NHS

Prescription Pricing Authority

RISK MANAGEMENT POLICY AND STRATEGY

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Approved:

CHANGE RECORD

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2.	Following achievement of objectives for 2001, and updates after risk workshops		
3	Following update to include framework	L Simpson	07/11/03

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Issue No.	No. Copies	Issued To	Position *(Role/Responsibility)*	Issued by
1.1	8	All	Management Board	L Simpson
			Audit Committee	
			Authority	
			Risk Management Team	

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RISK MANAGEMENT POLICY AND STRATEGY DOCUMENT

1. INTRODUCTION

THE NEED FOR RISK MANAGEMENT

1.1 The PPA has clearly defined business objectives within its five year strategy, three year business plan and Directorate business plans, each containing key performance targets. A "risk" can be viewed as the chance of an adverse outcome from any decision or action, including the action of doing nothing, which compromises our ability to achieve business or performance targets. Good risk management, at all levels, is therefore critical to success in achieving our goals.

The Authority acknowledges that risk taking can bring both rewards and penalties. We understand the consequences of taking those risks, and by using quality management tools and other controls in a controlled environment we are able to take risks with an improved level of confidence in our success.

1.2 PPA managers and staff manage risk every day. Sometimes this is done consciously and systematically but, at other times, it is ad hoc or without realising it. Implementation of risk management has therefore not added new layers of activity and bureaucracy to existing systems, nor has it become another initiative competing for scarce managerial resource. Instead, risk management is about fostering a culture in which:

- Risks to the achievement of business objectives are understood at all levels;
- A consistent and systematic approach to mitigating risks is followed throughout the PPA; and
- Risk management actions are focused and co-ordinated to avoid duplication of effort and inefficiency.

1.3 We already have a wide range of systems which manage risk: for example, ISO9000 quality management systems, health and safety policies and security systems. The risk management process does not replace these systems or add to them where they already provide assurance that risks to the achievement of objectives are under control. Instead, it regularly reviews whether these systems continue to adequately and efficiently manage risk and it uses outputs from these systems to assess the effectiveness of risk management in practice. Under existing systems, risk management could take the form of following laid down procedures without understanding or ownership of the risks under control. Risk management provides the focus to maintain the effectiveness and efficiency of controls.

The key elements of a successful risk management process are:

- Awareness and ownership of risk by those in a position to manage them (which could be Directors, managers or team leaders); and
- Regular self-assessment of the management of risk at all levels.

This standard of risk management cannot be achieved overnight, or maintained without effort. It will require commitment from the Authority and Management Board and the training and involvement of staff at all levels.

NHS CONTROLS ASSURANCE

1.4 Risk management is one of the core standards, and underpins the controls assurance process. Controls assurance is "the system of management which is fundamental to governance in the NHS. It exists to inform NHS Boards about significant risks within the organisation for which they are responsible. It is intended to assist Chief Executives and Board Members to identify risks, to help them determine unacceptable levels of risk and then to decide on where best to direct limited resources to eliminate or reduce those risks (NHS Guidelines issued November 1999). The NHS has stressed that the effective involvement of people and functions throughout the organisation, through the application of self-assessment techniques, is fundamental.

1.5 The Authority has implemented a risk management system that enables Internal Audit to verify that the Authority is doing its reasonable best to manage its risks. With Internal Audit verification the Chief Executive is then able to publish the Statement of Internal Control, in the Annual Accounts and Annual Report.

1.6 The NHS guidelines stipulate that failure to comply with legislation and good practice in internal control should be seen as a risk. Accordingly they have issued twenty one standards against which NHS bodies are required to assess themselves. Baseline assessments against these standards have been made and updates are reported annually to the Controls Assurance Support Unit (CASU). In addition the Authority is able to benchmark its performance against other Special Health Authorities.

1.7 The standards are primarily designed for trusts. As such they do not deal with the most significant risks to the PPA's operations; they follow an order of priorities which does not reflect the relative significance of systems (for example IT systems) to our business; and some of the specific requirements are not relevant. In addition, the risks underpinning the control criteria examined by the standards are not articulated, making it difficult to place the assessment against the standards within the context of the risk management process.

1.8 The Authority recognises the importance of the control criteria included in the standards in the management of risks pertinent to the PPA's business. In implementing risk management within the PPA, the following approach has been adopted in respect of the organisational controls standards issued by the NHS Executive:

- risks underpinning the standards will be identified and assessed for their relevance to the business;
- where relevant, the risks will be incorporated within the PPA's risk register and the risk management process will take account of the self-assessment work already carried out;
- the risks will be prioritised alongside, and according to the same criteria, as risks identified internally (see Section 4 below);

- actions identified through the self-assessment process will continue to be monitored by the Risk Management Team (which is referred to in more detail in section 3.12). The relative emphasis placed on these actions may be influenced by the prioritisation exercise referred to above.

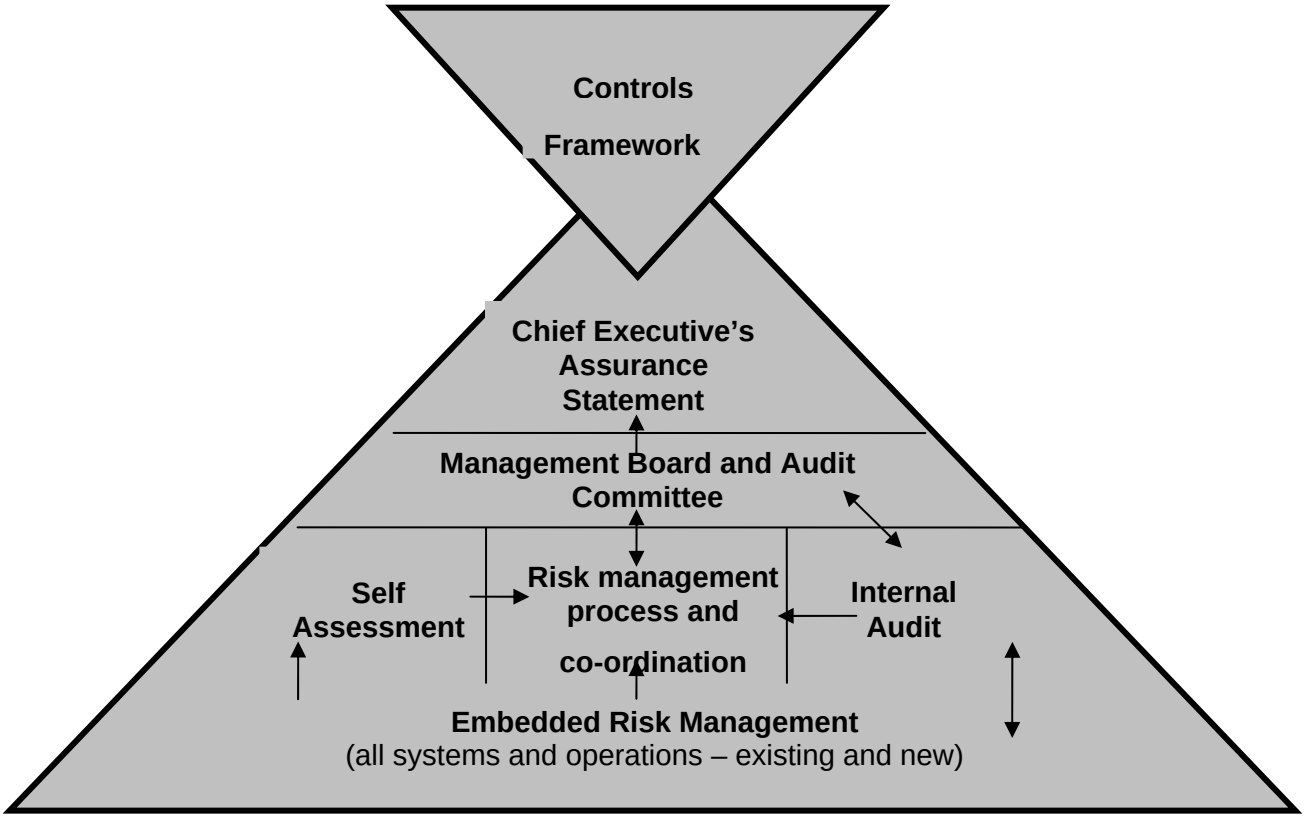
The above approach will ensure that the risk management process is focused on significant risks in line with the NHS guidelines and, moreover, scarce resources are directed to the most important risks to the achievement of business objectives.

The Risk Management Team will ensure that sufficient work is carried out in respect of those areas affected by the standards to meeting NHS reporting requirements.

The NHS has licensed the Australian/New Zealand risk management standard which provides a generic guide to establishing and implementing a systematic risk management process and programme in any organisation. It is capable of being customised to suit local circumstances.

LINKAGES BETWEEN EXISTING SYSTEMS, RISK MANAGEMENT AND CONTROLS ASSURANCE

The diagram below is a visual representation of how existing systems, the risk management process, Internal Audit activity and NHS controls assurance will fit together within the PPA.



A risk management culture, embedded in the organisation will inform the self-assessment process which identifies risks and initiates mitigating action against them.

The risk register, together with the status of actions being taken to mitigate risk will be maintained by the Risk Management Team who will provide reports to the Management Board and Audit Committee on the status of significant risks, the risk management process and significant control issues. The role of the Management Board and Audit Committee will be to refine and update the risk register, particularly in respect of strategic risks, and to review reports received, overseeing the effectiveness of the risk management process. The up-to-date risk register and reports received during the year will provide the evidence to support the Chief Executive's statement in the Authority's Annual Report.

Internal Audit will support the risk management process, providing assistance with understanding and assessment of risk to line managers and the Management Board and:

- carry out independent reviews to ensure the adequacy of self-assessment;
- provide an independent view as to the completeness of the risk register;
- follow up implementation of agreed risk management actions;
- provide assurance to the Chief Executive for the Statement of Internal Control;
- advise on the disclosure of significant control issues

The results of internal audit work would be reported to the risk management/controls assurance team as well as to the Audit Committee.

2. POLICY STATEMENT

2.1 The Authority acknowledges its commitment to the proactive management of risks to the achievement of business objectives at all levels of the organisation. This commitment will be reinforced through the dissemination of the Risk Management Policy and Strategy Document throughout the PPA.

2.2 The Australian/NZ standard is endorsed as the framework for managing risk, identifying opportunities and mitigation against effects which might have a detrimental effect on service to stakeholders. Implementation of the standard will focus on identification and prioritisation of the key business risks for the PPA.

2.3 A risk management process will be applied throughout the organisation which ensures that:

- risks to the achievement of business objectives are identified;
- risks are categorised across a range of factors, to provide a common description of risk type and risk group (see appendix 3)
- risks are prioritised according to the likelihood of them materialising and the severity of their impact on the achievement of business objectives and key performance targets (see appendix 4);
- actions are designed and implemented to mitigate identified risks;
- mitigating actions will be determined with reference to the significance of the risk and appropriate cost benefit analysis;

- significant control issues are disclosed, root causes are identified and controls to prevent future control issues are implemented.

2.4 The success of the risk management process will depend upon the establishment of appropriate levels of risk awareness and an appropriate focus on risk management at all levels of the business. The Authority will support the development of risk awareness and the risk management process with relevant communications and training.

2.5 The Management Board and Audit Committee undertake to regularly receive, review and endorse, as the basis for improvement (where applicable), reports on the performance of the risk management system, risk action plans and implementation of prioritised action plans. It will be the Audit Committee's responsibility to monitor the implementation of action plans based on information supplied by the Risk Management Team and Internal Audit.

2.6 We acknowledge that interests of stakeholders differ and sometimes compete. We recognise all our stakeholders' legitimate interests and will aim to ensure that our decision and actions are justifiable to all those affected by them.

2.7 The performance of the risk management process will be kept under review to ensure that it is working effectively and in a manner that adds value to the Authority's business.

2.8 The Chief Executive has appointed the Director of Finance and Administrative Services (DFAS) as the Director responsible for implementing Controls Assurance throughout the Authority. The DFAS will identify resource requirements and provide adequate resources, including the assignment of trained personnel for facilitation, co-ordination, training, assessment and verification activities including internal review.

2.9 This policy will be subject to periodic review (at least annually). Reviews may also occur when changes in the business, systems, guidance or legislation arise.

RISK MANAGEMENT DEFINITIONS

2.10 **Definition of risk** – the chance of an adverse outcome from any decision or action which will have a departmental or operational impact, leading to a failure to achieve business objectives, failure to meet targets or causation of some form of loss. Risks might be financial or organisational.

2.11 **Areas of risk** – areas of risk will include commercial and legal relationships; economic circumstances; human behaviour; natural events; political circumstances, technology and technical issues; management activities and controls and individual activities. Areas where risk can impact include: the Authority's asset and resource base, revenue and entitlement, costs, people, business performance, timing and scheduling of activities, the environment and organisational behaviour. Within its framework the Authority has chosen to categorise risks into generic areas of external, process and decision making information. A risk classification table is included as Appendix 4.

2.12 **Acceptable risk** – a management decision taking account of assessment of the likelihood and impact of risks and actions implemented to treat the risk which reduce the impact on stakeholders of failure to achieve objectives, loss or injury.

2.13 **Organisational risks** – risks which may lead to failure to deliver any part of the PPA strategy and annual corporate business plan.

2.14 **Departmental risks** – risks which may lead to the failure to deliver directorate targets as set out in the overall directorate level business plans. These risks include:

- Financial risk — risk arising from spending on capital projects or fraud or impropriety;
- Project risk — risk of equipment, construction projects or any other project exceeding budgets or running late;
- Reputation Risk — risk from damage to the Authority's credibility and reputation;
- Compliance Risk — the risk of failing to meet government standards/laws and regulations;
- Strategic Risk — risk arising from policy decisions;
- Operational Risk — risks associated with service delivery;
- Innovation Risk — risk of not learning from pilots;

  the risk of missing opportunities to improve on the delivery of Authority objectives;

  risks arising from new ways of working.

2.15 **Operational risks** – risks of a day-to-day nature which if not treated could lead to some form of loss or injury.

3. STRUCTURE FOR MANAGING RISK

IMPLEMENTATION

3.1 The PPA has produced risk registers at the strategic and operational objective level. This process has been developed to further consider the operational tasks at building or function level. The risk registers, which comprise risks identified and assessed at the Management Board level are updated and reviewed as a regular feature of the Authority and Management Board business process.

3.2 Risks underpinning the NHS controls assurance standards are identified and included at this stage but it will be essential that the register identifies the most significant risks to the Authority's business and therefore covers risks inherent in operations not covered by the standards.

3.3 As part of the update of the register at Management Board level a framework has been developed (see Appendix 2). This provides the ability to map and integrate directorate risk registers against the overall risk register. To enable the Management Board to concentrate on key high level risks, the framework allows the removal of the more detailed or component risks to a lower departmental level.

The framework links risk with performance management as follows:

- **Operational** planning level, involving operational management teams who take a 0-1 year view.

- **Management** planning level, involving the directorate management teams who take 0-3 year view.

- **Strategic** planning level, involving the Management Board who take a 0-5 year strategic view and 0-3 year business plan view.

In line with NHS gatelog reference 1054 ‘Building the assurance framework’, an assurance framework has been developed. The Assurance Framework provides the Authority with a simple but comprehensive method for the effective and focused management of the principal risks to meeting our objectives and delivering our main activities. It also provides a structure for the evidence to support the Statement of Internal Control. This simplifies Board reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management.

The framework provides the mapping of the assurance process which provides a clear management trail that links principal objectives to principal risks; principal risks to key controls; key controls to assurances and actions to mitigate risks and close gaps.

The framework introduces the new definitions (see the glossary at appendix 5.):

- The principal risks have been allocated numbers from the previous risk register;

- Key challenges (key objectives) are grouped under the principal risk for each of the challenges;

- Key challenges may appear more than once in the risk framework, as they are affected by principal risks in different ways;

- Controls are the ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected;

- Key Controls are controls to manage one or more principal risk;

- Assurance is the confidence, based on sufficient evidence, that internal controls are in place, operating effectively and that objectives are being achieved;

- Gaps in Assurance are the failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively;

- Gaps in control are the failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives;

- High level actions are those activities to close gaps in assurance or control;

- Action managers are Management Board members accountable for implementing the action;

- Pre action score is the risk rating with existing controls prior to actions being completed;

- Post action score is the risk rating following completion of the actions, and after obtaining assurance that the actions delivered the desired outcomes.

3.4 The risk register will form the basis of the Authority's risk management plan and programme. As risk evolves, so must the risk register to reflect the dynamic nature of risk and the Authority's management of it. Examples of information likely to be recorded will be:

- Findings from departmental and organisation wide self-assessment;
- Mapping the Board level key risk register against directorate risk profiles;
- Analysis of root causes of incidents or complaints;
- Analysis of root causes of poor performance trends;
- Actions to reduce risk which could not be implemented e.g. due to cost;
- Deficiencies or exceptions to the controls assurance standards.

3.5 To enable consistency in the risk management process the risk process is supported by standard risk categories and a consistent assessment criteria:

Standard risk categories – A schedule of standard risk categories has been created (see appendix 3). The categories are derived from HM Treasury guidance, together with other established reference lists.

Consistent assessment criteria – The risk classification table (RCT), at Management Board level is included as Appendix 4. This is used within the system the Authority have adopted for assessing risk, and is the mechanism for specifying levels of impact and probability. It is used to reinforce the initial reaction to any risk impact of probability.

3.6 In order to standardise the process risk assessment sheets and risk action plans are produced to support the risk management process.

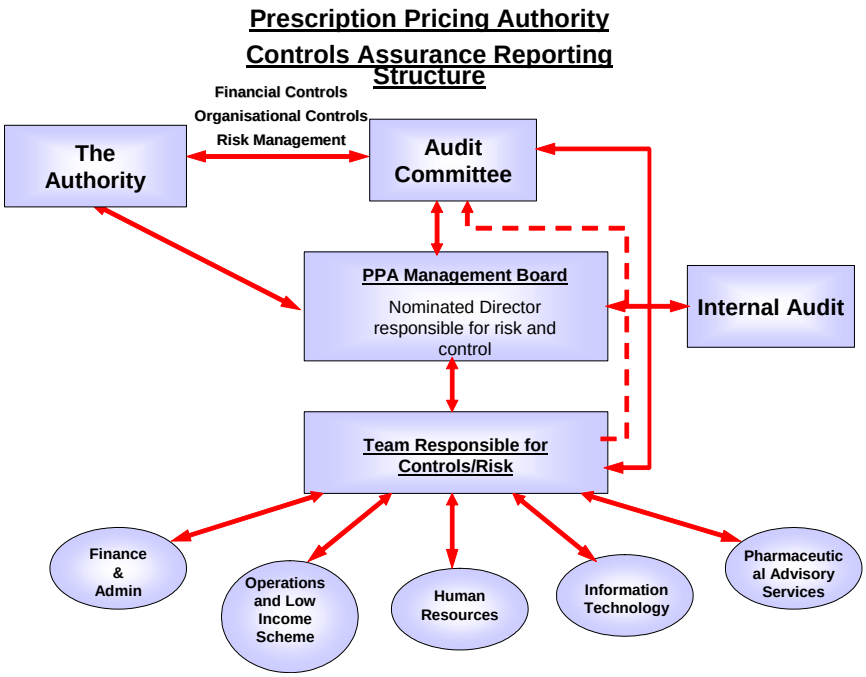
3.7 Risk control mechanisms are in place based on the likelihood and probability of a risk materialising. The business continuity planning process differentiates between risks where a fallback plan is required for continuity or contingency purposes and where it is not required. The risk review process is linked to the business continuity planning process, and changes are managed through change control.

3.8 Review of the assurance mechanisms is implemented to ensure that current controls are valid and under constant review. In addition significant control issues that have impacted the Authority are also to be disclosed under the Statement of Internal Control. The Authority has implemented an Incident Management System, to assist in this process.

3.9 It is a fundamental tenet of this policy that, whilst overall accountability and responsibility for risk management lies with the Chief Executive, all directors, managers and team leaders must take ownership of the management of risks in their departments on a day-to-day basis.

3.10 It is equally important that all staff are involved in the identification and reporting of risks which exist, and that managers address these proactively.

3.11 Certain groups or individuals have formal responsibilities in respect of the risk management process as set out in the diagram below.



3.12 On behalf of the Authority, the Audit Committee will:

- Oversee the effective implementation of the Risk Management Strategy and Policy;
- Oversee the implementation of risk management induction, training and education programmes.
- Review and advise upon the responsibilities for co-ordination and management of risk within the PPA;
- Monitor the ongoing programme of risk identification and analysis throughout the organisation;
- Review the completeness of risk registers and the effectiveness of the management of key risks, based on reports from the Risk Management Team and Internal Audit;
- Advise the Authority and liaise with the Chief Executive and Management Board on urgent or major risk management issues and required initiatives;
- Provide advice on the disclosure of significant control issues.

3.13 The Chief Executive and Management Board will:

- The Chief Executive will sign the Statement of Internal Control, as part of the Annual Accounts and Annual Report process;
- Ensure commitment through the endorsement of the Risk Management Policy and Risk Management Strategy;
- Ensure that the overall responsibilities for the management and co-ordination of risks are clear;

- Ratify major risk management actions and procedures; for example, in respect of strategic risks assessed at the Management Board level;
- Assess and approve any necessary risk management developments within the organisation;
- Identify and allocate the resources required to implement risk management activities;
- Review risks and controls for which they are responsible;
- Identify and communicate lessons learned from both successes and failures;
- Agree the reasons when significant control issues will be disclosed in the Statement of Internal Control.

3.14 Directorate and Departmental Managers will :

- Accept personal accountability for the active implementation of the risk management process in their directorate, division or building;
- Ensure that the appropriate directorate/building specific risk management systems are actively in place and adhered to;
- Ensure attendance of staff at appropriate risk management training sessions;
- Ensure that a list of directorate specific adverse indicators are produced;
- Raise risk awareness amongst staff at all levels;
- Seek advice on risk management issues;
- Notify the team responsible for risk of appropriate identified and assessed risks;
- Demonstrate a commitment to continuous improvement through the risk management process;
- Review risks and controls for which they are responsible;
- Identify and communicate lessons learned from both successes and failures .

3.15 All other staff will :

- Maintain a general risk awareness at all times;
- Notify their line manager of any identified risks;
- Comply with incident reporting procedures;
- Accept personal responsibilities for maintaining a safe environment;
- Undertake appropriate training;

- Demonstrate a commitment to continuous improvement through the risk management process;

- Review risks and controls for which the are responsible.

3.16 The Director of Finance and Administrative Services will be responsible for managing the implementation of the Risk Management Standard and Policy throughout the Authority. The DFAS will identify resource requirements and provide adequate resources, including the assignment of trained personnel for management, performance of work and verification activities including internal review.

3.17 There will be a team with responsibility for risk management and controls assurance, which will be chaired by the DFAS and will report to the Management Board and Audit Committee as appropriate. All directorates will be represented with each directorate being encouraged to produce local risk management policies and strategies in line with the overall risk management policy and strategy.

Responsibilities of the team are:

- To facilitate the development of, and review, organisational and directorate risk management programmes and risk treatment solutions, to enable the Authority to meet its obligations;

- To promote self-assessment of risks and controls at the organisational and directorate level to discharge the responsibility for facilitation above;

- To provide a professional advisory service in risk management, health and safety, security, fire prevention, pest control, project management and environmental issues to enable the Authority to understand the implications of new legislation and contribute to effective consideration and decision-making;

- To promote actions to prevent or reduce the adverse effects of risk;

- To monitor the treatment of risk until it becomes acceptable to the Authority;

- To build and develop a risk management network to ensure a structured approach throughout the Authority to the identification of actual and potential risks and appropriate control measures taking full account of existing systems and approaches where these can be used effectively;

- To develop and implement an adverse incident reporting procedure and associated statistical database to enable the Authority to clearly identify incident trends and costs, levels of performance, matters of concern requiring attention and the setting of targeted reductions for use as performance indicators;

- To review incidents and provide guidance on the disclosure of significant control issues;

- To develop appropriate procedures to provide the Authority with necessary guidance for achieving compliance with legislative requirements and provision of a safe and secure working environment;

- To liaise with Internal Audit and other specialists; to carry out compliance testing and audits on a regular basis to ensure that the Authority is achieving compliance with legislative requirements and effectively implementing risk management actions; to identify any problems which the Authority may have in managing risk and to verify the implementation of risk management actions and their effectiveness;

- To develop and maintain good relationships with the Authority, NHS Executive and key external organisations, acting as a single point of contact to enable a context in which risk management programmes can be carried out effectively and draw upon and influence best practice in risk related issues;

- To communicate this policy and strategy throughout the Authority and to other interested parties;

- To provide induction training, awareness training and training for managers and team leaders in risk management.

3.18 Internal Audit will be responsible for:

- Supporting implementation of the risk management process through advice at all levels, training in risk and control issues and, where appropriate, facilitation of self-assessment e.g. in a Control Self-Assessment workshop;

- Independent audit of the Authority's implementation and operation of the risk management strategy at least annually;

- To review incidents and provide guidance on the disclosure of significant control issues;

- Acting as a source of reference on risk and control issues for Directors, Managers, Team Leaders and the Risk Management/Controls Assurance Team;

- Providing independent quality assurance and corroboration of the results of self-assessment activities and of the completeness and adequacy of the overall and directorate-level risk registers;

- Conducting audit assignments to provide the assurances as to compliance sought by the Risk Management/Controls Assurance Team and to facilitate reporting to this team, and the Audit Committee on the implementation of agreed risk management actions;

- Providing the Management Board, Authority and Audit Committee with an opinion as to the Authority's implementation of controls assurance and the risk management standard in particular.

3.19 As the risk management process develops, Key Performance Indicators will be put in place to monitor the performance of risk management activities. Examples might include:

- Human Resource indicators such as staff retention or staff sickness;

- Risk management indicators such as number, type and severity of accidents.

- Financial indicators e.g. losses
- Trend analysis

4. SUPPORT AND EXPERTISE

4.1 Training

The Authority is committed to ensuring that all aspects of risk management and internal control are supported at all levels in the organisation, hence:

- Risk awareness will be incorporated into induction training;
- More detailed training will be made available and included in the Personal Development Plans (PDPs) of all staff who will be involved in risk management activities, as well as Audit Committee members.

4.2 Support policies and procedures

The following is a list of policies and procedures where more information on managing risk can be found:

- Fire procedures;
- Health and safety policies;
- Security assignment instructions (restricted);
- Incident reporting procedure;
- Permit to work system.

4.3 Record-keeping

As well as local records, a central file of pertinent information will be maintained by the team responsible for risk management and controls assurance:

- Records of staff training (in risk and controls assurance);
- Self-assessment documentation, including records of any CRSA workshops;
- Risk management reports.

4.4 Communications strategy

The Director of Finance and Administrative Services is the officer with delegated responsibility for risk management. Risks classified as external are allocated to the Management Board as owner, who then delegates a Management Board member as manager. Once a risk manager has been allocated, the risk will be assessed, risk reductions agreed and a risk action plan produced. Reporting will be at least quarterly. At this time there will be an opportunity to merge any duplicated risks. External risks will now be included as a quarterly item on the programmed Management Board reports.

Those risks that are not classified as external, are owned by one member of the Management Board, and the owner will appoint a member of their staff as Risk Manager. Risk will be reported as part of the normal programmed reporting system adopted for the Management Board, at the normal frequency.

The register will remain a combined register and will be updated for presentation to the Audit Committee by the Director of Finance and Administrative Services.

The reporting system will follow that currently implemented for programmed reports at Management Board and Authority meetings or as updated from time to time. Board members will table any risks where escalation for any reason has increased either the probability or the impact of the risk being managed.

Appendix 1 outlines the timetable for meetings and reporting under controls assurance and risk management.

4.5 Quality

Quality procedures will be implemented in support of risk management and organisational controls assurance. These will be augmented by regularly auditing the processes and procedures by Internal Audit.

4.6 Risk quantification

An outline of the risk quantification method to be used is attached as appendix 4.

Programmed Authority Reports : 2003

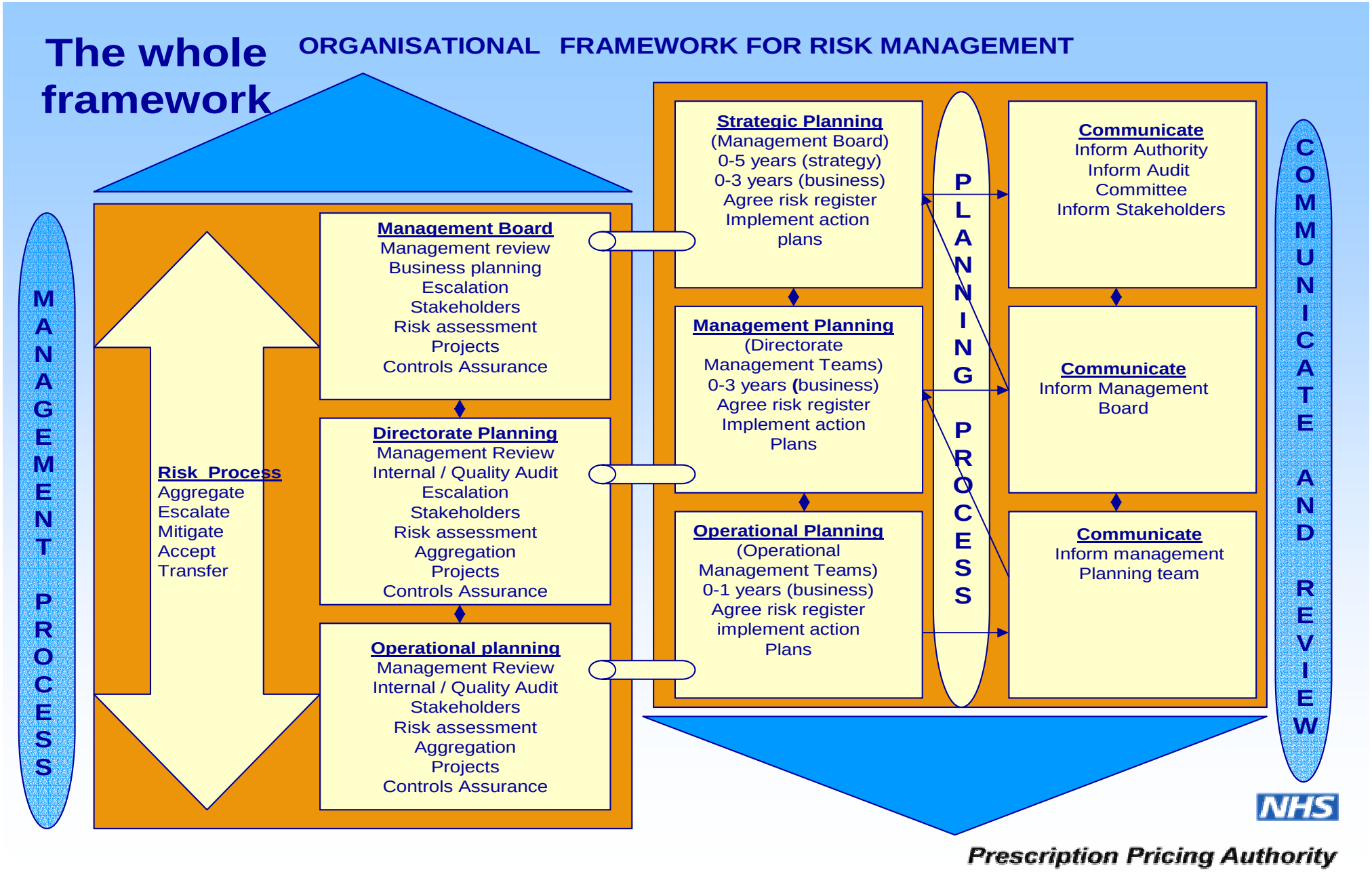
Report	Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov
Section 1 : Reserved/Standing Items											
Apologies for absence	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Minutes of previous meeting	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Matters arising from previous meeting	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Chief Executive Report	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Key Performance Indicators	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Financial Position	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Strategic Plan	Annual	λ		λ							
Business Plan	Annual	λ		λ							
Quality Assurance	Annual									λ	
Performance against business plan	Half Yearly	λ					λ				
Annual Public Meeting	Annual									λ	
Annual Report	Annual							λ	λ		
Amendments to SOs and SFIs	Annual						λ				
Annual Budget	Annual				λ						
Annual Accounts	Annual								λ		
Audit Committee Annual Report	Annual							λ			
External Audit Management Letter	Annual										λ
Race Relations Act	Annual						λ				
Appointments to Sub-Committees of Authority	When Required										

Report	Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov
Decisions reserved for the Authority by virtue of the Standing Financial Instructions	When Required										
Policies	When Required										
Verbal Report from Audit Committee	When Required										
Confirmed minutes of Audit Committee	When Required										
Register of Members' Interests	Annual			λ							
Membership of the PPA	Annual			λ							
Future Business	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Dates of future meetings	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Any other business	Monthly	λ	λ	λ	λ	λ	λ	λ	λ	λ	λ
Section 2 : Programmed Reports											
Operations Services (Processing, LIS, PPC)	Half Yearly		λ						λ		
Pharmaceutical Services (PiF, PCDD, UKCPRS)	Half Yearly	λ						λ			
Capacity and Growth Model	Half Yearly			λ					λ		
ETP Pilots	Three per year			λ				λ			λ
PPA Reengineering	Three per year		λ				λ			λ	
Controls Assurance	Annual							λ			
Customers Complaints	Annual					λ					
Stakeholder Relations	Half Yearly				λ					λ	
People Issues	Three per year		λ				λ			λ	
Managed Services Progress Report	Annual						λ				
Agenda for Change	Three per year	λ				λ			λ		
Net Cash Variance	Annual								λ		

Report	Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov

The whole framework

ORGANISATIONAL FRAMEWORK FOR RISK MANAGEMENT



NHS

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RISK CATEGORIES (PART OF THE RISK FRAMEWORK)

Each risk description needs to be **prefixed by** (F) Foundation, (D) Delivery or (V) Development. Where (D) Delivery is the default. This reflects the Business Plan.

Major projects will have a separate risk register. Projects will use the same categories as those in the table below.

Group	Type		Supporting Notes
EXTERNAL			**The risk arises from activity outside the Authority**
	"Act of God"	1.1	e.g flood earthquake.
	Political	1.2	change in government or policy
	Legal/Regulatory	1.3	all relevant statute and regulation
	Stakeholder Relations	1.4	Relates to relationships with stakeholders
	Funding Availability	1.5	DH provision of funds
	Markets	1.6	Relates to competition for services and to failure of outside parties e.g postal problems
	Economic	1.7	*Changes to interest rates, taxation or other economic factors*
PROCESS			**The risk arises from activity within the Authority**
Process Operational			**The risk arises from day-to-day operations within the Authority**
	Customer satisfaction	2.1	Complaints
	Stakeholder satisfaction	2.2	Complaints
	Human Resources	2.3	Relates to the availability and retention of suitable staff.
	Product/Service Failure	2.4	
	Volume/Complexity	2.5	
	Sourcing/Procurement	2.6	
	Innovation/ Obsolescence	2.7	
	Physical/Buildings	2.8	
	Environmental	2.9	Relating to issues such as pollution and sustainability
	Health & Safety	2.10	
	Product Development	2.11	
Process – Empowerment			***Relates to the way in which people work together.***
	Leadership/Authority	2.12	
	Performance Management	2.13	
	Communication	2.14	
Process – Technology			***Relates to the use of technology to achieve objectives***
	Access	2.15	Getting into the data or systems

Group	Type		Supporting Notes
	Integrity	2.16	Compromising the quality of data or systems
	Suitability	2.17	Suitability of the technology in use
	Availability	2.18	Being able to use the data or systems when needed
Process Integrity			***Relates to a lack of integrity in the way things are done***
	Fraud/ Theft	2.19	Fraud / theft of assets
	Illegal acts	2.20	Illegal acts
	Unauthorised use	2.21	Relates to the unproductive use of resources
	Reputation	2.22	Relates to how the Authority or Directorate is seen by others.
Process – Financial			***Relates to money***
	Budget	2.23	Relates to this financial year
	Capital Investment	2.24	Including Business Cases
	Liability	2.25	A financial impact which is not provided for in the accounts as yet.
DECISION-MAKING INFORMATION			**The risk arises from either bad information or from the way decision-making works**
Operational Decision-making			
	Contract management	3.1	Partnerships and contracts are not based on good quality information and review mechanisms
	Measurement	3.2	
	Completeness & Accuracy	3.3	
	Regulatory Reporting	3.4	
Financial Decision-making			
	Budget & Planning	3.5	One year planning information and decision-making
	Accounting information	3.6	Relates to accounting policies and reporting
	Resource Prioritisation	3.7	Relates to allocation of resources in this financial year
Strategic Decision-making			
	Policy	3.8	Policy within the Authority
	Organisational Design/Quality	3.9	The way the organisation is structured makes for bad decisions.
	Resource Allocation	3.10	Greater than one year resource allocation
	Planning	3.11	Greater than one year planning cycle
	Life Cycle	3.12	
	Project implementation	3.13	

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Risk Classification Table

Workshop

	Unit	Nil	Low	Med	High	
Probability		Remote	Unlikely	Possible	Probable	
Cost	**£**	Negligible	Under £100k	Upto £500k	Over £500k	
Service delivery		No service issues	Seen only to marginally affect Business Functions and BP cat	Seen to fail to meet one business function and BP category	Seen to fail to meet more than one business function & BP tr	
Reputation		No impact	Complaints from 5 stakeholders in any one event	Upto 20 complaints in any one event &/or National Press inv	Over 20 complaints in any 1 issue & Ministerial/Parlia enq	
Legal / Regulatory		Negligible	Minor Impact	Medium Impact	Major Impact	
Cost of Risk Reduction	**£**	Negligible	Less Than £100k	Between £100k and £500k	Greater Than £500k	

GLOSSARY

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved
Assurance Committee	A board level committee with overarching responsibility for ensuring appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance, or risk management committee
Assurance Framework	A structure within which boards identify the principal risks to the organisation meeting its principal objectives and map out both the key controls in place to manage them and also how they have gained sufficient assurance about their effectiveness
Board Assurance Action Plan	An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required
Board Assurance Reports	Key information reported to the board on the assurance framework, providing details of positive assurances and significant gaps in internal controls and assurances relating to principal risks. In addition to providing information leading to a board assurance action plan this will also provide evidence to support the annual Statement on Internal Control
Controls Assurance	A holistic concept based on best governance practice. It is a process designed to provide evidence that NHS organisations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds
Core Controls Assurance Standards	Three self assessment standards which underpin the annual Statement on Internal Control, these being: Governance Standard; Risk Management Standard; Financial Management Standard
Directorate Level Objective	How the organisation translates an overall goal into deliverables at directorate (or equivalent) level
Effective Control	A control that is properly designed, and delivers the intended objective
External Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, Commission for Health Improvement or Royal Colleges for example

Term	Definition
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
Head of Internal Audit Opinion	An annual opinion provided to inform the Board in completing their Statement on Internal Control. This provides opinions on (a) the overall assurance framework and (b) the effectiveness of that part of the system of internal control reviewed by Internal Audit during the year
Independent Assurance	Assurances provided by (a) reviewers external to the organisation and (b) internal reviewers working to government standards, such as Internal Audit
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical Audit or management peer review
Internal Control	The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected
Key Control	A control to manage one or more principal risks
Mapping of Assurance	A process, providing a clear management trail, that links • principal objectives to principal risks • principal risks to key controls • key controls to assurances
Organisational Controls Assurance Standards	Eighteen self assessment standards (excluding the core standards) which provide a framework to improve internal controls across a wide, but not all encompassing, range of organisational areas
Positive Assurance	Evidence that shows risks are being reasonably managed and objectives are being achieved
Principal Objectives	Objectives set at strategic and directorate (or equivalent) level
Principal Risk	A risk which threatens the achievement of Principal Objectives
Prioritisation of Risk	A process by which risks are graded in order based on the likelihood of their occurrence and the impact of their consequences
Reasonable Best	A decision or course of action, agreed by the board, that is based on sufficient evidence
Risk	The possibility of suffering some form of loss or damage. The possibility that objectives will not be

Term	Definition
	achieved
Risk Assessment	The identification and analysis of relevant risks to the achievement of objectives
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored
Sources of Assurance	The various reviewers, auditors and inspectors, both internal and external, who carry out work at NHS organisations (see Internal Assurance and External Assurance). Boards will have to determine which sources of assurance are relevant to principal risks and to what extent they are sufficient
Statement on Internal Control (SIC)	An annual statement signed by the Accountable Officer on behalf of the board that forms part of the Annual Financial Statements for the year. The SIC provides public assurances about the effectiveness of the organisation's system of internal control
Strategic Objective	An overall goal of the organisation
System of Internal Control	A system, maintained by the board, that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically