Shropshire Community Health
NHS Trust

Policies, Procedures, Guidelines and Protocols

Document Details	
Title	**Risk Management Strategy**
Trust Ref No	1349
Local Ref (optional)	
Main points the document covers	This strategy sets out the framework for managing all types of risk within the Trust including the roles and responsibilities of key persons and committees, risk assessment, recording risks on the risk register, training, and communication.
Who is the document aimed at?	All staff, those at all levels who manage functions within the Trust
Author	Director of Governance
Approval process	
Approved by (Committee/Director)	Audit Committee
Approval Date	17 June 2024
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N
Lead Director	Director of Governance
Category	Governance
Sub Category	Risk Management
Review date	June 2027
Distribution	
Who the policy will be distributed to	Key managers, available to all staff
Method	Via Trust Intranet and notification to managers
Keywords	Bed rails, Bumpers, Grab handles, risk assessment
Document Links	
Required by CQC	Yes
Other	Risk assessment is required as part of the management of Health and Safety at Work Regulations and specific assessments are required as part of other H&S regulations, e.g. COSHH, Manual Handling regulations

Amendments History		
No	Date	Amendment
1	22/03/17	Current added to rating on escalation table
2	02/07/2019	General update re roles and responsibilities
3	07/10/2019	Inclusion of Trust Risk Appetite Statement and risk categories. Updates on roles and responsibilities
4	18/07/2024	Review of entire policy, amendment to risk register escalation triggers, removal of risk appetite statement as reviewed annually and therefore signposting to document instead, update of roles and responsibilities

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1. Introduction

The International Standards Organisation, in its global risk management standard, ISO 31000 (2018), defines risk as *"the impact of uncertainty on objectives",* and risk management as *"coordinated activities to direct and control an organisation with regard to risk".* While risk is understood in terms of negative consequences and failure to achieve objectives, risks can sometimes represent an opportunity, as well as a threat.

ISO define risk management processes as the *"systematic application of management policies, procedures and practices to the tasks of communication, consultation, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk".*

Shropshire Community Health NHS Trust Board is committed to ensuring that it has in place structures that will effectively manage risks of all kinds to a level which is in line with its strategic aims and objectives.

The policy will support the understanding of current and future risks to the organisation, ensuring that risks are appropriately identified and reduction/mitigation strategies developed to address the risks. Further it sets out how the Trust Board will gain assurance that the controls in place to reduce those risks are working effectively.

To ensure that this document remains current and reflect the organisation's requirements, it will be reviewed by the Executive Team on an annual basis and ratified by the Audit Committee at least once every three years, and whenever significant changes to practice are proposed.

2. Purpose and Scope

The purpose of this document is to detail the risk management framework through which the Trust identifies and controls risks affecting its key functions and the quality of its services and furthermore, to fulfil regulatory and statutory requirements. Further it sets out the responsibilities for its implementation, the involvement of the Board, its sub-committees and other relevant committees and the recording and reporting of relevant risks.

The Risk Management Strategy applies to all substantive and temporary staff working at the Trust and covers the identification and management of all risks which will fall into the following categories. Risks relating to the Trust's emergency preparedness, resilience, and response (EPRR) may be identified in line with the Trust's EPRR Strategy and these will be recorded against the appropriate category:

Risk	Description
Clinical	Risks affecting the quality of care and treatment provided to patients, encompassing patient safety, clinical effectiveness, and patient experience.
Workforce	Risks relating to the trust's ability to recruit, retain, and develop a high-performing workforce in both clinical and non-patient facing roles, and to provide a supportive working environment.
Health and Safety	Risks which do not have the ability to directly affect individual patient care or harm the patient in a clinical or treatment focused way but may affect patients and others on site such as visitors, contractors, and staff, e.g. fire, security, environmental and health and safety issues.
Financial	Risks which could affect the financial wellbeing of the Trust, including risk of fraud and claims against the Trust. This also includes protecting intellectual property.
Information Governance	Risks which pose the possibility of a breach of confidentiality, either personal or professional (e.g. leak of information sensitive to the Trust)
Reputational	Risks which affect the reputation of the Trust and its relationships with partner organisations within the health care system
Compliance	Risks of failing to fulfil the requirements of external regulators and auditors

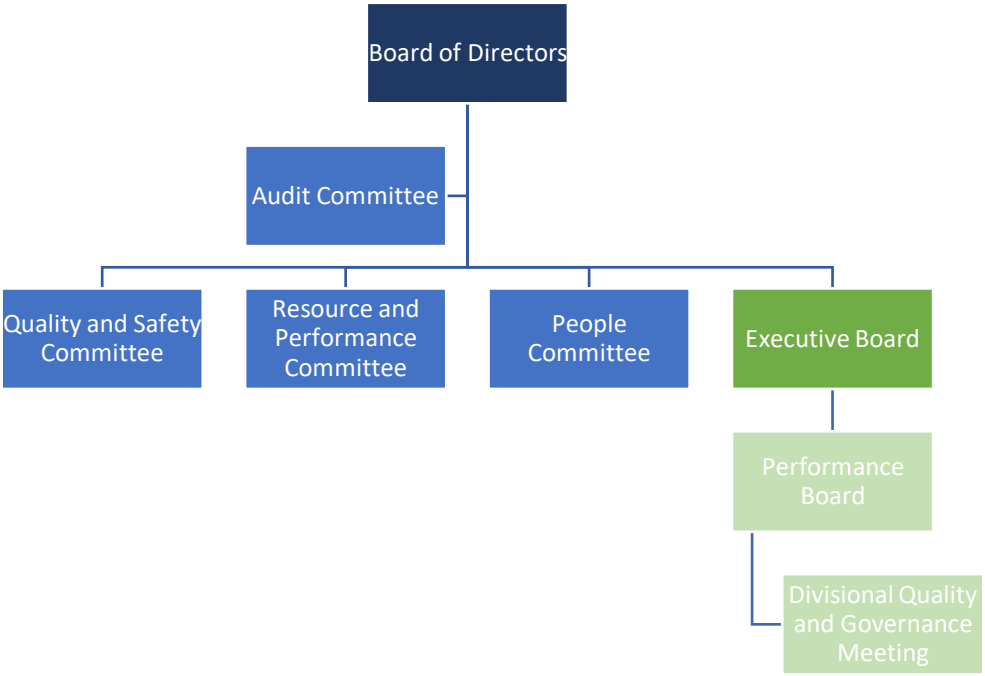
In addition to the above risks will be categorised into the following categories for population on to the risk registers.	
Strategic	Risk regarding the long-term strategic objectives of the trust. They can be affected by such areas as capital availability, political, legal, and regulatory changes, and reputation. These will usually be identified at Board, or Executive level ('top down')
Operational	Risks regarding day-to-day issues which will mostly be identified by departments or divisions ('bottom up') but that may be escalated to executive or board level if they are sufficiently serious. They may also become strategic risks if they may prevent achievement of the trust's strategic objectives.

3. Definitions

The following terms are used within this document:

Assurance	Evidence that the risk controls are being implemented effectively
Board Assurance Framework	The framework for managing risks that have potential to impact on delivery of the Trust's objectives
Risk	A circumstance that could cause harm to individuals or the organisation, expressed as the level of harm multiplied by the likelihood that the harm will occur
Risk Control	Measures in place to mitigate the risk either by reducing the level of harm or the likelihood of harm or both
Risk Handler	The trust officer responsible for leading on the day-to-day management of the risk
Risk Owner	The trust officer responsible for ensuring an identified risk that has been allocated to them is managed in line with this document. Risk owners will normally be executive directors or senior managers of the trust.
Initial Risk Rating	The consequence and likelihood rating of the risk if no risk controls were in place
Current Risk Rating	The consequence and likelihood rating after the risk controls have been put in place
Target Risk Rating	The lowest consequence and likelihood rating that can be achieved with all controls in place. This should align with the Trust's risk tolerance statement.
Tolerated Risk	The identification of a risk as having been mitigated to the lowest level possible in line with the Trust's risk tolerance statement
Treated Risk	The identification of a risk that requires 'treatment' that is further controls to be put in place to mitigate it to a tolerable level

2 Organisational structure, duties, and responsibilities



4.1 Committee Responsibilities

Clear lines of reporting and accountability are essential for effective risk management, and clarity about roles and responsibilities promotes a culture of transparency in decision-making. The Trust has a hierarchy of reporting arrangements to ensure the Board receives evidence-based assurance in relation to strategic and operational risks.

The specific responsibilities of each Board / Committee are outlined below:

4.1.1 Board of Directors

The Board will receive the Board Assurance Framework (BAF) at each meeting. The Board will consider whether the risks on the framework reflect the risks to Trust objectives and whether additional assurance is required. It will consider the risk associated with the entries especially in relation to its management decisions which impact on the risks on the Framework. The Board will receive the Corporate Risk Register to support its considerations of the BAF. In addition, the Board will receive a Chair's Report for each of its Assurance Committees which will identify any risks for escalation.

4.1.2 Audit Committee

The Audit Committee provides an overarching governance role and reviews the work of other governance committees and processes, including the establishment and maintenance of risk management and internal control. It will use the Board Assurance Framework to guide its work. The Committee will review the Board Assurance Framework entries at each meeting and will make recommendations to the Board relating to its findings on the management of the risks associated with the entries and the assurance it has received. It will raise to the Board or relevant Committees if it believes additional assurances are needed. The committee will consider the Corporate Risk Register at each meeting.

The Audit and Risk Committee also oversees the work of internal audit, external audit, the local counter fraud service, as well as the role of trust management in maintaining internal control and ensuring compliance with laws and regulations.

The Audit and Risk Committee is chaired by a Non-Executive Director and membership consists solely of Non-Executive Directors. Executives are invited to attend.

4.1.3 Board Assurance Committees (Quality and Safety Committee, Resource and Performance Committee, People Committee)

The Board has established several other committees covering topics such as quality, finance, and workforce. Those committees oversee strategic risks relating to their remit, as defined in their terms of reference, primarily through scrutiny of the Board Assurance Framework. In addition, they will receive the high operational risks relevant to its remit for consideration and scrutiny.

4.1.4 Executive Board

The Executive Board is responsible for maintaining oversight of delivery of the Trust's Risk Management Framework and for identifying any emerging risks for consideration and action. Members of the Executive Team are responsible for developing, maintaining, and monitoring the entries on the Corporate Risk Register for which they are the leads. The Director of Governance will co-ordinate the maintenance and update of the Board Assurance Framework with the relevant Executive Members.

4.1.4 Performance Board

In order for the Executive Board to fulfil its responsibilities in relation to risk management it has a monthly meeting with the Performance Board to oversee the management of risks and the identification and escalation of any emerging risks. Each division and corporate team present to the Performance Board on rotation, and this is a key part of the Ward to Board escalation of risks. It also ensures that there is a common approach to risks that cut across department or divisional boundaries and avoid duplication.

4.1.5 Divisional Quality and Governance Meeting

This is a divisional level meeting that oversees local risk management through the following:

- Monitoring the risk register by exception, with a focus on new risks, closed risks, risks overdue for review, and risks whose score has remained unchanged or not reached their target scores for more than twelve months
- Ensuring that risk is managed effectively in departments by means of deep dive reviews of local risk registers
- Discussing the outcomes of assessments of the risk management process, e.g. internal audit reports, and ensuring that their recommendations are implemented promptly and fully
- Adding to the Corporate Risk Register significant operational risks which cannot be managed locally within a division, and require involvement by one or more executive directors
- De-escalating risks from the Corporate Risk Register to divisional risk registers when they have been mitigated such that they no longer require corporate-level oversight
- Contributing to identification and review of strategic risks for inclusion in the Board Assurance Framework
- Developing a training needs analysis for risk management and monitoring levels of participation in the training

3.2 Individual Responsibilities of Key Personnel

All staff are responsible for identifying, reporting, and escalating risks and incidents promptly, thereby allowing risks to be managed and added to the risk register. In addition, staff are responsible for taking steps to avoid injuries and risks to patients, staff, and visitors. Specific duties and roles of key individuals in the risk management process are summarised below:

4.2.1 Chief Executive

The Chief Executive is the accountable officer for the management of risk with the Trust. They are required to sign an Annual Governance Statement, outlining the Trust's governance and assurance systems, and a Statement of Accounting Officer's Responsibilities which are submitted to NHS England, and published in the Trust's Annual Report. The Chief Executive is responsible for ensuring that the Executive Directors meet their risk management responsibilities detailed below.

4.2.2 Chair of the Committee
There is a named Non-Executive Director who has responsibility for risk management and chairs the Audit and Risk Committee.

4.2.3 *Director of Nursing, Quality and Clinical Delivery*
The Director of Nursing, Quality and Clinical Delivery has joint lead responsibility with the Medical Director for ensuring that there are arrangements in place to identify, mitigate and monitor risks associated with clinical care and treatment.

The Director of Nursing, Quality and Clinical Delivery has individual responsibility for compliance with the CQC fundamental standards and is the Director for Infection Prevention and Control (DIPC). They also lead on safeguarding issues at executive level and are the Accountable Officer for emergency preparedness, resilience, and response at executive level. They are the vetted member of the Local Resilience Forum 'Risk Assurance Working Group' who review the National Security Risk Assessment and Community Risk Register and ensure community and national risks are fedback to the organisation as part of the Trusts statutory EPRR provision.

4.2.4 Medical Director
The Medical Director has joint lead responsibility with the Director of Nursing, Quality and Clinical Delivery for ensuring that there are arrangements in place to identify, mitigate and monitor risks associated with clinical care and treatment.

The Medical Director is the Trust's Caldicott Guardian and has a responsibility for ensuring risks relating to patient information are managed appropriately. They are also the accountable lead for controlled drugs.

4.2.5 Director of Finance
The Director of Finance will ensure that there are arrangements in place to identify risks associated with finance, performance, strategy, estates, information and digital. Further, the Director of Finance will ensure that there are mitigation measures necessary to control the risk in place that these measures are monitored.

4.2.6 Director of Workforce and Organisational Development
The Director of Workforce and Organisational Development is responsible for the management of risk in relation to staff, including safe recruitment processes, negotiation with staff side, co-ordination of training and development programmes, and the adoption of human resources policies which enable the trust to comply with employment law.

4.2.7 Director of Operations
The Director of Operations is responsible for the performance and day-to-day management of the trust's clinical services, including their compliance with constitutional standards and patient access targets, and is therefore responsible for the management of risks relevant to their portfolio.

4.2.8 Director of Governance / Company Secretary
The Director of Governance will ensure that there are arrangements in place to support the application of the Risk Management Strategy and to monitor its effectiveness. They will be responsible for ensuring that systems are in place to monitor the Board Assurance Framework and the Corporate Risk Register and will assist with the moderation of risk at these levels. The Director of Governance is also the trust's Senior Information Risk Owner (SIRO)

As the lead for corporate governance the Director of Governance is responsible for:

- Ensuring compliance with the Constitution
- Accessing legal advice where appropriate
- Maintaining the Trust Policy Database, to ensure version control, and Records Management
- Drafting the Annual Governance Statement and the Board Assurance Framework
- Maintenance of appropriate insurances and indemnities
- Ensuring compliance with Freedom of Information

4.2.9 Associate Director of Governance

The Associate Director of Governance has operational responsibility for providing support to staff and managers with the application of this document. They are responsible for the maintenance of the systems supporting good risk management including the upkeep of the Risk Registers, the Trust's programme of risk management training, and for line management of the Governance Team.

4.2.10 *Health and Safety Manager*

The Health and Safety Manager oversees the management of health and safety risks within the Trust and provides expert advice to managers to maintain best health and safety practice. The Health and Safety Manager acts as a Trust link with the Health and Safety Executive (HSE) and ensures Trust wide health and safety audits are undertaken and action plans carried forward within the business units. The Health and Safety Manager will ensure RIDDOR reportable adverse incidents are reported to the HSE and identifies trends to mitigate recurrence.

4.2.11 Divisional / Departmental / Service Managers

Divisional / Departmental / Service Managers are responsible for ensuring Risk Registers for the areas they control are in place and kept up to date and that they identified risk controls are implemented and followed. They will ensure that risks are escalated according to the process detailed in this document.

4.2.12 Governance Managers

The Governance Managers are responsible for supporting the Divisional Managers with the implementation of this policy, for acting as a link between the Divisions and the Governance Team, and for promoting good governance within the Divisions.

4.2.13 Risk Owner

Identified Risk Owners are responsible for ensuring an identified risk that has been allocated to them is managed in line with this policy. Risk owners will normally be Executive Directors or senior managers of the Trust.

4.2.14 Risk Handler

Identified Risk Handlers are responsible for the day-to-day management of identified risks that have been allocated to them. There may be occasion when a Risk Handler is also the Risk Owner of the same risk.

4.2.15 All Trust Employees

All employees of the Trust have a responsibility to:

- Work in accordance with corporate policies and procedures
- Practice within the standards of their professional bodies, relevant national standards and trust clinical guidelines
- Identify through their own departments self-assessment process and line management arrangements, any risks which they feel exist within the service and their practice
- Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided
- Attend Corporate Induction and participate in mandatory training

5 Approach to Risk

The Trust will adopt both a proactive and reactive approach to risk management as follows:

5.1 Pro-active Approaches to Risk Management

- Developing and maintaining the BAF and Risk Registers
- Ensuring a consistent approach to risk assessments/development of Risk Registers
- Developing policies and procedures, as well as a process to keep them up to date and monitor their implementation
- Risk assessments required by legislation such as Management of Health and Safety at Work Regulations

- Maintaining an effective Safety Alert System
- Clinical Audit
- Emergency Planning, Preparedness and Resilience arrangements
- Dissemination of newly published National Institute of Clinical Excellence (NICE) guidelines and completion of gap analyses and action plans
- Ensuring training and development of staff

5.2 Reactive approaches to Risk Management

- Learning from patient safety incident investigations and serious data breaches and making improvements
- Learning from complaints and Patient Advice and Liaison Service (PALS) contacts and making improvements
- Making changes in response to litigation brought successfully against the trust, or to coroner's reports
- Implementing recommendations from National Enquiries, internal/external reviews/recommendations etc
- Implementing legislative changes and NHS national policy directives
- Using information in public domain published by the regulatory bodies such as the CQC
- Implementing recommendations from external or internal audit findings or external body inspections
- Sharing of post incident and post EPRR exercise reports within the local Health Resilience Partnership and review of identified lessons from NHS England's regional lessons and good practice register to ensure organisational improvements and recommendations are followed

5.3 Risk Appetite and Tolerance

5.3.1 Risk Appetite

Risk appetite is defined as *"the level of risk an organisation is prepared to accept in pursuit of its objectives."*

Our aim is to ensure an appropriate balance between uncontrolled innovation and excessive caution, while guiding staff on the level of risk permitted and encouraging a consistent approach.

The Trust Board reviews the organisation's risk appetite on an annual basis to provide direction on its appetite for taking or accepting different types of risk using guidance from the Good Governance Institute (see Appendix One). This provides guidance to Risk Owners and Handlers on the extent to which different types of risk can be accepted, mitigated, or avoided.

The Trust's Risk Appetite can be found at SCHT Staff Zone (shropcom.nhs.uk) and this is also available via Datix.

5.3.2 Trust's Risk Appetite Statement

'Shropshire Community Health NHS Trust will seek to prevent, mitigate, cope with, transfer, accept and/or reject risks which have the potential to;

- *Adversely impact reputation of the Trust*
- *Expose patients, staff, visitors, and stakeholders to harm*
- *Limit ability to deliver strategic and operational priorities*
- *Cause significant financial consequences which would jeopardise ability to deliver and carry out mandated priorities*
- *Cause non-compliance with the law and regulation*
- *Result in barriers to active engagement with system partners, research and innovation being embedded into shropcom culture'*

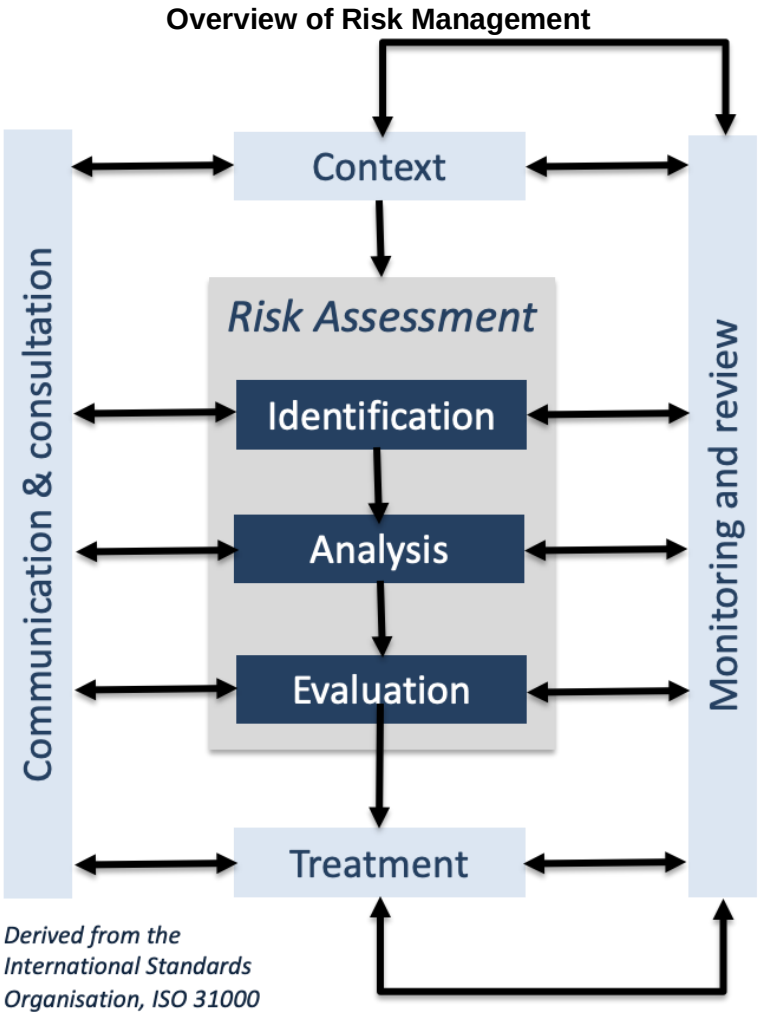
5.3.3 Risk Tolerance

Risk tolerance is defined as *'the level of risk an organisation is willing or able to endure in its day-to-day risk profile.'* The organisation may set its tolerance at different levels according to a number of factors, the type of risk, external factors and pressures, current performance etc.

The Trust's risk tolerance is assessed on an annual basis and is available at SCHT Staff Zone (shropcom.nhs.uk) and this is also available via Datix.

6 The Risk Management Process

An overview of the risk management process in use in the Trust is shown in the diagram below.



6.1 Risk Identification

The Trust takes both a proactive and reactive approach to identifying risks using both internal and external sources.

- **Internal sources of risk** may include, for example: adverse incidents complaints or claims; non-compliance by the trust with legal duties; environmental hazards; obsolete or faulty equipment; ineffective communication channels, unclear policies, and procedures; etc.

- **External sources of risk** include, for example: the economic climate; cybersecurity threats; changes in national policy and legislation; also hazard warnings and recommendations received by the Trust from regulators - such as the Medicines & Healthcare Products Regulatory Agency (MHRA), National NHS England, Care Quality Commission, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE) , Local Health

Resilience Partnership (LHRP) Local Health Protection Group (LHPG) Risk Assessment Working Group (RAWG)etc.

For a further non-exhaustive list of risk considerations refer to Appendix Two.

5.2 Risk Assessment

All risks that are identified will be assessed using the Trust Risk Grading Matrix at Appendix Three. The risk assessment process may identify single or multiple risks that require the creation of a risk record(s) on the Risk Register.

Risk assessments should be carried out by a manager with suitable experience and knowledge of the subject. Risk assessments should be discussed with the appropriate managers and clinicians to agree actions to mitigate or reduce potential risks. The key steps in the process are as follows:

1. Identify hazards (a hazard is anything which has the potential to cause harm or loss)
2. Establish which hazards are most dangerous and to whom
3. Assess adequacy of existing controls (the measures already in place to reduce the level of risk)
4. Assess how likely the risk is it to occur and what the impact would be if it did
5. Multiply the likelihood score by the impact score using the matrix to define the level of risk
6. Assign responsibility for the risk to an appropriate senior manager or clinician
7. Devise plans to meet any shortcomings
8. Establish how changes can be introduced

When completing a risk assessment, it is essential to avoid describing an issue or concern. The description should outline in plain English the risk in terms of its cause and effect (impact), i.e. what is giving rise to the risk, and what may happen if the risk materialises.

All risk assessments will be reviewed by a Governance Manager before going live on the Risk Register. The Governance Manager will check that all sections of the assessment have been completed, that the risk is expressed clearly, and that the risk score (see 6.3 below) appears reasonable given what is known about the issue.

For risks originating in non-patient facing corporate services, which do not form part of a division and do not therefore have a Governance Manager, draft risk assessments should be reviewed by a senior manager within the department which has identified the risk, before going live on the Risk Register.

6.3 Risk Evaluation

Risks are evaluated to establish the level of risk as part of the risk assessment process above, using the following Risk Matrix which enables a systematic approach to risk evaluation. The level of risk is estimated by quantifying and combining consequences and likelihoods.

Risk Rating Chart

Injury/Harm	Finance	Service	Reputation	Consequence Score	Will undoubtedly occur, possibly frequently	Will occur but not persistently	May occur occasionally	Do not expect to happen but is possible	Cannot believe this will ever happen
Likelihood Score					Almost certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Very minor or no harm	Less than £10,000	No or very little impact on services	Some negative publicity	None 1	LOW 5	LOW 4	VERY LOW 3	VERY LOW 2	VERY LOW 1
Minor injury/illness (e.g. cuts and bruises) will resolve within a month	£10,000 to £50,000	Disruption of services causing inconvenience. May cause efficiency/ effectiveness problems	Regular negative publicity	Minor 2	MODERATE 10	MODERATE 8	LOW 6	LOW 4	VERY LOW 2
Injuries of illness which requires extra treatment or protracted period of recovery. Should resolve within a year	£50,000 to £500,000	Loss of service for a significant period of time (less that a month)	Loss of public confidence, protest action	Moderate 3	HIGH 15	MODERATE 12	MODERATE 9	LOW 6	VERY LOW 3
Single serious (life threatening) injuries/illness	£500,000 to £3.5m	Loss of services to such an extent that effects on public health will be measurable	Punitive action, e.g HSE, Healthcare Commission, significant organisational change results	Major 4	HIGH 20	HIGH 16	MODERATE 12	MODERATE 8	LOW 4
Multiple Serious (life threatening) injuries/illness	£3.5m plus	Permanent loss of a significant service. Threatens the viability of the organisation	Damage to such an extent that the organisation must cease to exist as is	Catastro-phic 5	HIGH 25	HIGH 20	HIGH 15	MODERATE 10	LOW 5

Three risk ratings should be calculated for each risk: initial, current and target:

- **Initial** risk rating reflects the level of risk in the absence of any controls. In other words, this is the *inherent* risk.
- **Current** risk rating reflects the level of risk considering the controls currently in place (this enables assessment of the effectiveness of the controls, and is sometimes known as the *residual* risk)
- **Target** risk rating is the level of risk that could realistically be achieved once further actions have been taken and extra controls put in place. The target risk rating should not be higher than the trust's risk tolerance for that type of risk

6.4 Risk Treatment

Once the risk has been identified and assessed controls must be put in place to manage the risk ensure that the severity of any risk is minimised to an acceptable level, i.e. within the Trust's agreed risk tolerance. Whatever action is to be taken should be documented in an action plan and recorded on the relevant Risk Registers alongside the risk assessment. The action plan should make clear who is responsible for the action and the deadline for completion. Actions should be SMART: specific, measurable, achievable, relevant, and time limited.

There are four main approaches to managing a risk:

- **Terminate** - some risks may only be managed by terminating them i.e. avoiding the risk by not undertaking the activity that leads to the risk occurring
- **Treat** – identifying and implementing additional controls to address any gaps identified and thereby mitigating the risk to a tolerable level
- **Transfer** – transferring the risk to a third party who will carry the risk on the trust's behalf, usually in return for payment, for example by taking out an insurance policy, or outsourcing a service.
- **Tolerate (accept the risk)** – where the current score of the risk is within the trust's risk tolerance levels and no further controls are necessary, or where the cost of reducing or eliminating the risk any further may be disproportionate and / or create significant new risks elsewhere. Where a risk is considered tolerable it should be recorded as 'tolerated' on Datix and reviewed annually thereafter to ensure the risk has not increased to a level that makes further action necessary

6.5 Risk Escalation

The current risk score will determine the level of the organisation the risk should be escalated to for oversight and management. All operational risks entered into Datix are held in one register that is then reported at departmental, divisional, and corporate level according to the level of risk. Risks directly affecting the delivery of the Trust's Strategic Objectives are recorded on and managed through the Board Assurance Framework. The table below sets out the appropriate level of escalation for each of the risk levels:

Risk Rating	Escalation	Responsible for Risk on Register	Risk Register Escalation
Green 1-3 Very Low Risk	Risk should be managed at local level	Departmental Managers	Department Risk Register
Yellow 4-6 Low Risk			
Orange 8-12 Moderate Risk	Report to Divisional Manager.	Divisional Manager	Divisional Risk Register
Red 15-25 High Risk	Report to Director	Executive Director	Corporate Risk Register
Strategic risks (any score)	Board of Directors	Executive Directors	Board Assurance Framework

A rolling programme of review is in place to ensure that the risks are captured, recorded, and scored correctly, mitigated to the greatest extent possible, and escalated to the right level of the organisation. The Risk Handler and Risk Owner are responsible for ensuring that the risk assessment is kept up to date as follows:

- The description accurately reflects the nature of the risk, who is affected and describes the consequence
- The controls stated are in place and effective
- The current rating is correct
- For a risk that requires treatment actions are in place and being progressed
- Where actions have been completed the controls in place have been updated to reflect this
- The risk is moved to tolerated when the target risk level has been achieved

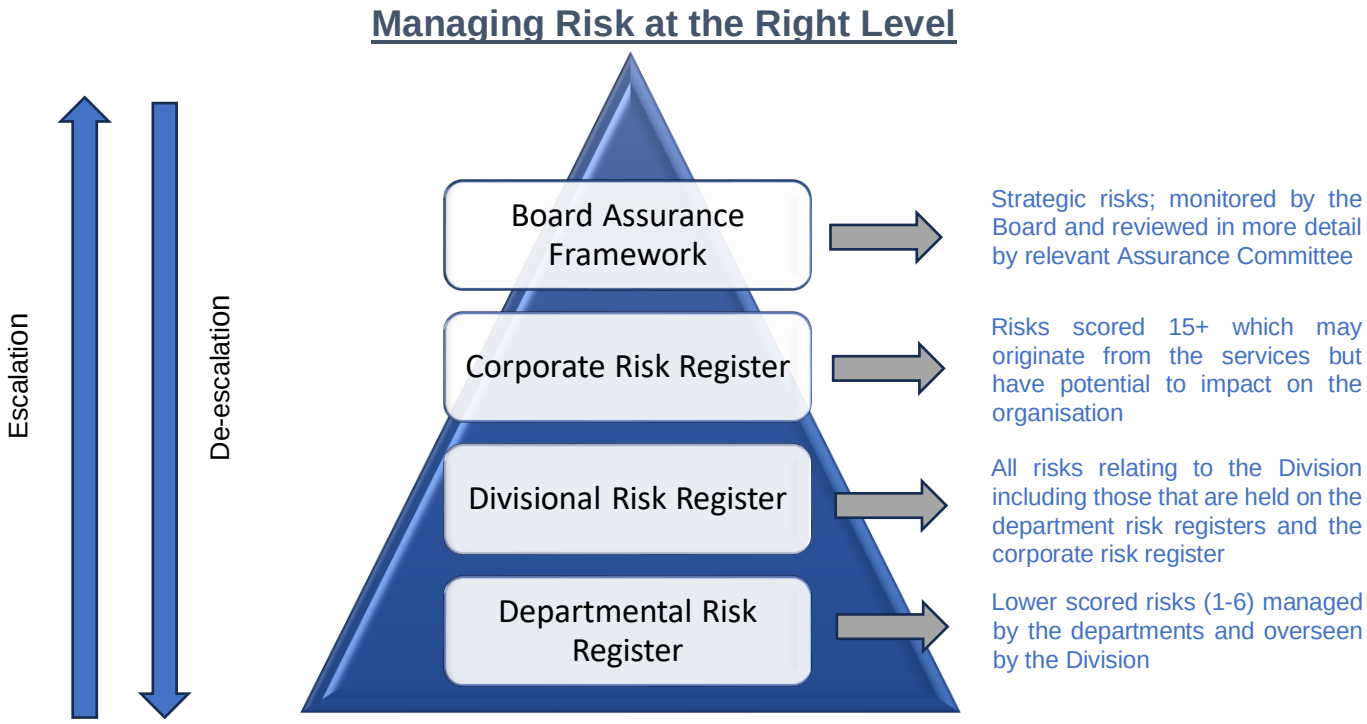
Further the Risk Handler and Owner are responsible for ensuring that the risk is reviewed at the following frequencies which have been determined according to the level of risk:

Risk Type	Score	Review Frequency
Very Low	1-3	Annually
Low	4-6	6 monthly
Moderate	8-12	Bimonthly
High	15+	Monthly
Tolerated	Any	Annually

7 Risk Registers

Risk Registers are vital tools which support management and review of risks and the prioritisation of risk reduction activities according to risk scores. The Risk Registers feed into the BAF where there is potential for impact on delivery of the Trust's Strategic Objectives. They are dynamic living documents which are populated through the organisation's risk assessment process and are updated regularly.

Datix is the organisation's risk management database system. It is used to record risk assessments and generate Risk Registers and other reports about the management of risks, incidents, complaints, and claims. It enables risks to be escalated to appropriate level of Risk Register. These are outlined in more detail below, and summarised in the following diagram:



7.1 Departmental Risk Register

This register relates to risks with a current risk rating of 1-6 and will be managed by departmental managers and escalated to the relevant Divisional Manager as and when required. These risks will be discussed at local team meetings.

7.2 Divisional Risk Register

The Divisional Risk Register includes all risks relating to the business unit irrespective of the risk level. However, the risks are escalated upwards through different levels of management according to the risk level. As outlined above, risks with a rating of 1-6 are managed at departmental level. Risk from 6-12 are managed by the Division. Any risks rated as 15+ remain the responsibility of the Division but also require escalation to Executive and Board level via the Corporate Risk Register.

Non-patient facing corporate services (finance, informatics, estates, human resources, communications, etc.) will also retain Risk Registers similar to a divisional Risk Register. These will be reviewed via local management arrangements and the risks will be overseen and escalated as appropriate to the Corporate Risk Register.

7.3 Corporate Risk Register

All new risks scored 15 or higher will be considered by the Executive Team for inclusion in the Corporate Risk Register (CRR) so that they can be monitored and managed at an organisation-wide level.

The Corporate Risk Register will be monitored by the Executive Team and will also be reported to the relevant Assurance Committees. The Audit Committee will have oversight of the management of the Corporate Risk Register and will report on this to the Board.

7.4 Risk Register Format

The Risk Registers, regardless of the level, must include the following information:

- Source of the risk (including, but not limited to, incident reports, risk assessments and local risk registers. These can be internal and external sources)

- Description of risk
- Categorisation of risk as strategic, operational or both
- Existing control measures
- Initial, current and target risk scores
- Action plan to manage the risk
- Date the risk was identified
- Review date of risk
- Risk owner and risk handler

8 The Board Assurance Framework

A Board Assurance Framework (BAF) is defined by HM Treasury as "*a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect."* The BAF brings together the trust's strategic objectives with the principal risks which may prevent those objectives from being achieved. It lists the controls in place to manage those risks, and how the Board obtains assurance that those controls are working effectively. It identifies any gaps in controls or assurances and includes an action plan to close those gaps. It is a robust, evidence-based, and objective document.

The BAF helps the Board to focus its scrutiny on the issues of greatest risk and shapes the work of the Board and its committees through their cycles of business.

It is maintained by the Director of Governance and reviewed at the Audit Committee at each meeting and by the Board of Directors quarterly. Other Board Committees scrutinise those strategic risks in the BAF which are relevant to their terms of reference.

9 Organisational Learning

The Trust will continue to promote an open learning culture so that we can learn from experience – including when things go wrong - and share local examples of good practice. In particular, analysis of themes and trends from incidents, complaints, litigation, and clinical audits can draw attention to emerging risks in the trust.

These are some of the ways in which the Trust learns from its risk management and governance processes:

- Adverse incidents, complaints and claims are triangulated in regular reports and discussed at the Quality and Safety Committee and disseminated to divisional management teams;
- National reports and external enquiries are reviewed at the Quality and Safety Committee or its sub-groups. A local action plan is drawn up and implemented in the Divisions;
- Adaptations to training programmes are made in response to learning from risks and incidents;
- Financial forecasts are adjusted in the light of identified risks; and,
- Identified groups consisting of executive directors and senior clinical managers receive daily or weekly incident reports.
- Through the Trust Lessons Identified and Good Practice Register for EPRR

10 Communication of the Policy

The Trust's Risk Management Policy will be made available on the intranet. Managers should make new staff aware of arrangements for risk management and governance in their departments through local induction. All staff are introduced to the principles outlined in the policy at Corporate Induction.

Amendments to the policy will be communicated as and when they occur.

11 Associated Documentation

This policy provides an overall framework for managing risks and there are areas where specialist risk management procedures must be followed such as; health and safety, violence prevention and reduction, infection prevention and control, safe moving and handling, control of substances hazardous to health,

incident management, prevention and management of falls, information governance. For further information on these specialist areas of risk management please refer to the policies for those areas.

12 Training

To ensure that all staff can access the training needed to fulfil their job roles and to develop professionally, the trust has a Learning and Development Policy. The training required for Risk Management is dependent on seniority and level of management responsibility. All staff will receive a basic awareness of risk management through mandatory training, while managers and clinical leaders will receive more tailored and in-depth training. Executive and Non-Executive Directors will be kept up to date with developments in risk management, and clinical governance more generally, through the Board Development Programme.

In addition to formal training, the Clinical Governance Team can provide ad hoc support with use of the Datix system and a risk management ‘how to’ guide will be made available.

Appendix 1 Risk Appetite Matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

WWW.GOOD-GOVERNANCE.ORG.UK

Appendix 2 Risk Considerations

- The Trust will review compliance with the Care Quality Commission (CQC) requirements on an on-going basis to identify any risks
- Effective health and safety audits and inspections and implementation of resulting action plans
- Each Director will be responsible for ensuring that departmental risk assessments are carried out, producing directorate Risk Registers and taking action to avoid/minimise risk as appropriate
- Regular multi-disciplinary review of incidents, complaints and claims data
- Patient and staff feedback surveys
- Public perceptions of the NHS e.g. media reviews
- Learning responses following significant adverse incidents, complaints, and claims
- Post business continuity incident reports and post exercise reports and structured debriefs
- Concerns raised by Trade Unions
- Whistle blowing
- Coroners' reports
- Financial forecasting and reports, Board Quality walkabouts
- New legislation and guidance
- Recommendation and reports from assessment/inspections from internal and external bodies
- Safety alerts
- Non-Clinical/Generic Risk Assessments completed by staff
- Incident Reports
- Serious Adverse Incident Reports
- Directorate Risk Registers (for the Corporate Risk Register)
- Health and Safety Audits
- Regular Health and Safety Checks e.g. Window checks, Fire Inspections
- Complaints
- National Guidance/Reports
- Patient’s conditions (e.g. inherent risk of falls in people with dementia)
- Major incident (exercise or live)
- Deficiencies with effective controls assurance standards
- Deficiencies with various elements of the CQC standards
- Recommendations and reports from external agencies such as NHSLA, Health and Safety Executive, Patient-led Assessments of the Care Environment (PLACE) etc
- Actions taken to reduce risks which could not be or were not implemented for various reasons such as resource limitations
- Any other sources of information that could be a threat to patient, staff, visitors, environmental safety, or the organisations wellbeing
- Estates risk profile
- Financial/business plans/IT reports
- Business continuity requirements
- Underlying causes related to poor trends identified from key performance indicators
- Considerable deficiencies in/non-compliance with staff mandatory training