Trust Strategy		

NHS Worcestershire Acute Hospitals NHS Trust

Risk Management Strategy

Department / Service:	Clinical Governance & Risk Management
Originator:	Sonia Lloyd, Interim clinical risk and governance lead
Accountable Director:	Vicky Morris, Chief Nursing Officer
Approved by: **Ratified by:** **Endorsed by:**	Risk management group (TLG) Quality Governance Committee Trust Board
Date of Approval: **Date Of Ratification:** **Date Endorsed:**	4th July 2018 19th July 2018 17th July 2018
Review Date: **This is the most current document and is to be used until a revised version is in place**	Every 3 years or sooner if circumstances dictate 27th January 2021
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Departments
Target staff categories	All Staff

Strategy Overview:
This strategy 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, 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 05	Revision with more detail about Risk Registers, targeted training, revised risk management objectives, Directorate Performance reviews etc.	C. Rawlings
Nov 06	Revision includes actions to meet the requirements of the pilot NHSLA Risk Management Standards, including the need for risk management strategies for all areas and a revised risk escalation process.	C. Rawlings

Jan 08	Editing to define the strategy and policy elements. Revision of the means of monitoring compliance with / implementation of this strategy. Revised 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
July 08	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 08	– 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 to replace Director of Operations. DoF associated with business risks and COO with business continuity risks.	C. Rawlings
Jul 09	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 09	Objectives revised and provided in appendix D	Executive Team
Jul 10	Minor changes made to: reflect operational structure and responsibilities and the extended life of the 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 12	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 12	Clarification of 6.3 training. Minor change approved by Chairman	C. Rawlings
Jul 14	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
Feb 15	Revised likelihood definitions and formatting of Appendix 3 Risk Scoring Matrix	J.King
Apr 15	Minor update following annual review, titles, committees and implementation plan updated.	J.King
Nov 16	Minor amendments to reflect the changes to the Trust governance structure and Trust Risk Officer post	W. Huxley Marko
April 17	Amendments to escalation process for adding risks to the Corporate Risk Register	C.Geddes
May 17	Amendments to objectives, references and risk description. Additions made to reflect changes to structure.	S Lloyd

April 18	Amendments to roles and responsibilities, the addition of risk profiling, updated objectives and updated references.	S Lloyd / C Geddes/V Morris
July 2020	Document extended for 6 months during COVID 19 period	QGC/Gold meeting

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List of Appendices

Introduction

1. Risk is an inherent part of the delivery of healthcare. This risk management strategy outlines the Trust's approach to risk management throughout the organisation.

2. Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.

3. This Board approved strategy for managing risk identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

4. Successful risk management involves:
   - Identifying and assessing risks
   - Taking action to anticipate or manage risks
   - Monitoring risks and reviewing progress in order to establish whether further action is necessary or not
   - Ensuring effective contingency plans are in place.

Aim

5. The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:
   - The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected.
   - The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Trust Board.

Scope

6. The objective of the Risk Management Strategy is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

7. The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels and they are expected to take an active lead to ensure that risk management is a fundamental part of their operational area linking ward/ Dept. risks through to corporate risks and reference to the Board assurance Framework.

8. The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.

9. Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance and the organisation will provide ongoing risk management training to ensure adequate awareness and skills for staff at all levels to manage risk effectively

Risk Statement

10. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

11. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

12. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

13. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

14. Senior management will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

15. Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

16. All Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

17. Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.

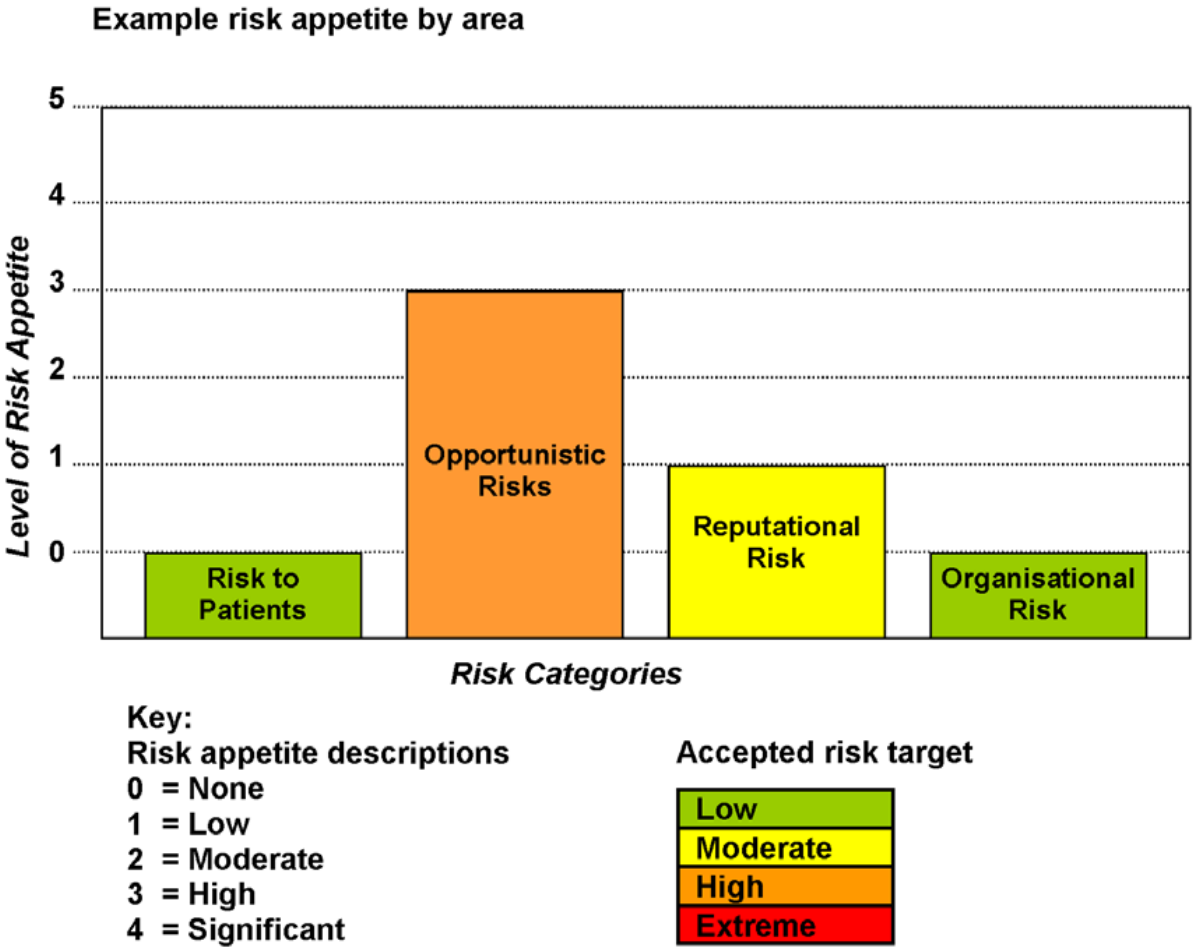
18. There will be active and frequent communication between staff, stakeholders and partners.

Risk appetite statement

11. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:
    - The nature of the risks to be assumed;
    - The amount of risk to be taken on;
    - The desired balance of risk versus reward.

12. On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:
    - Risk to patients
    - Organisational risk
    - Reputational risk
    - Opportunistic risk

These categories of risk are more fully explained in Appendix 1.



13. The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

14. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

15. The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Board to determine the organisational capacity to control risk. The review will consider:
    - Risk leadership

- People
- Risk policy and strategy
- Partnerships
- Risk management process
- Risk handling
- Outcomes

16. Tolerances for each management level of the risk management framework are defined for staff in the Risk Management Handbook.

17. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

Definitions of Risk and Risk Management

18. A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.

19. Risk Management is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 2 for further definitions that relate to this strategy.

Principles of successful Risk Management

20. It is the role of the Trust Board to lead and support risk management across the organisation. The principles of successful risk management are:
    - to embrace an open, objective and supportive culture
    - to acknowledge that there are risks in all areas of work
    - for all staff to be actively involved in recognising and reducing risk
    - to communicate risks across the Trust through escalation and de-escalation processes
    - to learn from mistakes.

Responsibilities and accountabilities for risk management

21. Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

22. Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks. To support the governance and escalation process, Appendix 3 sets out the specific risk management responsibilities of the following staff/staff groups:
    - Chief Executive
    - Chief Finance Officer
    - Chief Medical Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Directors
    - Clinical risk and governance lead

- Patient safety and risk manager.
- Divisional Directors
- Clinical Directors
- Directorate managers
- Senior Managers and Senior Staff
- All staff
- Staff side representatives.

Risk Management Process

23. The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

24. Risks are events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. Risk management also includes issues that 'have' happened and were not planned, but require management action.

25. Risks are clarified and managed in the following key stages:
    - Clarifying objectives
    - Identifying risks that relate to objectives
    - Defining and recording risks
    - Completion of the risk register
    - Identifying mitigating actions
    - Recording the Likelihood and Consequence of risks
    - Escalation, de-escalation and archiving of risks as appropriate.

Stage 1: Clarifying objectives

26. Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.

27. In order to clarify:
    - Strategic (Corporate) Objectives, determine which Trust Strategic Objective(s) is relevant to the Division, Directorate, Service area.
    - Local Objectives, determine objectives that are only relevant to the Division, Directorate, Service area.

Stage 2: Identifying risks to objectives

28. Once the objectives are clarified, risks are more easily identified.

29. Where appropriate, working collaboratively with colleagues with consideration of the following suggested questions, will enable stakeholders to more accurately identify risk:
    - What are the risks which may prevent the delivery of your objectives?
    - What risks have an impact on the delivery of high quality, safe care?
    - What could happen or what could go wrong?
    - How and why could this happen?
    - What must we do to enable continued success in achieving objectives?
    - Who else might provide a different perspective on your risks?

• Is it an operational risk or a risk to a strategic objective?

Stage 3: Describing Risk and Assigning Controls

30. Risks are described in a clear, concise and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

31. When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk that….. This is caused by ….. and would result in…. leading to an impact upon……"

32. The Trust's standard for recording risks is to define risks in relation to:

• A **Risk** is described as something uncertain that may happen and could prevent us from meeting its objectives
• The **Cause** is the problem or issue that 'could' cause the risk to happen
• The **Effect** is the result of something that will happen if we do nothing about the risk
• The **Impact** is the wider impact of the risk on the objectives if we do nothing.

33. An example of describing risk in the Trust standard is detailed in table 1 below:

Objective: To ensure safe staffing levels
Risk: • Risk of failure to maintain safe staffing levels Cause: • High staff sickness rate • Difficulties in recruiting clinical staff • Inability to release clinical staff for mandatory training Effect: • Staff not receiving compulsory training in resuscitation or blood safety Impact: • Increased safety risk to patients

Table 1: Example risk

34. **Key Controls** are the actions put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an owner (i.e., a named individual, responsible for the action) and target completion date.

35. Key controls must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

36. Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to anyone considering how to manage risk:
    - **Tolerate** – the likelihood and consequence of a particular risk happening is accepted
    - **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)
    - **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party
    - **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity
    - **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit.

37. In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:
    - Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
    - When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

38. Contingency Plans – if a risk has already occurred and cannot be prevented *or* if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the register. Good risk management is about being risk aware and able to handle the risk, not risk averse.

39. All risks and controls are to be described in accordance to the Trust standard and recorded in the risk register following assessment.

Stage 4: Completing the Risk Register

40. Trust Risk Registers are web based and stored electronically. All staff with permissions to access risk registers are able to see risks for the whole organisation. It is a transparent system to enable users to share learning.

41. The process for completing risk registers

• Assign an **owner** to the risk

• List the **key controls** (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact

• If it is a severe risk (red or orange) then consider what the contingency action plan is, i.e. what will you do should the risk happen (see escalation)

• Rate the **likelihood** of the risk materialising

• Rate the **consequence** of the risk happening.

42. Headings in the register that need to be completed are:

- **Risk Identification** (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk. Risks without a risk ID will be omitted from any report. It is therefore crucial to include an ID for each risk and control.
- **Risk Owner** is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the Action Owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many Action Owners. The Risk Owner must know, or be informed, that they are the owner, and accept this.
- **Source** of how or where the risk was identified. This could include:

• Business planning
• Clinical audit
• Complaints/PALS
• External Audit
• External Review
• Incident
• Internal Audit
• Legislation
• Litigation
• NICE guidance
• Regulatory standard
• Risk Assessment
• Risk Register (existing).

- **Proximity** – this indicates when the risk is likely to materialise or anticipated timescale. There are three categories:

• Within three months
• Between three and twelve months
• Twelve months or longer

- **Previous Risk Rating** and **Current Risk Rating** - these columns are mirror images of each other. Each time the register is reviewed or updated the risk register should move the current rating into the previous column and recalculate the current rating. This is so the history and progress of a risk can be reviewed. The Trust's guidance on the matrix and advice on scoring in contained in Appendix 4.

- **Trend** shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by an appropriate arrow on the corporate risk register spreadsheet.
- **Review Date** should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.
- **Residual Risk** is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to. When deciding the risk target, consider the following:
    - What risk rating should an individual risk be managed down to in an ideal world?
    - What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
    - Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?
    - What are the defined tolerance and escalation thresholds for the level of risk? (see the Risk Management Handbook for detailed guidance).

43. Having considered the above, assign the risk target a colour that best represents what it is possible and practical to manage it down to using the existing risk matrix. If the risk target is:

- **RED** represents a very high tolerance of the risk, i.e. willing to tolerate a risk rated with either a very high likelihood or consequence (or both).
- **AMBER** – represents a reasonably high tolerance to the threat occurring i.e. more open to the threat occurring, often if there are operational or resourcing constraints.
- **YELLOW** – prepared to tolerate and accept a little more threat but are prepared to be more 'scared' as more risk is accepted, but still cautious.
- **GREEN** – averse to the risk as if the risk materialises this cannot be tolerated.

Stage 5: Escalation and De-escalation of Risks

44. The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Directorate risk register to a Divisional register, or from the Divisional risk register to the Corporate Risk Register reviewed by the Trust Leadership Group (Risk Management Group), Clinical Governance Group, Finance and Performance, Audit and Assurance, and Quality Governance Committees, and finally the Board.

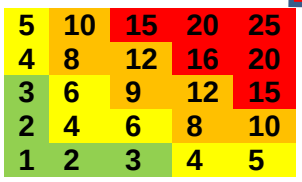
45. Risks will be escalated or de-escalated within the defined tolerances and authority to act for each level. Further guidance is contained in the Risk Management Handbook.

Escalating and De-escalating Risks

Stage 3:
Risks are evaluated by the RMG and a decision is made as to whether it is necessary to escalate the risk to the CRR or de-escalate to the Divisional Risk Register

Stage 2:
Risks are considered by the Division and a decision is made as to:
1. Accept the risk onto the Divisional Risk Register.
2. Escalate the risk to the Corporate Risk Register
3. De-escalate the risk back to the Directorate

Stage 1:
Risks that the Directorate cannot adequately mitigate are escalated to the Divisional Risk Register



46. The risk owner should discuss and seek approval from their manager who in turn should consult the risk register owner before risk escalation to the next level.

47. A risk will then be reviewed and either accepted at the next level and agreed at the relevant risk forum, or rejected and returned to the management team to review and rescore, or for further action.

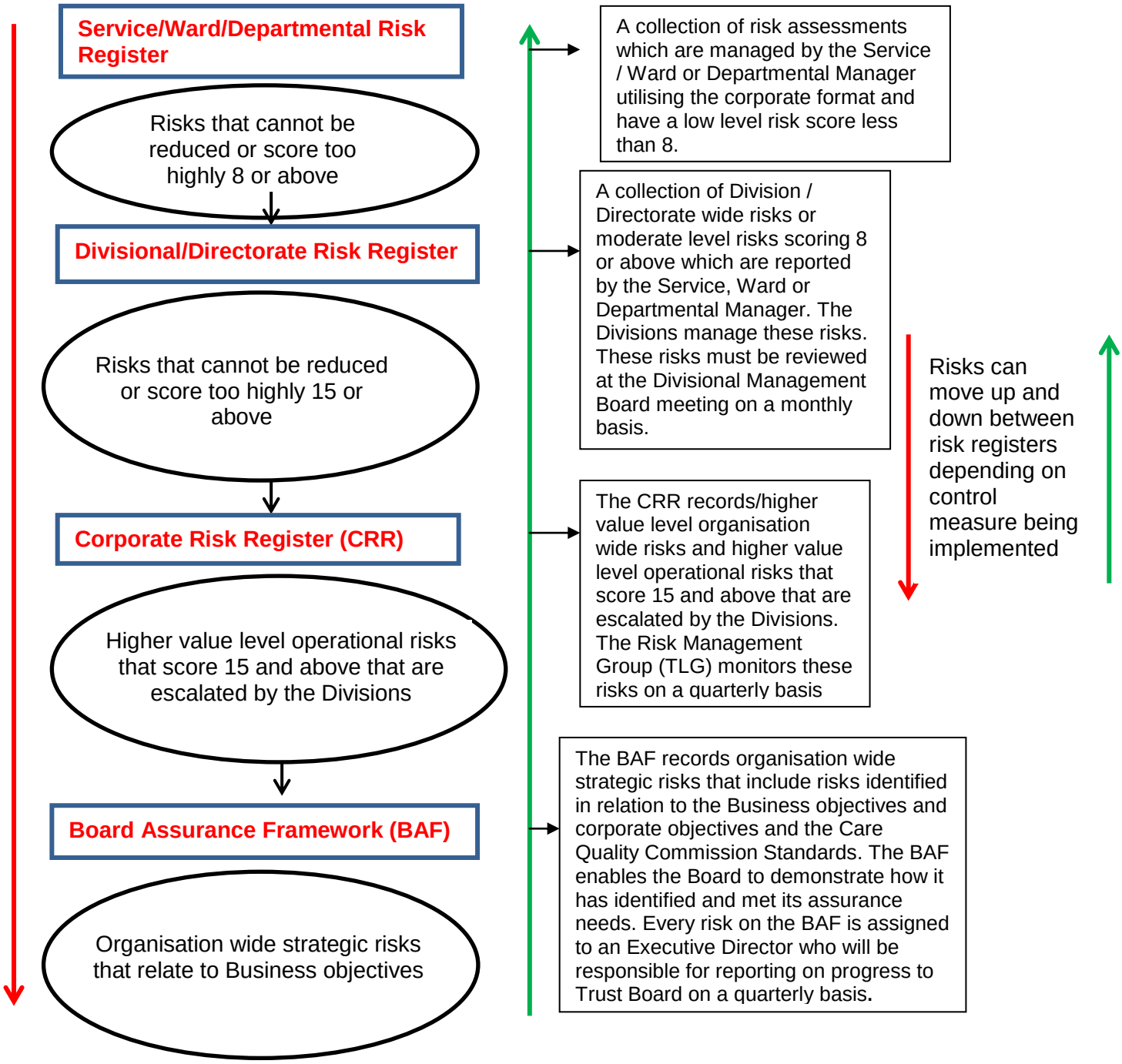
48. Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e. a risk rated 25 (red, or extreme) at Divisional level will be re-evaluated and may not be rated at 25 at Trust level.

49. Once an escalated risk has reached the accepted target for the risk, following mitigating actions or a change in the nature of the risk, it will be de-escalated. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

50. It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

51. Risk registers at Divisional level are also reviewed to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. This will aid in identifying lower risk issues which may be common across many areas. Registers will also be reviewed to identify high impact but low frequency risks which may pose a threat. These will be included in the Corporate Risk Register reports for review.

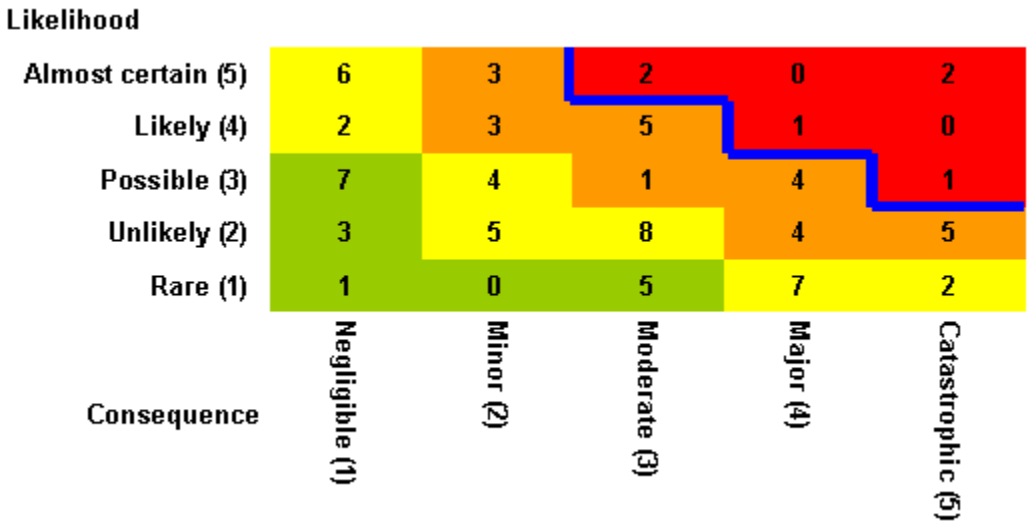
52. The flowchart below sets out the risk the risk flow from Ward to Board



Risk Profile

53. A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing Risk Register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be considered.

Example risk profile diagram



Project and Programme Risk

61. 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 as part of project documentation.

62. Project and programme opportunities and threats are generally identified:

- If a programme, through the escalation of risks from projects within the programme
- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with this project or programme
- By operational areas affected by the project or programme.

Although a project or programme should adhere to the Trust Risk Management Strategy it should also have its own risk management guidelines, which should:

- Identify the owners of a programme and individual projects within the programme
- Identify any additional benefits of adopting risk management within this project or programme
- Identify the nature and level of risk acceptable within the programme and associate projects.

- Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level
- Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects
- Identify how inter-project dependencies will be monitored and managed
- Clarify relationships with associated strategies, policies, and guidelines.

63. Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

64. In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising. This should be recorded in the risk description column of the risk register as part of the impact description. The cost of mitigating the risk should also be recorded in the 'Key controls and Contingency Plans' column, if this can be determined. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

Governance Structure

A chart depicting the Committee reporting structure can be found at Appendix 5.

65. The Trust's governance structure identifies the relevant Committees and their relationship to the Board. Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by the following Committees and further detailed in Appendix 5:

- Trust Board
- Trust Leadership Group (TLG)
- Audit and Assurance Committee (A&AC)
- Finance and Performance Committee (F&PC)
- Quality Governance Committee (QGC)
- People and Culture Committee (P&CC).

66. Additionally the Audit and Assurance Committee and other Board subcommittees (Finance and Performance, Quality Governance Committee, People and Culture Committee) exist to provide assurance of the robustness of risk processes and to support the Board of Directors

67. Each Division, Clinical Directorate, and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.

68. Risks are correspondingly monitored at operational level (Ward, Clinic and Service) through the following team meetings and forums:
    - Divisional or Corporate Management,
    - Directorate Management, and
    - Directorate and Divisional Management Team.

69. Risk Management by the Board is underpinned by a number of interlocking systems of control: The Board reviews risk principally through the following three related mechanisms:

- The **Board Assurance Framework** (BAF) sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the Trust Board agenda.
- The **Corporate Risk Register** is a high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
- The **Annual Governance Statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

Horizon Scanning

70. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

71. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

72. The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health publications
- Local demographics
- Seeking stakeholders views.

73. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

74. Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

Training

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

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

77. 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.

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

79. The specific training required by staff group is outlined in the Risk management training plan.

Monitoring Compliance

80. The Risk Management Strategy is subject to Annual Review as set out below.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency of Monitoring	Group of Committee
Risk Management Strategy	Review	Risk and Governance team	Annual	RMG.CGG and QGC and Audit Committee
Annual Governance Statement	Internal / External Audit	Risk and Governance team	Annual	Audit Committee
Risk Management Process	Internal Audit	Risk and Governance team/ Divisions	Annual	Audit Committee

Review

81. This strategy will be reviewed every three years or sooner if circumstances dictate.

82. All documents in existence prior to the issue of this policy will remain in effect until such time as they are reviewed, replaced or cancelled.

References and related documents

The references relating to this strategy are:

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- NHS Audit Committee Handbook, Department of Health (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)

- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- The Care Quality Commission Fundamental Standards: The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013
- Home Office Risk Management Policy and Guidance, Home Office (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010).

Internal supporting policies and procedures

The Trust has the following policies and documents which also relate to risk management and should be referred to for further information:

• Health & Safety Strategy (which includes security management)	WAHT-CG-808
• Incident Reporting Policy	WAHT-CG-008
• Risk Assessment Procedure	WAHT-CG-002
• Concern and Complaint Policy and Process	WAHT-PS-005
• Serious Incident Investigation Policy	WAHT-CG-009
• Business Planning process	Unable to locate a key document on business planning
• Standing Financial Instructions	Finance, unique reference

Equality Impact Assessment

As part of its development; this strategy and its impact on equality has been reviewed. 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.

List of Appendices

Appendix 1	Categories of Risk
Appendix 2	Definitions of risk and risk management
Appendix 3	Roles and Responsibilities
Appendix 4	Committees and Governance Structures
Appendix 5	Trust training for the management of risk
Appendix 6	Risk matrix and risk scoring guidance
Appendix 7	Sources of assurance
Appendix 8	Board assurance framework
Appendix 9	Equality impact assessment.

Appendix 1- Categories of Risks

Risks to patients

1. 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

2. 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.

3. 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.

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

Reputational risk

5. 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.

7. 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 - Definitions of risk and risk management

For the purposes of this strategy, the following key terms are in use:

• Assurance – External evidence that risks are being effectively managed

Assurance provides confidence, evidence and certainty to Directors, Non Executives and management that what needs to be happening is actually happening in practice.

• Control(s) – Actions in place to manage the risk in order to reduce the likelihood and / or consequence of that risk

• Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.

• Inherent Risk – the level of risk before any control activities are applied.

• Impact – The potential consequence if the adverse effect occurs as a result of the hazard

• Likelihood - the chance or possibility of something happening.

• Residual Risk - The current risk 'left over' after controls, actions or contingency plans have been put in place

• Risk – The chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.

• Risk Appetite – the level of risk considered the Trust is prepared to accept, tolerate or be exposed to at any point in time

• Risk Capacity - Maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available

• Risk Management - 'all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress'.

• Risk Maturity – the overall quality of the risk management framework

• Risk Owner – the individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated

• Risk Profile – the overall exposure of the organisation to risks (or a given level of the organisation).

• Risk Rating – the total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix

• Risk Register – the tool for recording identified risks and monitoring actions and plans against them.

• Risk Tolerance - the boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 3 - Roles and Responsibilities

Risk management is a task carried out by managers. Responsibilities are therefore set out under specific management roles. However, some cross-cutting risks apply across the organisation and lie outside the remit of any one business unit. In this case a Trust committee will be assigned its ownership, management and reporting.

Individual's Duties and Responsibilities

Risk Owner:
The owner of the objective is also the owner of the risks to meeting that objective. They have accountability and authority to manage the risk and MUST:

- Understand and monitor the risk
- Be able to report on the status of the risk
- Ensure appropriate controls are enacted
- Ensure the risk management strategy is followed.

Chief Executive
The accountable officer with overall responsibility for risk management including Health and Safety. As such, the Chief Executive must take assurance from the systems and processes for risk management and ensure that these meet statutory requirements and the requirements of the regulators. Responsibility is delegated through the Executive Team. The Chief Executive shall attend the Audit Committee to discuss matters pertaining to the management of risk as required.

Chief Nursing Officer (CNO)
The Board lead for quality, risk management, patient experience, nursing and midwifery practice, Infection Prevention, Safeguarding, and also professional lead for Allied Health Professionals and Clinical Health Scientists. He/she is accountable to the Chief Executive for risks arising from these areas. He/she is responsible for the Trust's risk management and incident reporting system, administration and maintenance of the Datix system, the production of incident reports and for the management and investigation of complaints and liaison with the Coroner. He/she will ensure the identification and management of risk and work closely with the Trust Board secretary who oversees progress against the Board Assurance Framework for the Board.

Chief Medical Officer (CMO)
The Board lead for patient safety, clinical quality, clinical effectiveness, education & research and medical practice (including professional lead for pharmacists). The CMO is responsible for the management of the Central Alert System, arrangements for incident investigation, clinical audit, overseeing compliance with NICE guidelines and the Human Tissue Act. Caldicott Guardian responsibility sits within the office of the CMO and has been delegated to the Deputy Chief Medical Officer. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Chief Finance Officer (CFO)
The board lead for finance, information, business planning and performance. He/she shall ensure that activities are controlled and monitored through effective audit and accounting mechanisms that are open to public scrutiny and presented annually.

He/she shall ensure that risks arising from activities related to Information Technology, and Estates & Facilities management are identified and managed and coordinate compliance with relevant Fire & Safety legislation and related regulations.

He/she shall also fulfil the function of **Senior Information Risk Officer (SIRO)** and so be responsible for the Information Risk Policy, management of information risks and provision of leadership and training for Information Asset Owners. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Chief Operating Officer
The Board lead for operational performance. He/she is accountable to the Chief Executive and has a specific responsibility for identifying, recording, advising on and coordinating actions around operational, performance risks, and emergency planning. He/she shall at all times He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Director of People and Culture
Responsible for risks arising from the workforce including Health and Safety ensuring compliance with health and safety policies/procedures and all relevant legislation and regulation. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Company Secretary/Data Protection Officer
The lead for corporate governance and is responsible for the production and maintenance of the high level committees terms of reference, working with the Chairman and non-executives to maintain high standards of governance and manage the process for updating the Board Assurance Framework. The role also encompasses the statutory function of Data Protection Officer (required under the General Data Protection Regulations).

Chair of the Audit Committee
He/she is responsible for keeping the Trust Board informed of any material matters which have come to the committee's attention. He/she will provide the Board with an opinion letter about the proposed Annual Governance Statement, and report to the Board on the effectiveness of the risk management system.

Divisional Directors
With reference to the Trust's risk appetite, Divisional Directors are responsible for applying the Risk Management Strategy within their divisions – this includes the identification, assessment, response, reporting and review of all risks to the achievement of objectives and delivery of services in line with the requirements set out in this document. They shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

All Clinical Directors, Directorate Managers, Ward Managers, Departmental Managers, General Managers or Heads of Service Are responsible for identifying, assessing, responding, reporting and reviewing risks within their ward, department or service. They shall ensure risks are identified, evaluated, controlled, decisions on treatment/tolerance escalated where necessary, reviewed and updated at least quarterly. In addition, they will ensure that all their employees have an understanding of the risks to their service and at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

All Employees, partners and contractors have a responsibility to:

- Observe and comply with the policies and procedures of WAHT;
- Take reasonable care for the health, safety and welfare of themselves and others;
- Co-operate on matters of risk management and health and safety;
- Participate in induction and all relevant mandatory training as defined by the Trust policies;
- Comply with the requirements of WAHT policy, procedure and approved guidance;
- Report all identified hazards and adverse incidents;
- Undertake reasonable actions as required to reduce or eliminate risks associated identified hazards or adverse incidents.

Clinical risk and governance lead - is accountable to the Chief Nursing Officer. He/she is specifically responsible for providing systems to support the Trust's risk management activities including:

- Developing risk management strategy, procedures and guidance
- The Trust's Risk Management Database
- The Incident Reporting System
- Ensuring the analysis of reported incidents and the identification of trends.
- Overseeing the management of serious incidents and reporting to external agencies
- Ensuring the provision of expert advice on risk management and patient safety as required
- Ensuring the provision of risk management training and patient safety as required

He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Patient Safety and Risk Manager –is accountable to the Clinical risk and governance lead and supports them in the implementation and embedment of the risk management framework. They are responsible for:

- Providing a strategy and assurance systems for risk management and patient safety.
- Influencing senior management to develop both a risk and safety culture within the Trust
- Providing direction and support to lead managers, Executive Directors, Divisional Directors and support staff to implement and maintain systems for risk management and patient safety and .prepare for assessments and inspections.
- Managing the teams providing corporate level support for patient safety and risk management
- Training and supporting the Trust's staff to improve their understanding of risk management and patient safety and the effective use of tools and techniques to deliver effective systems and achieve the desired outcomes.
- Maintaining the Trust's Risk Management Database
- Writing and revising the Trust's Risk Management Strategy, associated policies, procedures and forms and lead on their implementation

- Leading on and preparing the Board Assurance Framework for Significant Risks (including the integrated assurance & performance framework) and the Corporate Risk Register, with an accompanying paper for the relevant committees to review.
- Provision of expert advice on risk management and patient safety as required.

Health & Safety Manager and Local Security Management Specialist - is accountable to the Chief Operating Officer and is responsible for

- Development of the Health & Safety Strategy, Health & Safety policies, procedures and guidelines
- Leadership, co-ordination and overseeing compliance with Health & Safety legislation and regulations
- Provision of expert advice to managers and staff on all aspects of health and safety management
- Provision of training on health & safety and security management as required
- Overseeing the management of non-clinical incidents
- Reporting notifiable incidents to relevant external agencies or regulators as required
- Liaison with WAHT's PFI partners, service providers and enforcing authorities (for example Environmental Health, HSE).
- The post also encompasses the role of Local Security Management Specialist as required by NHS Standard Contract.

He/she shall at all times ensure compliance with health and safety policies/ procedures and all relevant legislation and regulation.

Non-executive Directors

The Non-executive Directors have an important part to play in risk management. They are represented on and chair the Audit & Assurance Committee and the Quality Governance Committee. Both these committees provide reports to the Board on the suitability and effectiveness of systems to manage risk.

Appendix 4 – Committees and Governance Structures

The Trust's risk management structure is led by the Trust Board and supported by the following sub-committees and groups:

- **Trust Board** - Executive and Non-Executive Directors share responsibility for the success of the organisation including the effective management of risk and compliance with relevant legislation. They have a collective responsibility as a Board to:
  - Protect the reputation of the WAHT and everything of value;
  - Provide leadership on the management of risk;
  - Reduce, eliminate and exploit risk in order to increase resilience;
  - Determine the nature and extent of the significant risks it is willing to take in achieving its strategic objectives
  - Ensure the approach to risk management is consistently applied; and all reasonable steps have been taken to manage them effectively and appropriately.

  Following review at TLG (Risk management Group), the Trust Board will receive the CRR update quarterly indicating escalation, and rationale for changes in risk scores to the CRR.

- **Trust Leadership Group (TLG)** –

  This Group is set up to drive the strategic agenda for the Trust. The Group will drive the business objectives for the Trust. It will ensure that the risks are identified and mitigated as well as ensuring that the Trust achieves its performance targets. The committee is responsible for the management of risk and the principal management committee attended by the Executive and Divisional Directors. TLG will receive the minutes of the RMG meeting every quarter highlighting progress to divisional and corporate risks. Any updates to the Board Assurance Framework and Corporate Risk Register will also be provided and agreed.

  The TLG will make decisions about the treatment or tolerance of risks that lie beyond a Division's ability or responsibility to control effectively, informing the Board of its decisions and, when the nature of the risk requires it, requesting the Board to make a decision.

- **Risk Management Group (RMG)** - is established to provide oversight and scrutiny of the management of risk throughout the Trust and as part of its role within the Trust Leadership Group. The divisions (including corporate teams) will present a report quarterly outlining risks of 15 and above, paying particular attention to those where they have specific concerns about and where they require more senior support and possible inclusion on the corporate risk register (15 and above). The Company secretary and the Clinical risk and governance lead will also provide a report on the Board Assurance Framework and Corporate Risk Register to allow for discussion at this group and to ensure that the controls and actions are effective in managing the risk.

- **Clinical Governance Group (CGG)** will review divisional clinical risks in line with the Trust's clinical governance agenda. Each division will be required to discuss key areas of concerns relating to the safety, effectiveness and experience of patients and ensure these are aligned with the risk register.
  It will also review corporate nursing and governance risks and any risks that are linked to:
  - Mortality Review
  - Clinical Audit and Effectiveness
  - Patient care and public engagement

- Infection, Prevention and Control
- Research and Development
- Safeguarding
- Medicine management
- Patient safety, incident investigation and learning
- Resuscitation and deteriorating patient.

A quarterly report will be provided to the CGG, detailing all the moderate and high clinical risks to provide assurance that the risks are being effectively managed.

- **Quality Governance Committee** – will receive an executive summary every month detailing assurance and escalation relating to governance and risk management functions discussed at CGG.
- **Finance and Performance Committee** – oversees the identification, evaluation, response to and monitoring of financial risk.
- **People and Culture Committee** – oversees the identification, evaluation, response to and monitoring of risks to the workforce. This will feed into the Risk Management Group.

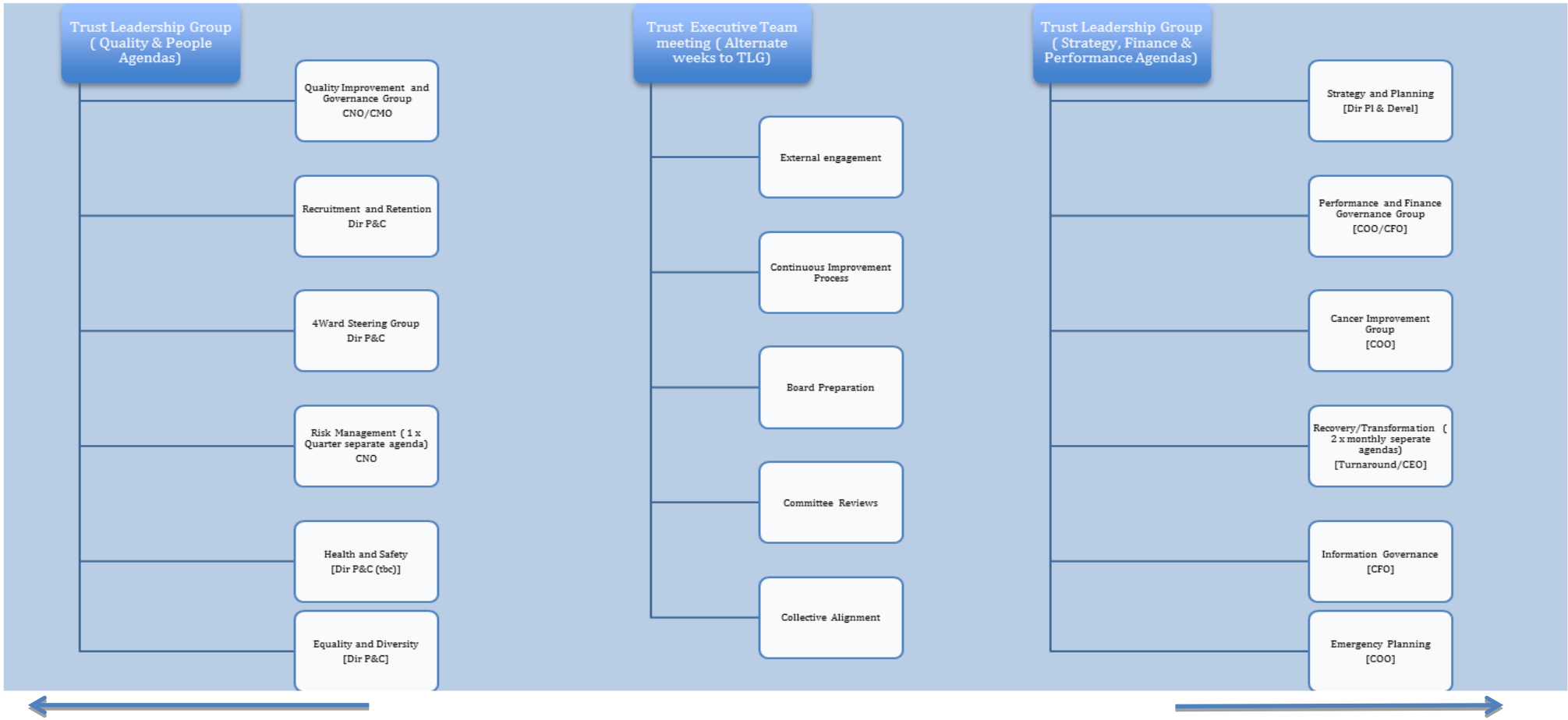
The Trust's **oversight committee** with a responsibility for seeking assurance on the management of risk is the:

- **Audit & Assurance Committee** - reviews the establishment and maintenance of an effective system of internal control and risk management, including the Board Assurance Framework.

  The AAC will receive the corporate risk register on a quarterly basis along with the Board Assurance Framework (BAF). At this meeting non-executive scrutiny and challenge will take place around the organisations
  - appetite for risk.
  - ability to identify and manage strategic and operational risk.
  - future strategic risks, namely assurance around identification and mitigation with a forward view of at least two years.

5. Strategy Review

The Risk Management Strategy will be reviewed by the Clinical risk and governance lead, with input from key executives on an annual basis.



Performance Review/Confirm and Challenge meetings
Executive and Divisional leads to provide updates on Performance into relevant TLG

Appendix 5 – Risk management training

Risk management training will be delivered by the Patient Safety and Risk Team in collaboration with the Health and Safety Lead. The training programme will be reviewed on an annual basis and will be based around the framework set out below. Details of the courses can be found at the Trust Learning and Development intranet page.

Training Content

Level 1 - All staff (corporate induction)

- Incident Reporting
- Risk assessment awareness.

Level 2 - **Managers**

- Incident Reporting (Managerial Responsibilities)
- Undertaking local Investigations
- Risk Register/ risk assessment training
- General risk awareness training
- Using Datix
- Incident Reporting Policy Requirements.

Level 3 - Senior Managers and Governance Leads x 2 half days

- Incident Reporting (Managerial Responsibilities)
- RCA Training and Investigation Management
- Using your Risk Register
- General risk awareness/assessment training
- Management of risk for senior managers
- Using Datix
- Policy Requirements.

Level 4 Risk registers - Divisional and Directorate Managers

- Table top review of risk owner's register
- Review of moderate and high risks
- Guidance on the risk management process
- Building a new risk (as required).

Level 5 - Board Members and Senior Managers

- Board Risk Awareness training - overview
- The Corporate risk register
- The Board Assurance Framework.

Appendix 6 - Risk matrix and risk scoring guidance
Calculate the consequence and likelihood rating using the scales below.

Likelihood					
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	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

In grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

First, cross reference the likelihood and impact scores on the matrix above. For example, if you have a '*moderate*' consequence and '*almost certain'* likelihood then the overall risk rating would be:

Consequence x Likelihood = Overall risk rating

3 x 5 = 15

Moderate x Almost certain = Extreme Risk

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements and any relevant publication can be used to inform a judgement.

Likelihood – consider how likely it is that the risk will occur

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency (general) 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
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
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

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. In some cases it may be more appropriate to assess the probability of a risk occurring, especially for specific areas of risk which are time limited.

Consequence – consider how severe the impact, or consequence, or the risk would be if it did materialise.

Consequence is the term given to the resulting loss, injury, disadvantage, or gain if a risk materialises. Remember – there are likely to be a range of outcomes for this event.

Note - Evaluating risk is an iterative process. Once you calculate the risk rating, it could lead to the conclusion that, for example, a particular risk seems to have too high a risk rating. In such cases the rating may need to be reviewed, checking the likelihood and/or consequence rating.

Appendix 6 - Risk Scoring Matrix cont.

SECTION 1 – HARM / CONSEQUENCE SCORING

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution 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 Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) 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 Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/32rganiza Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ 33organizational development/staffing/ competence	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/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ 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

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Ref: NPSA

SECTION 2 - LIKELIHOOD OF OCCURRENCE

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
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

SECTION 3 - RISK SCORING MATRIX

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

SECTION 4 - ACTION AND REPORTING REQUIREMENTS

Score	Risk	Action	Reporting Requirements
1-3	Risk is within tolerance	Within risk appetite / tolerance Managed through normal control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
4-6		Within risk appetite / tolerance Review control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
8-12	**Risk Exceeds tolerance**	Exceeds risk appetite / tolerance Actions to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management
15-25		Exceeds risk appetite / tolerance **Immediate action required** Treatment plans to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management With Executive Director approval - enter onto Corporate Risk Register

APPENDIX 7 – Sources of Assurance

Internal sources of assurance

Internal audit
Performance reports to Board and its Committees
Clinical audit
Quality Audits
Ward environmental risk assessments
Staff satisfaction surveys
Staff appraisals
Training records
Results of internal investigations
Serious Incident investigation reports
Complaints records and reports
Infection control reports
Information governance toolkit self-assessment
Patient advice and liaison services Reports (PALS)
Staff sickness reports
Internal benchmarking
Local Counter Fraud work
Local Security Management Specialist work
Patient-Led Assessments of the Care Environment (PLACE)
Health and safety reports
Maintenance records.

External sources of assurance

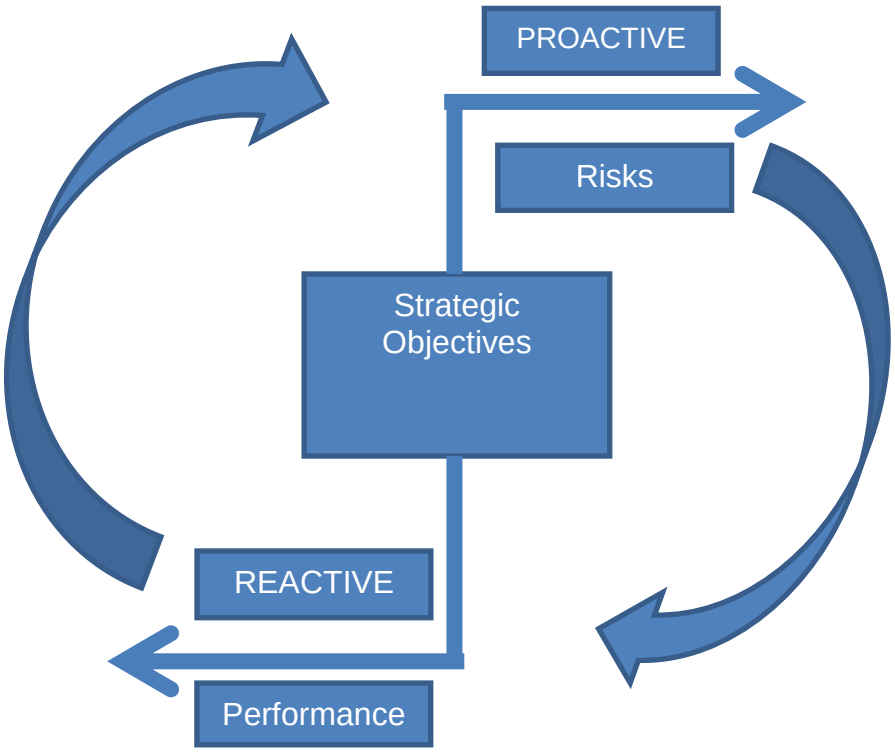
Intelligent Monitoring Report
Friends and Family Test
Care Quality Commission inspection reports
External audit
CCG reports/reviews
Area Team reports
HSE Reports
Royal College visits
Deanery visits
External benchmarking
Patient-Led Assessments of the Care Environment (PLACE)
National and regional audits
Peer reviews
Feedback from service users
External advisors
Local networks (for example, cancer networks)
Dr Foster reports
NHSI and NHSE feedback
PHSO reports.

Appendix 8

The Board Assurance Framework

The Board Assurance Framework is an information tool that allows for detailed analysis of all strategic risks which could impact on the Trust achieving its objectives. It requires the Trust to consider the effectiveness of each control through a process of obtaining assurances that the mitigation is in place and operating effectively. This will also identify which of the Trust's objectives are at risk because of gaps in controls or assurance.

The Trust is working towards an integrated Assurance Framework report which brings together information on achievement of milestones/targets, performance and risks to enable the Board to evaluate progress in meeting objectives. This will form the assurance cycle, considering both reactive (performance) and proactive (risk) information.



Board Assurance Framework Reporting & Review

The **Board Assurance Framework** is reviewed by the:

- Risk Management Group – every quarter
- Trust Board – every two months following detailed review by assurance committees
- Audit & Assurance Committee will receive the approved BAF every two months, to review its relevance and effectiveness
- Audit & Assurance Committee will commission an annual review of the effectiveness against practice.

Appendix 9

Supporting Document 1 - 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.

Supporting Document 2 – Financial Impact Assessment

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

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	Yes – but covered in the implementation plan and to be delivered within existing resource
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.