. Australia / New Zealand 4360 and reflects organisational realities.		
	• includes assessment of inherent and residual risk		
	• Communicated through a risk management guidance note which is available to all staff		
	• Reviewed on a regular basis by an appropriate group or committee		
	• Communicated to Board		

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.8	Review a sample of risks from the organisation's risk register and check that:		
	• the narrative description of the risks adequately describes the risk		

• the scoring method used was in compliance with the approved scoring mechanism		
• the scores allocated were based on judgement that appears appropriate and consistent with available evidence e.g. incidents, performance management data		
• Risk tolerance is in line with the organisation wide agreed risk appetite		
• Scores and tolerances have been applied consistently		
• Risks have been reviewed in line with procedures and at a frequency appropriate to the scoring of the risk and at least annually		
• the identified risk owners and managers are appropriate and their responsibilities for risk are included in their objectives		
• responses to risk are SMART, effective but not excessive in managing risks within the risk appetite.		

Recording

TEST 2.9	There are data quality checks of the risk register which include:	Select Yes/No from the Drop Down List	Comments
	• Completeness of all fields		.
	• Adequacy of information		
	• Risks updated in line appropriately and in line with policy		
	• Scoring appears reasonable		

TEST 2.10	Review the risk register to ensure that:	Select Yes/No from the Drop Down List	Comments
	• All corporate risks are recorded		
	• it includes details of the movement in the scoring of risks from one period to the next		

TEST 2.11	Review the risk management reports produced and check if reporting is appropriate to the audience at each level of the organisation and includes:	**Select Yes/No from the Drop Down List**	**Comments**
	• New risks (by category)		
	• Movement in risks (up or down)		
	• Changes in corporate risk appetite		
	• Breached risks i.e. not updated		
	• Identify any gaps in reporting		

TEST 2.12	Document and assess arrangements for risk reporting across the organisation and check that there is regular reporting to Board / Standing committee including:	**Select Yes/No from the Drop Down List**	**Comments**
	• Process in place for immediately reporting and serious emerging risk to the Board / Senior Management		
	• Corporate risk register, link to assurances and movement of risks		
	• Action plans detailing outstanding actions		
	• Audit reports on the effectiveness of risk management		
	• HIS reports on the effectiveness of risk management		
	• Annual and mid term reports on the effectiveness of risk management		

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.13	Check a sample of responses to risks to confirm that the responses are operating as expected and achieving their objectives in relation to managing the risk(s) they were designed to address.		

		Select Yes/No from the Drop Down List	Comments
TEST 2.14	For a sample of departments ensure that where it is not considered appropriate or necessary to record risks on the organisation risk register, risks are recorded and managed at a local level i.e. record on a local risk register and appropriately reviewed and monitored.		

Monitoring

		Select Yes/No from the Drop Down List	Comments
TEST 2.15	Determine whether the organisation has established a corporate risk register which is regularly reviewed and updated by senior management and presented to Board		

		Select Yes/No from the Drop Down List	Comments
TEST 2.16	Role of risk management group		

		Select Yes/No from the Drop Down List	Comments
TEST 2.17	Review Board and committee minutes to confirm that:		
	• risk management is included as an agenda item and is discussed		
	• corporate risks are assigned to an appropriate Standing Committee and reviewed in line with protocol		
	• Papers to Board / committee include appropriate and meaningful risk assessments		

TEST 2.18	Check that methods to monitor the proper operations of key processes, responses and action plans are in place and managers regularly provide assurance on the effectiveness of their risk management. Assurance can be provided through:	**Select Yes/No from the Drop Down List**	**Comments**
	• corporate risk reporting to Board		
	• strategic and operational risk management meetings		

		Select Yes/No from the Drop Down List	**Comments**
TEST 2.19	From discussion with a sample of risk managers, determine how risks are monitored at departmental / operational level and assess adequacy.		

RISK AND CONTROL EVALUATION (RACE) 3

RISK

Appropriate risk responses may not be appropriate and aligned with the organisation's risk appetite (PIAS 2020)

TEST DETAILS *(Testing section of guidance)*

		Select Yes/No from the Drop Down List	Comments
TEST 3.1	Determine if the organisation's objectives support and align with the organisation's mission statement.		

		Select Yes/No from the Drop Down List	Comments
TEST 3.2	Review the corporate risk profile and ensure it maps to the Boards vision, LDP / corporate objectives i.e. risk have been considered for all key objectives		

		Select Yes/No from the Drop Down List	Comments
TEST 3.3	Check if the organisation has formally discussed and agreed its risk appetite. Evidence should include:		
	• Board agreement and formal approval of an overall risk appetite including risk levels for key elements of financial / VFM, Compliance / regulatory, Innovation / Quality / Outcomes, Reputation.		

		Select Yes/No from the Drop Down List	Comments

TEST 3.4	Check if the risk appetite of the Board has been communicated to staff		

		Select Yes/No from the Drop Down List	**Comments**
TEST 3.5	Determine what has already been done to improve the risk maturity of the organisation such as training, risk workshops, questionnaires about risks and interviews with risk managers.		

		Select Yes/No from the Drop Down List	**Comments**
TEST 3.6	Determine whether managers feel that the risk register is comprehensive. Discuss whether an understanding of risk management is embedded so that managers feel responsible not only for identifying, assessing and mitigating risks but also for monitoring the framework and the responses to risks.		

		Select Yes/No from the Drop Down List	**Comments**
TEST 3.7	Check a sample of responses to risk scoring to confirm that they align risks to and are consistent with the risk appetite expressed by the Board.		

		Select Yes/No from the Drop Down List	**Comments**

TEST 3.8	Check that where risks are above the risk appetite, or here risk mitigation actions are not sufficient to manage the risk in line with the risk appetite of the organisation, appropriate escalation and remedial action is undertaken		

TEST 3.09	Conclude on the overall risk maturity of the organisation based on all information available. Ensure that overall, evidence of the following has been obtained:	**Select Yes/No from the Drop Down List**	**Comments**
	• The objectives of the organisation		
	• How risks are analysed, for example by scoring their impact and likelihood.		
	• A definition, approved by the board, which defines its risk appetite in terms of the scoring system used for risks.		
	• The processes followed to identify risks which threaten the organisation's objectives.		
	• How management considers risks as part of their decision making. For example, including risks and the response to them, in project approval documents.		
	• The processes followed to report risks at different levels of management.		
	• The sources of information used by management and the Board to assure themselves that the framework is working effectively to manage risks within the risk appetite.		
	• The risk register of the organisation, including the types of information described in the previous section.		
	• Any existing assessment by management or the board of the risk maturity of the organisation.		
	• Any other documents which indicate the commitment to risk management.		

RISK AND CONTROL EVALUATION (RACE) 4

Risk

Relevant risk information may not be captured and communicated in a timely manner across the organisation, enabling staff, management and the board to carry out their responsibilities (PIAS 2020).

TEST DETAILS *(Testing section of guidance)*

		Select Yes/No from the Drop Down List	Comments
TEST 4.1	Review the reports and other data produced from the risk register and determine whether risk information is communicated across the organisation in an appropriate and timely manner e.g. reports on breached risks, red risks, escalated risks, reporting relevant to committee / audience.		

		Select Yes/No from the Drop Down List	Comments
TEST 4.2	Check how risk owners are made aware of their responsibilities for recording and managing risks and from discussion with risk owners determine if this process is working e.g. risk management guidance note, training.		

TEST 4.3	Check that a training programme for all relevant staff is in place for risk management and includes:	Select Yes/No from the Drop Down List	Comments
	• Risk Identification		
	• Recording of Risks		
	• Risk Assessment		
	• Risk Tolerance & appetite		
	• Risk Responses		
	• Risk Response Monitoring		

TEST 4.4	Obtain details of number of staff trained to date and check that:	Select Yes/No from the Drop Down List	Comments
	• risk management is included in Board development events		
	• all corporate risk owners and managers have received appropriate training		
	• For a sample of other risk owners, training has been provided		
	• risk management is included in induction training		

TEST 4.5	Check that there is adequate risk management support available including:	Select Yes/No from the Drop Down List	Comments
	• A Risk Management department / manager or Champion who can provide competent advice on risks and controls		
	• A support function available for risk register owners and managers e.g. web site, support team available to advise		
	Assessing if the risk register support arrangements are adequate and identify any potential improvements		

		Select Yes/No from the Drop Down List	Comments
TEST 4.6	Benchmark project / support resource across other clients using the same risk register system.		

		Select Yes/No from the Drop Down List	Comments
TEST 4.7	Determine whether 'business units' or departments:		
	• are aware of the organisation's risk priorities		
	• have a local risk register in place and carry out risk assessments in line with organisational guidance		
	• monitor projects and risk improvements and report up to appropriate committee which co-ordinates risk management activity		
	• have an embedded risk culture		

		Select Yes/No from the Drop Down List	Comments
TEST 4.8	From discussion with management and consideration of KPI outcomes determine whether the risk register system requires development to ensure it meets the needs to the organisation and determine the process for progressing developments.		

RISK AND CONTROL EVALUATION (RACE) 5

RISK

Risks with partner organisations may not be appropriately managed ('the extended enterprise').

TEST DETAILS *(Testing section of guidance)*

		Select Yes/No from the Drop Down List	Comments
TEST 5.1	Check that HSCI/partnership working has been considered as a corporate risk		

		Select Yes/No from the Drop Down List	Comments
TEST 5.2	Check that the Board has agreed with partner organisations an appropriate approach to management of joint risks.		

		Select Yes/No from the Drop Down List	Comments
TEST 5.3	Check there is a system in place to identify, evaluate, record and monitor joint risks.		

		Select Yes/No from the Drop Down List	Comments
TEST 5.4	Check that a joint risk register has been established which accurately records joint risks.		

		Select Yes/No from the Drop Down List	Comments
TEST 5.5	Check that joint risks are regularly and openly discussed with partner organisations.		

		Select Yes/No from the Drop Down List	Comments
Test 5.6	Obtain evidence that joint risks are appropriately reported and monitored at Board and operational level.		

ANNEX F: KEY LINES OF ENQUIRY FOR AN AUDIT COMMITTEE

This list of questions is not intended to be exhaustive or restrictive nor should it be treated as a tick list substituting for detailed consideration of the issues it raises. Rather it is intended to act as a 'prompt' to help an Audit Committee ensure that their work is comprehensive.

On the strategic processes for risk, control and governance, how do we know:

- that the risk management culture is appropriate?
- that there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable
- that the risk register is an appropriate reflection of the risks facing the organisation?
- that appropriate ownership of risk is in place?
- that management has an appropriate view of how effective internal control is?
- that risk management is carried out in a way that really benefits the organisation or is it treated as a box ticking exercise?
- that the organisation as a whole is aware of the importance of risk management and of the organisation's risk priorities?
- that the system of internal control will provide indicators of things going wrong?
- that the AO's annual 'Statement on Internal Control' is meaningful, and what evidence underpins it?
- that the SIC appropriately discloses action to deal with material problems?
- that the organisation is appropriately considering the results of the effectiveness review underpinning the SIC?

On risk management processes, how do we know:

- how senior management (and Ministers where appropriate) support and promote risk management?
- how well people are equipped and supported to manage risk well?
- that there is a clear risk strategy and policies?
- that there are effective arrangements for managing risks with partners?
- that the organisation's processes incorporate effective risk management?
- if risks are handled well?
- if risk management contributes to achieving outcomes?

On the planned activity and results of both internal and external audit, how do we know:

- that the Internal Audit strategy is appropriate for delivery of a positive reasonable assurance on the whole of risk, control and governance?
- that the periodic audit plan will achieve the objectives of the Internal Audit strategy, and in particular is it adequate to facilitate a positive, reasonable assurance?
- that Internal Audit has appropriate resources, including skills, to deliver its objectives?
- that Internal Audit recommendations that have been agreed by management are actually implemented?
- that any issues arising from line management not accepting Internal Audit recommendations are appropriately escalated for consideration?
- that the quality of Internal Audit work is adequate?
- that there is appropriate co-operation between the internal and external auditors?

On the accounting policies, the accounts, and the annual report of the organisation, how do we know:

- that the accounting policies in place comply with relevant requirements, particularly the

Financial Reporting Manual?

- there has been due process in preparing the accounts and annual report and is that process robust?
- that the accounts and annual report have been subjected to sufficient review by management and by the Board and Accountable Officer?
- that when new or novel accounting issues arise, appropriate advice on accounting treatment is gained?
- that there is an appropriate anti-fraud policy in place and losses are suitably recorded?
- that suitable processes are in place to ensure accurate financial records are kept?
- that suitable processes are in place to ensure fraud is guarded against and regularity and propriety is achieved?
- that financial control, including the structure of delegations, enables the organisation to achieve its objectives with good value for money?
- if there are any issues likely to lead to qualification of the accounts?

- if the accounts have been qualified, that appropriate action is being taken to deal with the reason for qualification?
- that issues raised by the External Auditors are given appropriate attention?

On the adequacy of management response to issues identified by audit activity, how do we know:

- that the implementation of recommendations is monitored and followed up?
- that there are suitable resolution procedures in place for cases when management reject audit recommendations which the auditors stand by as being important?

On assurances relating to the corporate governance requirements for the organisation, how do we know:

- that the range of assurances available is sufficient to facilitate the drafting of a meaningful Statement on Internal Control?
- that those producing assurances understand fully the scope of the assurance they are being asked to provide, and the purpose to which it will be put?
- what mechanisms are in place to ensure that assurances are reliable?
- that assurances are 'positively' stated (i.e. premised on sufficient relevant evidence to support them)?
- that the assurances draw appropriate attention to material weaknesses or losses which should be addressed?
- that the Statement on Internal Control realistically reflects the assurances on which it is premised?

On the work of the Audit Committee itself, how do we know:

- that we are being effective in achieving our terms of reference and adding value to corporate governance and control systems of the organisation?
- that we have the appropriate skills mix?
- that we have an appropriate level of understanding of the purpose and work of the organisation
- that we have sufficient time to give proper consideration to our business?
- that our individual members are avoiding any conflict of interest?
- what impact we are having on an organisation?

Extracted from the Audit Committee Handbook, Scottish Government, 2008