Risk Management Framework Policy and Procedures

Department/Service:	Clinical Governance and Risk Management
Originator:	Sarah Shingler – Chief Nursing Officer Allan Bailey – Associate Director Patient Safety and Risk
Accountable Director:	Sarah Shingler - Chief Nursing Officer
Approved by: **Ratified by:** **Endorsed by:**	Executive Risk Management Committee Trust Management Board Trust Board
Date of Approval: **Date of Ratification:** **Date Endorsed:**	Executive Risk Management on 1 March 2024 Executive Risk Manageemnt on 1 March 2024 Trust Board dated 12 March 2024
Next Revision Date: **This is the most current document and is to be used until a revised version is in place**	This Policy requires to be revised every 3 years or sooner if circumstances dictate
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Departments
Target staff categories	All Staff

Strategy Overview:
This Policy sets out the Trust's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees. It describes the Trust's appetite for risk for a range of circumstances and objectives. The form and functions of the Board Assurance Framework (BAF), which is informed by strategic risks and the risk register structure for operational risks, are also set out. The strategy is written in the context of good governance, business planning, performance management and assurance.

Key amendments to this Document

Date	Amendment	By:
Jul 2005	Revision with more detail about Risk Registers, targeted training, revised risk management objectives, Directorate Performance reviews etc.	C. Rawlings
Nov 2006	Revision includes actions to meet the requirements of the pilot National Health Service Litigation Authority (NHSLA) Risk Management Standards, including the need for risk management strategies for all areas and a revised risk escalation process.	C. Rawlings
Jan 2008	Editing to define the strategy and policy elements. Revision of the means of monitoring compliance with implementation of this strategy and to revise its objectives. Requirement for Directorate Risk Coordinators removed although GMs, CDs or equivalents have a responsibility for managing risk by having processes in place and allocating specific roles in supporting them. Addition of identification of partnership risks	C Rawlings
Jul 2008	Revisions made for FT application. Review and changes include: risk scoring matrix; risk escalation process; corporate risk register process; training requirements; monitoring arrangements; creation of the Risk Validation Group	C. Rawlings
Sep 2008	– Board Assurance Framework section re-established at section 5. Risk Validation Group added to risk management process in Appendix B Inclusion of Chief Operating Officer (COO) to replace Director of Operations (DoF) associated with business risks and COO with business continuity risks.	C. Rawlings
Jul 2009	Revisions made to accommodate the changes to the Trust's Management and Committee structures Risk Scoring Matrix (Appendix C) revised and re-issued Board Secretary now responsible for the BAF	C. Rawlings
Sep 2009	Objectives revised and provided in appendix D	Executive Team
Jul 2010	Minor changes made to: reflect operational structure and responsibilities and the extended life of the European Risk Management Council (ERMC); clarification of the Executive Team role in receiving new significant risks; Addition of Fraud risk identification; amendment to the escalation process; approved by Executive Team	C. Rawlings
Jun 2012	Revisions made to reflect operational structure, Monitor requirements and to separate this document out into a strategy and separate 'policy'. Monitoring / KPIs improved.	C. Rawlings
Sep 2012	Clarification of 6.3 training. Minor change approved by Chairman	C. Rawlings
Jul 2014	Revision and explanation of the risk management framework Widespread changes to the process and responsibilities to reflect the new Trust structure Description of the new approach to the Board Assurance Framework Revised risk scoring matrix	C. Rawlings

Date	Amendment	By:
Feb 2015	Revised likelihood definitions and formatting of Appendix 3 Risk Scoring Matrix	J. King
Apr 2015	Minor update following annual review, titles, committees and implementation plan updated.	J. King
Nov 2016	Minor amendments to reflect the changes to the Trust governance structure and Trust Risk Officer post	W. Huxley-Marko
Apr 2017	Amendments to escalation process for adding risks to the Corporate Risk Register	C. Geddes
May 2017	Amendments to objectives, references and risk description. Additions made to reflect changes to structure.	S. Lloyd
Apr 2018	Amendments to roles and responsibilities, the addition of risk profiling, updated objectives and updated references.	S. Lloyd C. Geddes V. Morris
Aug 2019	Amendments to risk description, escalation process, changes to reflect current governance structure, addition of frequency of review, authority for managing risks and monitoring process.	D Johnson
July 2023	Amendments to font, correction of typing errors and inclusion of 'residual risk log' description	K.Apps and S.Sugar
July 2023	Amendments to Risk Appetite	R. O'Connor S.Sugar
December 2023	Policy rewritten to align with Foundation Group reporting and governance arrangements	S Shingler

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1 SCOPE AND PURPOSE

All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary). Breaches of adherence to Trust policy may have potential contractual consequences for the employee.

The Trust's aim is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

The Board recognises that to deliver their strategic objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: these are cornerstones of building safer, effective, and efficient care for the future.

The Trust will continue to promote and maintain a safe environment for staff, patients, visitors and those required to undertake work on trust premises, to:

- Ensure that risk management is an integral part of Worcestershire Acute Hospitals Trust culture
- Minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy
- Maintain a cohesive approach to corporate governance and effectively manage risk management resources
- Ensure that Worcestershire Acute Hospitals Trust meets its obligations in respect of Health and Safety.

2 INTRODUCTION

Worcestershire Acute Hospitals Trust culture ('The Trust') recognises that successful risk management must be the responsibility of all staff and be comprehensive and coordinated, that proactive and continuous identification and management of risk is essential to the delivery of high quality services. The Trust acknowledges the delivery of healthcare can never be risk free and taking decisions about risk and opportunity is a part of everyday clinical and non-clinical practice and management.

Risk Management must be recognised as a fundamentally integral and central way that the Trust operates and be considered 'good management practice'. It must form part of the overall decision making process and day to day management activities and should not be seen as a

separate activity that is carried out once decisions have been made.

The basic standard for a Risk Management system is compliance with the Law as a minimum standard, for example Employment Law, Health and Safety Legislation, Fire Safety.

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the Trust's reputation, its ability to deliver statutory responsibilities, the delivery of objectives and the delivery of safe and effective patient care. It is a key component of general management practice as it aims to ensure achievement of objectives is more likely if:

- Adverse (damaging) events are less likely
- Costly re-work and 'fire-fighting' is reduced
- Capital and resources are utilised more efficiently and effectively
- Performance is improved (including quality, finance for example)
- Decision-making is better informed
- Positive outcomes for stakeholders are increased
- Reputation is protected and enhanced

In summary, **risk** is defined as the uncertainty of achieving an objective that has not yet occurred at the time of writing. In contrast, an **issue** is an event or set of circumstances which is already occurring which poses a concern relating to the ability to deliver objectives.

The Risk Management Framework is supported by the Trust's wider suite of policies, with a clear connection to the following policies:

- Business Continuity Policy
- Claims Handling Policy and Procedure
- Risk Management Strategy
- Concerns and Complaints Policy and Procedure
- Fraud, Bribery and Corruption Policy
- Information Risk Policy
- Health and Safety Policies – to include the Health and Safety Policy and the Infection Control Policy
- Serious Incident investigation Policy
- Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3 DEFINITIONS

Risk Management	Risk Management is the term used to describe the activities required to identify, understand and control exposure to uncertain events which may threaten the achievement of objectives.
Risk	Risk is defined as an uncertain event or set of events, which should it occur, will have an effect upon (i.e., threaten) the achievement of objectives. Risk consists of a combination of the likelihood of the

	'threat' happening and the impact of that threat happening and is described as the combination of: • Cause: If… (something happens) • Event: Then… (this may occur) • Effect: Resulting in…. (The impact)
Issue	An issue is an event or set of events that have already occurred. These can be added to the incident management system for highlighting, monitoring and escalating where needed by selecting "issue" instead of "risk". Issues should be managed as per risks noting planned actions, mitigations, review dates and target dates for closure and should be discussed at Care Group and Divisional Governance and Corporate Meetings
Control	Actions in place to assist in the mitigation of the risk and the achievement of an objective, by reducing the likelihood or impact. For example, a policy or training programme.
Assurance	Assurance is the evidence which describes how effective the controls are. For example, a report summary of incidents may tell us that we have very few patient falls, therefore suggesting that our controls to prevent falls are working effectively.
Risk Appetite	Sets out the levels and types of risk we are prepared to accept, tolerate, or be exposed to at any point in time, in pursuance of our objectives.
Risk Tolerance	The amount (risk level/score) prepared to take to achieve strategic and operational goals.
Risk Register	A record of all identified risks relating to a set of objectives, including their history, status and risk score. The purpose of a risk register is to evidence and drive risk management activities, and it is used as a source or means of risk reporting. The Trust has implemented several types of register that support the overall Risk Management system. These are: • Board Assurance Framework • Trust-wide risks • Divisional-wide risks • Directorate risks • Local (ward and department) risks • Specialty risks
Project Programme Risks	Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the

	approach. Risk registers or logs will still be maintained for risks to programmes or projects, but these are held as part of the project documentation held within the Programme Management Office. However, this project documentation may be referred to as a source of control and/or assurance, within related risks held on the Risk Register.
Strategic Risks	These are reported via the Board Assurance Framework. These include strategic risks which concern the Trust's main purpose and could impact the achievement of key objectives.
Trust-wide Risks	These are reported via the Divisional Risk Registers. These include cross-cutting internal risks over which the Trust has full or partial control and/or that can be managed through internal controls e.g., fraud, health and safety, workforce and data security.
Directorate / Divisional Risks	These are reported via the Divisional Risk Register. These include local/delivery risks that could impact the achievement of divisional and directorate business plans.

4 DUTIES

The day-to-day management of work place risks are the responsibility of everyone in the Trust and the identification and management of risks requires the active engagement and involvement of staff at all levels. Individual staff are best placed to understand hazards relevant to their areas of work and must be enabled to manage risks arising from these hazards, within a structured management framework. This can only be achieved within a progressive, honest, open and 'just' environment where hazards, accidents, incidents, mistakes and near misses are identified quickly and acted upon in a positive and constructive way.

4.1 All Staff

Including Bank, agency Staff and Contractors - have a personal responsibility for risk management and compliance with this policy, including awareness of the risks within their working environment, how their role impacts on those risks and taking reasonable steps to reduce the risk if possible. All members of staff have a responsibility to contribute to the effective management of risk by maintaining risk awareness, identifying, reporting and managing risks as appropriate to their Divisional Directors, Divisional Nurse Directors, Clinical Directors, Directorate Manager or Line Manager. They will ensure that they familiarise themselves with the risk management procedure for the Trust and attend/complete risk management training as appropriate.

4.2 Trust Board members

The Trust Board members have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

4.3 Non-Executive members

Non-Executive Directors have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

4.4 Chief Executive

The Chief Executive has overall responsibility for risk management. As Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives and signing the Annual Governance Statement in the annual report and accounts.

4.5 Managing Director

The Managing Director will:

- Ensure delivery of the strategic objectives
- Ensure that employees and the public are properly protected against exposure to risks arising out of or as a result of the Trust's activities

4.6 Chief Nursing Officer

The Chief Nursing Officer will:

- Ensure that the Trust has an effective structure and system in place to manage risks within the organisation
- Chair the Executive Risk Management Committee

4.7 Executive Directors

Executive Directors are responsible for:

- ensuring delivery of the strategic objectives
- identification, control, monitoring and reporting of the risks which may threaten achievement of strategic objectives
- maintaining accurate and up to date risk registers, relevant to their objectives and in addition report through the Board Assurance Framework (BAF)
- providing oversight of operational risks which have been escalated to the Executive Risk Management Committee.

4.8 Corporate Governance and Risk Department

The Corporate Governance and Risk Department is responsible for:

- development and review of the Risk Management Policy
- provision of education, support and expertise in relation to Risk Management
- provision of training on the Risk Management Policy
- monitoring and reporting compliance with the Risk Management Policy
- facilitating the reporting of appropriate risks to the Board, Committees and Executive Groups

- quality checking of risks on the register and subsequent risk management

4.9 Divisional Triumvirates, Divisional Directors, Associate/ Deputy Directors, Divisional Directors of Nursing (or equivalent for non-clinical divisions) and Clinical Governance Leads

- leading and overseeing implementation of the Risk Management Policy at Divisional level which includes effective identification and ongoing review of, controls, monitoring and reporting of the risks which may threaten achievement of Divisional objectives
- facilitating the reporting and where necessary, escalation of appropriate risks to the Divisional Board and the Executive Groups
- maintaining accurate and up to date risk registers, relevant to their Directorate / service objectives.

4.10 Divisional Governance Leads (or equivalent nominated person for non-clinical divisions)

- facilitating implementation of the Risk Management Policy at Divisional level which includes the effective identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Divisional objectives, in accordance with the procedure set out within this policy
- monitoring and reporting compliance with the Risk Management Policy at a Divisional level, as identified by the Corporate Governance and Risk Department

4.11 'Risk Owners' including all Departmental/Ward/Service Managers

All risk registers, which are managed on the Risk Management System (Datix) contain individual risks and each risk is allocated a risk owner, which is recorded on Datix**.** The Risk Owner is responsible for taking appropriate action to minimise its impact and ensuring the risk is kept current, with updates recorded. Risk owners are responsible for:

- identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Directorate objectives, in accordance with the procedure set out within this policy
- maintaining accurate and up to date risk registers, relevant to Directorate objectives

4.12 Chairs of Monitoring Committees

Chairs of Monitoring Committees are responsible for:

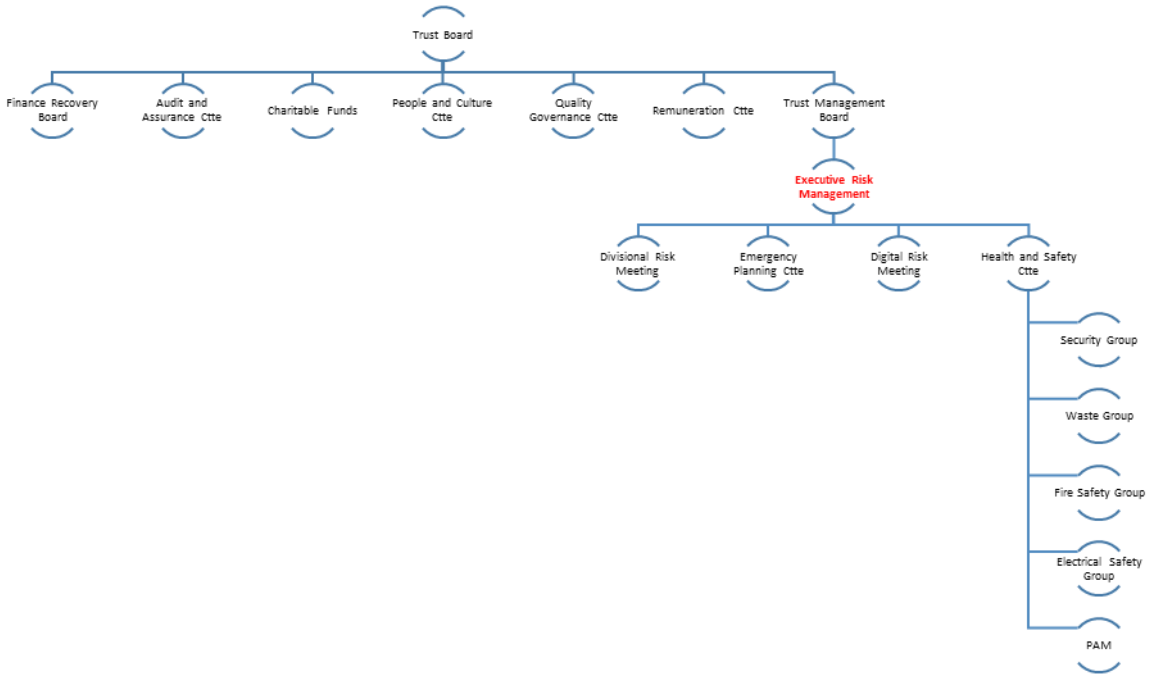
- identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken
- reporting, where appropriate to the Executive Risk Management Committee

4.13 Internal Auditors

The **Internal Auditors** are accountable for agreeing (with the Audit Committee) a programme of internal audits, which assess the exposures and adequacy of mitigation of the risks affecting the organisation.

The priorities contained in the internal audit programme should reflect the risks set out in the BAF and the Risk Registers. The reports and advice produced by internal audit should inform the management of risk.

4.14 The Trust Reporting Structure



4.15 Trust Board

The Trust Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. A robust risk management framework ensures the systems and processes of control are in place to deliver the responsibility for implementing risk management throughout the Trust.

The Trust Board is required to produce statements of assurance which declare that it is doing its 'reasonable best' to ensure that the Trust meets its objectives and protects people using services, staff, the public and other stakeholders against all types of risk.

The Trust Board oversees the Trust's strategic risks in the following ways:

- Where a risk is rated 15 or above, the risk will be escalated to the Trust Board following discussion with the Executive Risk Management Committee.
- The Trust Board defines the structure of the BAF to ensure that it drives the Board's agenda and ensures the robust oversight of strategic risk. The BAF is the means by which the Trust Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic objectives. The BAF defines the control systems in place to mitigate strategic risks and confirms the assurances that the Trust Board wishes to receive throughout the year to evidence the effective operation of controls and mitigation of principal risks.
- The Trust Board utilises the BAF as a working document and reviews the BAF structure and content routinely, at minimum bi-annually.
- Members of Trust Board receive the Chair's Reports of the Audit Committee, Quality Governance Committee and Charitable Funds Committee. Through these reports, Trust Board receives a summary of key assurances and risks escalated by the Chairs

of each Board Committees.

The responsibility for monitoring the management of risk across the organisation is delegated by the Trust Board to the following Committees:

- Audit Committee
- Executive Risk Management Committee

4.16 Executive Risk Management Committee

The overall purpose of the Executive Risk Management Committee is to ensure the effective implementation of the Risk Management Strategy and there are core processes in place to manage risks across the organisation. The Executive Risk Management Committee will be chaired by the Chief Nursing Officer and will report on any issue where the Trust Board may require additional assurance or where a Trust Board decision is required.

The Executive Risk Management Committee will:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Trust.
- Coordinate the identification of all risks; Clinical, Health & Safety, IT, Finance, Human Resources, Workforce and Estates and ensure risk assessments are undertaken Trust wide, and that all risks are appropriately evaluated.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Trust-wide.
- Enable risks which cannot be dealt locally to be escalated, discussed and prioritised.
- Through the Divisional Risk Registers review new risks rated Red (15-25) and Amber (12) to consider whether they have been appropriately rated and agreeing action plans to control them.
- Through the Divisional Risk Registers review and monitor risks rated Red (15-25) ensuring action plans are being implemented to control the risks. In addition the Executive Risk Management Committee will review risks rated Amber (12), on a quarterly basis, to consider whether they have been appropriately rated.
- Review the risks on the Divisional Risk Registers to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, the risk will be added to the BAF.
- Review the BAF prior to its presentation to Trust Board.
- Advise the Board of Directors of exceptional risks to the Trust and any financial implications of these risks.
- Monitor the effectiveness of the agreed risk mitigating actions.
- Recommend priorities for resources to manage risks.
- Oversee the work of the Divisional Risk Governance Groups, the Corporate Division Risk Group, the Health, Safety & Wellbeing Committee and the Emergency Planning Committee.
- Review and monitor the implementation of the Risk Management Strategy
- Ensure that all appropriate and relevant requirements are met to enable the CEO to sign the Annual Governance Statement
- Approve documentation relevant to the implementation of the Risk Management Strategy

4.17 Divisional Risk Meetings

The overall purpose of the Divisional Risk Meetings is to ensure the effective management of divisional risks within the Trust, thereby contributing to the implementation of the Risk Management Strategy. The Divisional Risk Meetings will report to the Executive Risk Management Committee on divisional risks or where a decision may be required.

The Divisional Risk Meetings will:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key corporate risk management issues within the Trust.
- Coordinate the identification of all corporate risks; Health & Safety, IT, Finance, Human Resources, Workforce and Estates and ensure risk assessments are undertaken Trust wide, and that all risks are appropriately evaluated.
- Ensure appropriate actions are applied to Trust-wide risks.
- Enable risks which cannot be dealt locally to be escalated, discussed and prioritised.
- Through the Divisional Risk Registers review new risks to consider whether they have been appropriately rated and agree actions to control them.
- Review the risks on the Divisional Risk Registers to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, the risk will be added to the BAF.
- Monitor the effectiveness of the agreed actions.

4.18 Audit Committee

The Audit Committee is responsible for reviewing the adequacy and effectiveness of all risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the Trust Board; and the underlying assurance processes that indicate the degree of achievement of strategic objectives, the effectiveness of the systems and processes for the management of risks, the BAF and the appropriateness of disclosure documents.

4.19 Health and Safety Committee

The Health and Safety Committee supports the Trust in the discharge of its statutory health and safety duties, by setting strategy, monitoring health and safety performance, reviewing audit findings, agreeing plans where required and identify risks and the appropriate mitigating actions, monitoring their effective implementation. It also provides:

- a focal point and source of expertise for the Trust and its employees on health and safety issues and risks;
- a forum where all members can raise issues, concerns and good ideas relating to health and safety in the Trust, for consideration and action as appropriate.

4.20 Monitoring Committees

All risk registers, which are managed on the Risk Management System (Datix) contain individual risks and each risk is allocated a monitoring committee which identifies, manages and oversees risks relevant to their specialist subject, ensuring appropriate action is taken.

5 MAIN CONTENT

5.1 Key Risk Documentation

5.2 Risk Management System (Datix)

All staff are required to enter perceived and real risks onto the Risk Management System (Datix). This process ensures the Trust maintains contemporaneous local and divisional risk registers, underpinning the Trust's overarching BAF. The compilation and maintenance of an up to date and comprehensive Risk Register and BAF is one of the key elements of the Trust's Risk Management Framework.

The Risk Management System is an electronic database that holds the main record of all identified risks to the Trusts objectives and operations. These risks are recorded within individual risk registers allocated to teams, local delivery units, directorates or divisions. Any risks to the delivery of the Trust's strategic objectives are added to the Trust's BAF.

Each of these Risk Registers are dynamic documents readily accessible to all staff with risk management roles. Risk registers contain individual risks which are given a target and current risk rating (which is dynamically updated) along with relevant controls, assurances, gaps and mitigating actions. Actions are detailed to reduce the risk to the lowest acceptable level, or to a level determined as acceptable by the Trust Board and these are included within their relevant risk register. All identified risks will be monitored and reviewed on a continuous basis by the relevant management groups or monitoring committees.

Regular review and updating of all Risk Registers is a routine part of the risk management process. This ensures that new risks that arise will be identified and risks that are no longer relevant can be closed.

5.3 Board Assurance Framework (BAF)

The BAF is a tool via which risks to the achievement of the Trust's strategic objectives are managed and reported to the Board. Risks recorded on Divisional Risk Registers may also appear on the BAF if they have the potential to compromise delivery of Trust strategic objectives. Not every high scoring item on the divisional risk registers will appear on the BAF. The Board Secretary produces the BAF and oversees the relationship between the BAF and the Risk Register in conjunction with the Chief Nursing Officer.

5.4 Risk Assessment Process

A risk assessment is simply a systematic and effective method to identify and examine 'what could cause harm' in the workplace and will help identify the significant risks affecting the Trust, to minimise and remove these and to avoid wasted effort by effectively targeting these, therefore protecting the stability of the organization.

It is a valuable tool that can help professionals and managers improve the safety and quality of care given to the people we provide services to. It is an essential part of any risk management programme.

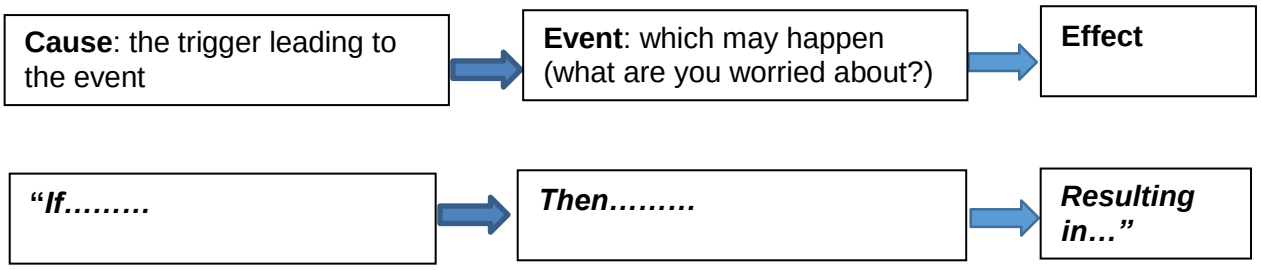
Any individual who identifies a hazard will bring it to the attention of their manager and

undertake a risk assessment using the Trust's risk assessment process.

Risk assessment must be entered onto the Trust's risk management system (Datix). Once registered onto the Trust Risk Management system, the risk will be quality checked before proceeding to the designated approval level. It is important to ensure that all risks are reviewed and updated including current and planned controls, assurances, and any identified gaps.

5.5 Risk Description

Risk is uncertain. There should only be one cause and one event, but the risk may have multiple effects.



Supplementary Information

It is particularly helpful to include actual evidence to support the risk description. This could be the result of an increase in particular incident reports or complaint, poor audit results, unsatisfactory external review or a nationally recognised problem.

5.6 Likelihood and Impact Assessment

To assess the likelihood of the risk, focus on the "If…." section on the risk description.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Time framed	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

To assess the consequence of the risk, focus on the ***"Resulting in"*** section on the risk description using the Trusts risk scoring matrix on Page 19.

It is possible that the risk may have more than one impact, for example financial loss, service-disruption and patient safety. Using the scoring matrix to impact score each of the categories separately and then select the one that has the highest consequence.

To identify the initial risk score, multiply the result of the likelihood assessment and the result of

the consequence assessment. The score is to be calculated before the introduction of controls and remains unchanged once calculated.

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

5.7 Current Controls and Assurances

Consider what existing controls and assurances are in place.

Existing controls Should make a risk less likely to happen and/or reduce the impact if it does happen. Controls can also be a contingence to be enacted should the risk happen

Existing gap in controls Any part of a control that has a breach, for example, training is the control, but no attendance at training is the gap in control.

Existing assurance Assurances provide information or evidence about the effectiveness of the controls. An assurance description needs to state what the source of assurance is and more importantly information the assurance is providing and, if possible, the time period to which it relates.

Identify your current risk score (likelihood x consequence as described above), taking in to account existing controls and assurances and whether the controls have reduced the likelihood or impact of the risk.

5.8 Target Risk Rating

Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved and what further resources may need to be allocated to reduce the risk. This is included on the risk assessment form as the Actions. The Actions is the fundamental driver of mitigating a risk and requires timeframes and action owners.

To achieve the target risk rating, Actions MUST be evident.

Risk consequence descriptors examples:

Domains	Consequence Score (Severity Levels) - Examples				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Safety **Patients, staff or public (physical /psychological harm)**	• Minor Harm • Requiring no/minimal intervention or treatment. • No time off work	• Short term injury or illness, < 1 month. Requiring minor intervention • Increase in length of hospital stay by 1-3 days • Requiring time off work for >7 days	• Semi-permanent harm, 1 month to 1 year. Requiring professional intervention • Increase in length of hospital stay by 4-15 days • An event which impacts on a small number of patients • Requiring time off work for 8-14 days • RIDDOR/agency reportable incident	• Major permanent loss of function – for a patient unrelated to natural course of illness/underlying condition/pregnancy etc. • Increase in length of hospital stay by >15 days • Requiring time off work for >14 days	• Unanticipated death, multiple permanent injuries. • An event which impacts on a large number of patients – eg breast screening errors.
Quality	• Peripheral element of treatment or service suboptimal	• Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on.	• Non-compliance with national standards with significant risk to patients if unresolved • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted on • Gross failure to meet national standards
Complaints	• Informal complaint/inquiry	• Formal complaint (stage 1) • Local resolution	• Formal complaint (stage 2) • Local resolution (with potential to go to independent review)	• Multiple complaints/ independent review	• Inquest/ombudsman inquiry
Human **Resources**	• Short-term low staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory/ key training	• Non-delivery of key objective/service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training /key training on an ongoing basis
Statutory Duty and inspections	• No or minimal impact or breech of guidance/ statutory duty	• Breech of statutory legislation	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action Multiple breeches in statutory duty • Improvement notices	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Severely critical report

Reputation	• Rumours	• Local media coverage	• Regional media coverage	• National media coverage for <3 days. Increased level of political & public scrutiny.	• National media coverage for >3 days. • MP concerned (questions in the House) • Total loss of public confidence • Chair/CEO &/or Exec team removal.
Service Delivery	• Service disruption that doesn't affect patient care - >1 hour	• Short disruption to services that affects patient care - >8 hours	• Sustained period of disruption to services - >1 day to 1 week	• Intermittent failures in a critical service - >1 week	• Breakdown or closure of a critical service.
Financial Loss	• No or minimal impact on cash flow • Loss of <0.1 percent of Trust's annual budget • Some adverse financial impact affecting the ability of the service to operate within its annual budget. • Low risk of claims.	• Readily resolvable impact on cash flow • Loss of 0.1–0.25 per cent of Trust's annual budget • Noticeable adverse financial impact affecting the ability of the directorate to operate within their annual budget. • Claims up to £100k	• Individual supplier put Trust "on hold" • Loss of 0.25–0.5 per cent of Trust's annual budget • Significant adverse financial impact affecting the ability of the division to operate within their annual budget. • Claims £100k-£250k	• Major impact on cash flow • Loss of 0.5–1.0 per cent of Trust's annual budget • Uncertain delivery of key objective. • Significant adverse financial impact affecting the ability of the organisation to achieve its annual financial plan. • Claims £250k-£500k	• Critical impact on cash flow • Loss of >1 per cent of Trust's annual budget • Non-delivery of key objective / specification. • Significant adverse financial impact affecting the long-term financial sustainability of the organisation • Claims >£500k
Business objectives and projects	• Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Environmental impact	• Minimal or no impact on the environment	• Minor impact on environment	• Moderate impact on environment	• Major impact on environment	• Catastrophic impact on environment

5.9 Risk Source

A range of information sources can be used to identify risks. These include, but are not limited to: adverse events, incidents, near misses, serious incidents, investigation reports, complaints, claims, risk assessment, audit/internal control reports, assurance framework, CQC standards, legislation, financial reports, workforce reviews, survey reports and stakeholder reviews.

Although the above list is not exhaustive, it provides an indication of the various sources of information used to identify risks and types of risk that may impact upon the delivery of services. It is important to be rigorous in the identification of sources and impacts as the risk treatment strategies will be directed to sources (preventive) and impacts (reactive).

It is particularly helpful to include actual evidence to support the risk description. This could be the result of an increase in particular incident reports or complaint, poor audit results, unsatisfactory external review or a nationally recognised problem. This information can be added to the 'Supplementary Information' section on the risk assessment form.

5.10 Update and Management of Risks

The management of a risk is the key to mitigation, therefore risk rating makes it easier to understand the Trust-wide risk profile. It provides a systematic framework to identify the level at which risks will be managed and overseen in the organisation; prioritise remedial action and availability of resources to address risks; and direct which risks should be included on the Trust's risk register. The table below provides guidance on the urgency of actions to mitigate the risk and clarifies reporting and oversight arrangements.

Rating of risk	How the risk should be managed – *All risks should be added to the Risk Register on Datix straight away and be manged through this means.*
Extreme (15-25) Risk to be reviewed on a monthly bases*	**Requires immediate and active management with robust contingency plans (Action Plan)** High impact / High likelihood: risk requires immediate active management to bring down the likelihood of the risk, thus allowing the activity to continue. A robust Action plan must be put into place, with realistic timeframes and allocated Action Lead to mitigate/reduce the risk likelihood. ***Must Do's:*** Inform/escalate and discuss the risk immediately with the Divisional Tri, Directorate Manager, Speciality Manager and Governance & Risk Co-ordinator. This risk will need to be monitored through Specialty, Directorate and Divisional Governance Meetings monthly until the Likelihood score is reduced.
High (8-12) Risk to be reviewed on a one to two monthly basis*	**Contingency plans** A robust Action plan must be put into place, with realistic timeframes and allocated Action Lead to mitigate the risk straight away and this needs to be monitored through Specialty, Directorate and Divisional Governance. ***Must Do's:*** Inform/notify and discuss the risk with the Governance & Risk Co-ordinator, Speciality Manager, and Directorate Manager and finally the Divisional Tri/Quad through the Divisional Governance Meeting monthly. Risk to be reviewed one to two monthly at Specialty and Directorate Governance Meeting
Moderate (4-6) Risk to be reviewed three monthly basis*	**Good housekeeping** Will require risk mitigation through an Action Plan, this will reduce the likelihood, but the main area is good housekeeping to ensure the impact (likelihood) remains low. Reassess frequently to ensure conditions remain same and do not escalate. ***Must Do's:*** Inform the Governance & Risk Co-ordinator and Specialty Manager and review through Speciality Governance Meetings at least three monthly.
Low (1-3) Risk to be reviewed on a six monthly basis*	**Review periodically – Theses risks generally sit under Local Risks** Risks are unlikely to require many mitigating actions but status should be reviewed frequently to ensure conditions have not changed. ***Must Do's:*** Inform Governance & Risk Co-ordinator, Ward or Department Manager and Specialty Manager and Review through Speciality Governance Meetings at least three monthly.

** This is the official review timings of risk - however you must never lose sight of risks at whatever level they sit at, as risks can significantly change (escalate or de-escalate) on a daily, weekly and monthly basis, dependant of the service need, sources of information (Incidents, SI's, Never Events, Near Misses, Complaints, Claims, Health and Safety), new National Guidance and front door activity.*

Irrespective of the score it is important that the key individuals responsible for advising and coordinating specific risk issues are kept informed of new risks or changes to existing risks (this is not an exhaustive list and advice should be sort by whomever the expert is where the risk is identified or has an impact).

All risks must be reviewed at the appropriate meeting for oversight, progress check and challenge as required. For example, any risks on the Divisional Risk register should be discussed at the Divisions Governance meetings.

If concern is raised that a risk can no longer be managed within their area, this needs to be formally escalated for consideration. This can be undertaken electronically using the escalation tab. It is then for the risk owner to discuss and determine whether it is appropriate to accept that risk onto the register.

When risks are reviewed as part of the governance structure within the Specialty, Directorate or Division, the following questions should be incorporated during the review:

- Is the risk still relevant (what changes have occurred in the internal/external environment)?
- How do I know the controls have been effective – have there been any internal or external reports to provide assurance?
- What progress has been made in managing the risk?
- Given the progress (or not), does the risk score need revising?
- Are any further controls required, if so what should these be?
- Are the actions still relevant or are there any further that are required?

5.11 Control Considerations

Terminate the risk. The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently. However, this option is limited and rarely an option in the NHS (compared to the private sector), where many activities with significant associated risks are deemed necessary for the public benefit, this may be possible for some non-core activities or some actives that have so much risk involved it is not deemed in the best interests of the organisation, staff, patients or contractors. The Executive Management Team are the only designated people who can agree to terminate a risk.

Tolerate/accept the risk. Applies to risks within the tolerance threshold or those where the costs of treatment far outweigh the benefits. If the decision is made to tolerate the risk, consideration should be given to develop and agree contingency plans, business continuity plans or recovery plan arrangements for managing the consequences if the risk is realised. The Executive Risk Management Meeting are the only means to agree tolerating a risk, whereby they will make the risk 'Accepted'.

Transfer the risk. Risks may be transferred in their entirety* or in part, for example by conventional insurance or by subcontracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets or Estates. It should be noted that responsibility can be transferred, accountability rarely can and therefore the risk continues to need close monitoring. * It is important to note that reputational risk cannot ever be fully transferred.

Treating the risk. This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level.

5.12 Actions

Actions must be documented within the risk on the Risk Register and be SMART (Specific, Measurable, Achievable, Realistic and Time-bound), have a nominated owner and progress monitored by the appropriate risk forum and provide:

- Containment action (lessen the likelihood or consequence and apply before the risk materialises), or
- Contingent actions (put into action after the risk has happened, i.e. reducing the impact, must be pre-planned).

5.13 Assurance

Assurances confirm that the controls in place are effective and having the anticipated impact in reducing and mitigating risks. For example, intelligence data such as incident reports may indicate that a control that is in place is not effective. A gap in assurance is where there is no source of evidence to assess the effectiveness of a control.

Any identified gaps in controls or assurances might require additional controls or action to be taken to reduce the risk. The Trust Board expects all reasonable steps to be taken by all staff and particularly managers to reduce impact and likelihood of risk, particularly for those risks that are rated moderate and high risk.

The most objective assurances are derived from independent sources and these are supplemented from non-independent sources such as clinical audit, internal management reports and self-assessment reports. If there is a lack of relevant reviews, or concerns about the scope or depth of reviews this should be recorded on the Risk Assessment form as a gap in assurance.

Internal sources of assurance	External sources of assurance
• Internal audit reports • Performance reports to Board and its Committees • Local counter fraud work • Clinical audit • Staff satisfaction surveys • Staff appraisals • Training records • Results of internal investigations • Serious Incident reports (SI's) • Complaints records • Infection Prevention Control reports • Annual Health Check self-assessment • Information governance toolkit self-assessment • Patient advice and liaison services (PALS) reports • Human resource reports • Internal benchmarking • Local Security Management Specialist (LSMS) work • Patient environment action team (PEAT) reports • Health and safety reports • Maintenance records	• External audit • Audit Commission • NHS Resolution Risk Management Standards • Strategic health authority reports/reviews • Care Quality Commission hygiene code reports • Care Quality Commission inspections and reviews • OFSTED • HSE Reports • Royal College visits • Deanery visits • External benchmarking • Accreditation schemes • National and regional audits • Peer reviews • Feedback from service users • Feedback from CCG • External advisors • Local networks (for example, cancer networks) • Investors in People • Patient Reported Outcome Measures

5.14 New Risk Approval and Validation

Once new risks have been added onto the Risk Management System (Datix), all risks should be approved at Specialty and Directorate Risk/Governance Meetings prior to final approval at Divisional Risk Meetings.

5.15 Closing a Risk

If it is identified that a risk is no longer required to be managed on the risk register, this needs to be formally discussed and agreed (as per the meeting structures described above) and documented on the risk. Once it is agreed, the rationale for closure will need to be submitted onto the risk management system by the risk owner.

5.16 Risk Appetite

Risk appetite is the level of risk the Trust Board is willing to tolerate, based on the types of risks faced and the environment in which the Trust operates. The Trust will measure, monitor and adjust as necessary, the actual risk position of individual risks against the agreed risk appetite.

The Trust Board will adopt a risk appetite statement, reviewed annually, setting out the level of risk it is willing to accept in seeking to achieve its purpose and strategic objectives.

The Trust's risk appetite statement will be made available on the Intranet, and will make clear the Trust Board's expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable.

The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk. The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls.

6 TRAINING

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this framework will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trusts Statutory and Mandatory Training Policy which can be accessed on the Learning and Development pages on the Trust intranet.

Specific training will be provided in respect of high level awareness of risk management for the Board. Risk awareness sessions are included as part of the Board's development programme.

Training will be available on risk assessment, particularly the scoring or grading of risks and how to use the risk register.

7 IMPLEMENTATION

This policy will apply to all staff and will be available on the Trust Intranet for information.

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trust's monitoring arrangements for this document.

Registered Audit Reference Number: [Insert reference number here]

Aspect of compliance or effectiveness being monitored	Monitoring Method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group/ committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
An annual audit of Risk Management and annual reviews of the BAF and the Statement on Internal Control.	Internal Audit undertakes a risk- based Programme of audits agreed with the Trust which provides independent assurance.	Internal Audit	Annually	Audit Committee	External Audit
Full breadth of risks identified	Monitor the range of risk descriptors on department, divisional and departmental risk registers.	Risk Management Team	Monthly and Bimonthly	Executive Risk Management Meeting, and Specialty, Directorate and Divisional Governance Meetings	Risk Facilitator

9 RELATED TRUST DOCUMENTS: POLICIES / PROCEDURES / GUIDELINES

- Business Continuity Policy
- Claims Handling Policy
- Concerns and Complaints Policy and Procedure
- Fraud, Bribery and Corruption Policy
- Information Risk Policy
- Health and Safety Policies – to include the Health and Safety Policy and the Infection Control Policy

10 REFERENCES

- Management of Risk in Government January 2017
- NHS Audit Committee Handbook Version 4 2019
- Code of Governance for NHS Provider Trusts 2022
- NHS Providers - the essentials of risk management - 2023

11 EQUALITY IMPACT ASSESSMENT

The Equality Impact Assessment has been completed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

12 APPENDICES

Appendix 1 – Categories of Risks
Appendix 2 – Equality Impact Assessment Tool

Appendix 1- Categories of Risks

Risks to patients

- The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

Organisational risks

- The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

- The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.

- A range of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

Reputational risk

- The Board of Directors models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

Opportunistic risks

- 6. The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Integrated Business Plan, whilst respecting and abiding by its statutory obligations.

- Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure safety and quality is maintained.

Appendix 2 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Transgender	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.