East Suffolk and North Essex NHS Foundation Trust

# Risk Management Policy

## Version 2.1

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| **Purpose:** | To advise and inform all Trust staff of the processes to identify and manage risk |
| **For use by:** | All Trust staff |
| **This document is compliant with/supports compliance with:** | CQC Fundamental Standards<br>Well Led Framework June 2017. |
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| **Approved and Ratified by:** | Board of Directors |
| **Date Approved and Ratified:** | |
| **Implementation date:** | |
| **Review date** | |
| **In case of queries contact Responsible Officer:** | Head of Risk and Compliance |
| **Division and Department** | Corporate Governance |
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## Version and document control

| Version | Date of issue | Change Description* | Author |
|---|---|---|---|
| 1.0 | July 2018 | Amalgamation of policies to create ESNEFT version | Head of Risk and Compliance |
| 2.0 | February 2019 | Entries to Corporate Risk Register amended to 15 from 12.<br>Added Statement of Risk.<br>Added approved Risk Appetite Matrix.<br>Added project Risk Management.<br>Added de-escalation from the corporate risk register.<br>Added Training matrix. | Head of Risk and Compliance |
| 2.1 | January 2021 | Amended to reflect findings from IA review associated with risk appetite statement.<br>Amendment to Committee Structure. | Trust Risk Manager/ Corporate Governance Manager |

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## Section 1 - Introduction

### 1.1 Statement and Rationale

Risk management is both a statutory requirement and an indispensable element of good management at East Suffolk and North Essex Foundation Trust (the Trust). It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff. It is expected that all risk management activities in the Trust will follow the process described within this document to ensure a common approach is adopted to risk management.

Good governance is synonymous with sound risk management; and the management of risk underpins the achievement of the Trust's objectives. The Trust is committed to achieving excellence in the delivery of patient-centred care in an environment that promotes safety wellbeing and enhances experience for patients, staff and visitors whilst safeguarding the business continuity of services, assets and reputation of the Trust.

To achieve this, the Board of Directors must be confident that the systems, policies and people it has put in place are operating in a way that is effective, is focused on key risks and is driving the delivery of the organisation's objectives. The Board of Directors must also demonstrate that it has been properly informed, through evidence from the Board Assurance Framework and Corporate Risk Register, that it is aware of the totality of the risks facing the organisation, and that it has made decisions on the management of that risk based on all of the available evidence.

The Trust recognises that risk management must be embedded in order for the organisation to function safely and effectively. The Board of Directors is therefore committed to ensuring that risk management forms an integral part of the organisation's philosophy, practices, activity and planning, and should not be viewed as a separate programme of work at any level within the organisation. All stakeholders, internal and external, must be considered within the Trust's risk management arrangements.

The Trust will ensure that risk management is supported by the development of formal mechanisms to assess risk and to measure the effectiveness of risk management plans and processes. In particular:

- Risk management will be supported by accurate, timely and effective reporting, including categorising the likelihood and consequences of risk;
- Preventative risk management processes will be applied to the management of facilities, equipment and clinical practice;
- Safe systems of work will be in place to protect patients, visitors and staff;
- There will be a process of probity of Divisional Risk Management by the Risk Oversight Committee in relation to assumptions underpinning identified risks, their ratings and plans for dealing with them; and
- There will be a process of scrutiny and assurance of allocated risks relevant to the corporate risk register and the committees of the Board.

## Section 2 – Duties and Responsibilities

### 2.1 Purpose

The purpose of the Risk Management Policy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health & Safety legislation, terms of authorisation and deliver its strategic objectives.

### 2.2 Definitions

**An adverse event** - is the unintentional harm, suffering or loss from an activity, situation or event (e.g. an incident or an issue).

**A patient safety incident** - is any unintended or unexpected event which could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.

**Assurance Framework -** It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them.

**Consequence** - the impact or outcome or outcome component of a risk

**Controls** - the available systems and processes which help minimise risk

**Corporate Risk Register -** This document provides the organisation with a simple but comprehensive method of risk assessment and management to meet the Trust's corporate objectives. At the same time, it provides structured assurance that risks are being effectively managed.

**Hazard** - anything with the potential to cause harm

**Likelihood** - the probability of a risk occurring or recurring on a scale of 1 – 5

**Risk Management** - Risk management is the process by which the Trust will manage the protection of its patients, employees (including contractors and agency staff), property, resources, information and environment. It is assessment, analysis and management of risks. It is simply recognising which events (hazards) may lead to harm in the future and minimising their likelihood (how often) and consequence (how bad).The Risk Management process encompasses the identification and assessment of risks, assigning ownership and monitoring and reviewing progress with the actions taken to deal with them.

**Risk** - is defined as the potential materialisation of one or more adverse outcomes arising from an activity, situation or event which may impact on the organisations ability to achieve its objectives. The trust is exposed to a range of risks which have the potential to damage or threaten the achievement of the trusts objectives. The broad categories of risk faced by the trust include:

**Strategic risk** – risks associated with the trusts ability to maintain its longer term viability and the delivery of development national and local priorities.

**Performance risk** – the ability of the trust to deliver high quality care for patients in accordance with the trusts business plan and the standards set by the Care Quality Commission.

**Financial risk** – the risk that a weakness in financial control could result in a failure to safeguard assets, impacting adversely on the trusts financial viability and capability to provide services.

**Reputational Risk** – risk that the organisation receives negative publicity, which impacts on public confident in the organisation.

**Operational risk** – risks that threaten the day to day delivery of clinical care and services.

**Clinical Practice Risk** - risks to individual patients relating to their clinical care and treatment will start on admission and continue throughout the patient's episode of care. Assessment of risks and the process for documenting the outcome of any risk assessment is set out in clinical policies and guidelines.

**Acceptable Risk/Tolerable Risk** - is defined based on the following principles:

Tolerability does not mean acceptability. It refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk.

It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing, is even greater.

**Risk Appetite** - At the organisational level risk appetite is the amount of risk or exposure, or potential adverse impact from an event that the organisation is willing to accept or retain. Once the appetite threshold has been breached, risk management actions and business controls are implemented to bring the exposure level back within the accepted range. The Trust has not set a risk appetite within this policy.

**Risk Assessment** - A process by which information is collected about an event, process, organisation or service area, in order to identify existing risks/hazards, the consequences and the likelihood of harm and what control measures are in place or are required to be put in place.

**Risk Assessors** - persons who has the knowledge, skills and experience to undertake risk assessments

**Risk owner -** All risks will have an identified risk owner who is responsible for ensuring that risk is managed, including the ongoing monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk and reporting on the overall status of the risk. It is the responsibility of the risk owner to escalate risks where appropriate in line with the risk escalation process.

**Risk Rating** – Each risk is rated, using a 5x5 matrix, (consequence x likelihood) which determines the risk rating (current risk or exposure)

**Risk Register** – A register of assessed risks prioritised according to risk rating.

**RIDDOR** - the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

**PUWER** - the Provision and Use of Workplace Equipment Regulations

**COSHH** - the Control of Substances Hazardous to Health Regulations

**Action owner** - All risks have action owner(s), to whom the risk owner has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk and to provide regular reporting on progress.

### 2.3 Aims

The overall aim of this policy is to ensure continuing improvement in the quality of care received by our patients and to ensure the maintenance of a safer environment for patients, employees and visitors, to reduce the Trust's losses to a minimum, and to enable the achievement of our objectives. The delivery of a first class service requires everyone to take responsibility for the management of risks, in a way that informs operational decision making and that improves safety and quality.

East Suffolk and North Essex NHS Foundation Trust aims to:

- Adopt an integrated approach to risk management whether risk relates to clinical, non-clinical, organisational or financial issues;
- Identify and control risks which may adversely affect the Trust's operational ability;
- Manage risk in accordance with best practice using processes that ensure a continuous, systematic approach to risk assessment and that this is followed throughout the organisation;
- Prevent loss, disruption, damage or injury and reduce the cost of risk, thereby maximising resources;
- Provide and maintain a safe and secure environment for patients, staff and visitors;
- Encourage and support innovation and service development within a framework for risk management;
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer. Ensuring the organisation openly and explicitly accepts the remaining risks and determines appropriate mitigations;
- Create awareness and a proactive approach regarding the importance of managing risk;
- Ensure risk management systems and processes are clear and simply described in order to be understood by all staff;
- Develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role;
- Establish clear roles, responsibilities and reporting lines within the Trust for risk management;
- Provide opportunities for shared learning on risk management across the Trust;
- Anticipate and respond to changing legislative and regulatory requirements; and
- Share risk data with stakeholders in an appropriate form.

### 2.4 Objectives 2018 - 2024

Key objectives which have been endorsed by the Trust Board include:

- To have in place a clear structure and robust leadership to deliver risk management within divisions.

- Risk management processes and associated policies and procedures to be embedded throughout the organisation.

- To continually review the Risk Oversight Committee function and make any changes as necessary.

- For staff at all levels of the organisation to receive role specific risk management training.

- Risk management to be fully integrated into Trust working and the delivery of quality care.

- To establish a risk management maturity self-assessment process to enable transparent tracking of progress.

## 2.5 Risk Appetite

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
- On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:
- Quality/Innovation/Outcomes Risks
- Financial/Value for Money (VFM) Risks
- Compliance/Regulatory Risks
- Reputational Risks
- The statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The table below is the agreed risk appetite framework for ENEFT.

The risk appetite will be reviewed, set and communicated by the Trust Board on an annual basis or sooner should there be a significant change to the operating landscape.

## 2.6 Implementation Plan

To achieve the objectives an implementation plan which defines the actions needed to embed risk management principles throughout Trust activities is held by the Risk and Compliance Team.

## 2.7 Roles and Responsibilities

The Board of Directors demonstrates its commitment to risk management through the way it conducts its business and through the endorsement of this Risk Management Policy. It delegates authority to Board Committees to act on its behalf and receives annual reports from these committees.

**Chief Executive**
As Accountable Officer, the Chief Executive (CEO) has overall responsibility for ensuring Governance and Risk Management systems (including health and safety) are adequate within the Trust to cover all of its activities. Various aspects of risk management and assurance, including implementation of this policy, are delegated to individual Executive Directors with areas of responsibility reflected in the senior responsible office (SRO) delegations.

**Non-Executive Directors**
The Trust Board Committees are chaired by Non-Executive Directors. They are accountable to the Trust Board through the Chairman. They play an essential role in ensuring that the Trust's governance and risk arrangements are robust and effective.

**Chief Medical Officer and Chief Nurse**
The Chief Medical Officer and Chief Nurse provide clinical leadership and scrutiny for quality (patient safety, clinical effectiveness and experience) and clinical risk. They work closely with the Director of Governance who leads on corporate governance, compliance and risk systems / processes. Other areas are delegated as detailed below:

**The Executive and Non-Voting Directors**
All Directors of the Trust are accountable to the Chief Executive and have responsibility for the management of risk within their individual portfolios (including maintenance of portfolio Risk Registers), for contributing to the construction and on-going review of the Board Assurance Framework, and the implementation of resulting action plans.

The fundamental role of the Directors is to provide leadership by ensuring that the plans for the management of risks for which they are responsible are continuously developed and communicated across the organisation.

Specifically, the roles and responsibilities of Executive Directors are to:

- Ensure through their offices, the implementation of this Risk Management Policy, with the support of the governance managers.

- Prepare assurance frameworks, policies and strategies to ensure risks within their area of authority are identified, assessed and managed within the scope of the available resources;

- Ensure the implementation, monitoring of risk assessments and their control measures are in place within their designated area(s)

- Ensure staff are given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations, including agency staff, sub-contractors, members of the public and visitors; and

- Authorise and empower senior managers to resolve risks locally and escalate/inform to the appropriate Board sub-committees of significant risks which cannot be managed at local level.

The Chief Medical Officer or Chief Nurse sit on all key governance committees.

In addition, various aspects of risk management, including implementation of the policy are delegated to executive leadership as follows:

| Executive Director | Areas of Authority for Managing Risks |
|---|---|
| Managing Director | Operations & Performance Management Emergency Planning and Business Continuity. |
| Chief Medical Officer | Caldicott Guardian, Post Graduate Medical Education Training, Continuing Professional Development, Medicines' Optimisation, Patient Safety, and Clinical Effectiveness. |
| Chief Nurse | Continuing Professional Development (nursing, midwifery and allied professionals), Infection Control, Safeguarding Adults and Children, Patient Experience and Complaints. Systems of clinical governance for: Serious Incidents, Clinical Audit, Clinical Effectiveness, Medical Devices |
| Director of Human Resources | Recruitment, Retention, Staff Management, Staff Engagement and Organisational Development |
| Director of Finance | Financial Fraud<br>NHS Resolution |
| Director of Governance | Corporate Affairs<br>CQC registration, clinical negligence claims, risk management.<br>Information Governance.<br>Health and Safety. |
| Director of Estates | Estates, Facilities and the Environment |
| Director of ICT | ICT |
| Director of Communications | Reputational management |
| Director of Strategy, Research and Innovation | Research and Development, Strategic Objectives / Business Planning |

**Director of Governance**
The Director of Governance has delegated responsibility for leading on the development and implementation of risk management systems and processes and for providing reports to the Board of Directors and its committees. This includes maintaining and developing the Corporate Risk Register and Board Assurance Framework to ensure that the Board of Directors is provided with accurate and intelligent information on which to base their decisions.

**Head of Risk and Compliance / Trust Risk Manager**
The Head of Risk and Compliance is responsible for overseeing the day to day management and coordination of the risk management system. With the Risk Manager he/she is responsible for providing support and advice on risk management issues across the Trust. In addition, the Risk Manager will work closely with a number of specialist advisers within the Trust who provide advice on specific areas of risk management. For example: Health & Safety; Fire; Infection Control; Decontamination; Tissue Viability; Manual Handling; Security; and Information Governance.

They will provide aggregation of operational and corporate risks for reporting to the Executive Risk Oversight Committee, relevant Board Committees and the Trust Board. This forms the basis of 'bottom up' population of the risk register and will be used to inform the Corporate Risk Register and the Board Assurance Framework.

They are responsible for the on-going development, implementation and evaluation of risk management systems. These systems will align with the requirements of related regulatory bodies such as the CQC. The Risk Manager will fulfil the role of Central Alert System Liaison Officer (CASLO) and is responsible for ensuring that there are systems in place to ensure that safety alerts are disseminated, implemented and monitored.

**Divisional Governance Managers**
The Divisional Governance Managers have operational responsibility for implementation of risk management systems and for providing support and advice on risk management issues within their Divisions.

The Divisional Governance Managers will provide timely updates of all risks to enable the aggregation of Division and Corporate risks for reporting and escalation to the Executive Risk Oversight Committee, relevant Board Committees and the Trust Board.

For Clinical Directors, Associate Directors of Operations, Associate Directors/Heads of Nursing/ Midwifery and Clinical Leads, risk management is one of their key responsibilities and is explicit within their job descriptions.

Their roles and responsibilities are to:

- Clarify local risk management roles and responsibilities; raise the overall divisional risk management profile and acting as the divisional leads for risk management.

- Communicate to all staff within their division the content of this strategy and the importance of managing risk.

- Taking ownership and commissioning divisional risk assessment which will inform their business planning process. Risks should be prioritised, managed, minimised and, where possible eliminated; the division managers are authorised to resolve all risks within available resources and to the level of their authority.

- Ensure the development and maintenance of a live divisional risk register, which will demonstrate a systematic and consistent approach to risk management. The divisional risk registers will be monitored monthly by their respective Division Boards.

- Responsible for assessing the risk impact on other parts of the organisation/ partners in health and social care when implementing new care pathways and services.

- Facilitate staff training to support the implementation of risk management procedures.

- Escalate risks, with scores of 15 and above, to the corporate risk register.

- Regularly review data from incidents, claims and complaints, to identify any clinical risk and areas for action.

- Ensure information given to patients is accurate, appropriate and contains information regarding risks and benefits of treatment.

- Identify appropriate risk reduction strategies as appropriate in response to information received e.g. Central Alert Systems (CAS), HSE risk assessments, NICE guidance, national audits / confidential enquiries, clinical audits and external reviews.

**General Managers, Heads of Department and Line Managers**

- Ensure the development and maintenance of a live risk register, which will demonstrate a systematic and consistent approach to risk management. All risks 8 and above are escalated to the divisional risk register. The divisional risk registers will be monitored monthly by their respective Division Meetings.

- Ensure that documented risk management procedures and systems are in place and adhered to.

- Ensure attendance of staff at appropriate risk management and completion of other mandatory and statutory training.

- Raise risk awareness amongst staff at operational level.

- Seek advice on risk management issues, as required.

- Notify the appropriate manager of identified and assessed risks.

- Champion a culture of proactive risk identification and management within their department.

- Respond to and review in a timely manner, all incident reports to identify clinical risks, investigate and implement remedial action as appropriate.

**All Staff (including temporary staff and contractors)**

All staff should:

- Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks.

- Report incidents, accidents, mistakes and 'near misses' and actions taken, in accordance with Incident Reporting Policy.

- Ensure their own safety and the safety of all others who may be affected by the Trust's business.

- Comply with, policies and procedures in order to protect the health, safety and welfare of anyone affected by the Trust's business.

- Maintain confidentiality of patient and Trust information.

- Be aware of their individual roles in complying with emergency procedures e.g. resuscitation, evacuation and fire precautions, as relevant to the employee's particular work area.

- Complete all mandatory and statutory training applicable to their role within the organisation.

- Raise any concerns about particular risks/incidents with their line manager. Where this may not be possible, the alternative mechanism is the Freedom to Speak up Guardian. They provide a way for staff to speak out if they are concerned about any aspect of management including the care and safety of patients. Providing a confidential process to enable staff to challenge others if it is believed they are acting in an unlawful or unethical manager.

### 2.8 Committee Roles and Responsibilities

The role and remit of Board Committees are reviewed annually; this review is led by the Trust Chairman. All Board Committees review their effectiveness in line with their terms of reference and prepare an annual report. Monitoring of the organisational risk management structure is undertaken on an annual basis to ensure that members attend the relevant committees as per the terms of reference, appropriate reporting is carried out according to the reporting schedule, actions completed in a timely fashion and risk registers are updated and reviewed.

Within the organisation committees / groups are categorised into three tiers - Tier 1, 2 and 3 committees. For purpose of this policy only the Board Committees are defined.

| | |
|---|---|
| Trust Board | |
| Board Committees | These Committees have delegated responsibility from the Trust Board |
| Executive Committees / Groups | These Committee / groups have responsibility for monitoring the effectiveness of risk management for specific areas e.g. Patient Safety; Patient Experience; Clinical Effectiveness and Safety |
| Trust wide subject specific groups | These are a framework of Trust wide groups that lead and provide operational assessment, management and monitoring of specific risk areas e.g. Resuscitation; Infection Control, Safeguarding. |

#### 2.8.1 Board of Directors and Board Committees

**Board of Directors**
The Board of Directors is accountable for reviewing the effectiveness of internal controls: clinical, financial, environmental and organisational. The Board of Directors is required to meet its statutory obligations on financial management and use of resources, and the quality (safety, effectiveness and experience) of healthcare delivery. In addition, it is required to produce an annual Governance Statement that it is doing its reasonable best to manage the Trust's business affairs prudently and effectively through the implementation of internal controls to manage foreseeable risks. The Board of Directors will facilitate openness, accountability and probity of decision making and risk assessment as part of its duty to lead the organisation. The Board of Directors demonstrates its commitment to risk management through the way it conducts its business and through the endorsement of its Risk Management Policy.

**Audit and Risk Assurance Committee**
In line with the requirements of the NHS Audit Committee Handbook (2018), NHS Codes of Conduct and Accountability, an Audit and Risk Assurance Committee has been established to provide the Board of Directors with an independent and objective review of its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The function of the Committee is to assess the level of assurance, to ensure that appropriate organisational systems of control are in place in respect of all relevant areas of operation and activity, and that timely and systematic management actions are taken where significant weaknesses or failures in systems of control are identified. An independent Non-executive Director chairs this Committee and two other Non-executive Directors form its membership. It reports directly to the Board of Directors but is intrinsically linked to the other Board Committees who have responsibility for risk. Terms of reference are available on the intranet / intranet. The Audit Committee will review the controls involved in the management and monitoring of the Board Assurance Framework in order to provide assurance of effectiveness to the Board of Directors.

**Quality and Patient Safety Committee**
The Quality and Patient Safety Committee has delegated authority to oversee the overarching clinical risk and clinical governance. This Committee meets a minimum of six times a year and is chaired by a Non-Executive Director with membership comprising of directors, non-executive directors and the senior clinical leadership team on invitation. Minutes of Quality Committee meetings are submitted to the Board of Directors and a key issues report presented by the chair. Terms of reference of the Quality and Patient Safety Committee are available on the internet / intranet.

**Performance Committee**
The Performance Committee provides the Board of Directors with an objective review of the financial strategy, financial position and the operational performance of the Trust. This Committee is chaired by a Non-Executive Director and the Director of Finance, Director of HR, Deputy Chief Executive / Managing Director, Chief Nurse and Chief Medical Officer. Terms of reference are available on the internet / intranet.

**People and Organisational Development Committee**
The purpose of the Committee is to provide the Board of Directors with an independent and objective oversight of workforce, organisational development and education issues; to ensure, suggest and make recommendations to support the Board of Directors in ensuring the Trust continues to maintain a fit for purpose workforce and is a place where people want to work and learn. This Committee is chaired by a Non-Executive Director and membership including the Chief Executive, Director of Finance, Director of HR, Chief Nurse and Chief Medical Officer. Terms of reference are available on the internet / intranet.

**Innovations Committee**
The purpose of the Committee is to create optimal alignment between the Trust strategy and the programmes of work in the Trust 3-year strategic plan. The Committee acts as a 'design advisory group' to ensure that these plans align well with each other, and with the user-centric ideal of the *time matters* philosophy.

**Executive Management Committee**
The Executive Management Committee is the senior management decision making group of the Trust to create a single line of accountability for all aspects of performance including patient safety, patient experience, operational standards, financial performance and staff engagement. The Executive Management Group receives the Corporate Risk Register quarterly.

**Executive Risk Oversight Committee**
The Executive Risk Oversight Committee meets on a monthly basis and is chaired by the Director of Finance. Membership comprises divisional leadership, and senior management. The Committee oversees all risk management strategies within the Trust. The Committee considers the entries in the risk registers on a monthly basis; and validates the Corporate Risk Register.

The Committee reports to the Audit and Risk Assurance Committee and gives assurance that the Trust is fulfilling its risk management responsibilities. The Committee's specific responsibilities include the coordination and prioritisation of risk management issues across the organisation and fostering greater awareness throughout the Trust and at all levels. The Committee receives the Divisional Risk Register Reports to inform the Corporate Risk Register and the Risk Management Key Controls Report on a monthly basis.

**Health and Safety Committee**
The Health and Safety Committee provides a forum for managers and staff representatives to meet and discuss issues including health and safety, security and personal safety, fire safety, training, infection control and occupational health. The Committee advises the Executive Risk Oversight Committee on all matters regarding the health, safety and welfare of patients, staff and visitors in line with legislation.

**Time Matters Board**
Time Matters Board has a portfolio of the oversight of all transformation programmes being managed across ESNEFT. Each programme has a number of projects which are being managed at any one time. Within each project, there will be a number of risks to delivering the project, these are managed in line with Section 3.10.7 of this policy.

**Specialist Advisory Groups**
The Trust has established a number of specialist advisory groups and the reporting arrangements for each of these can be found in the Trust organisational charts on the intranet.

## 2.9 Levels of Authority for Managers and Escalation of Risk

Each operational group captures and records risk assessments locally, with any departmental risks which score 8 or above are assimilated onto the Division Risk Register. These risks are discussed, monitored and managed at the Divisional Governance Meetings and presented to the Executive Risk Oversight Committee on a bimonthly basis in the form of the Division Risk Oversight Report.

For each risk, a lead individual for managing the risk should be identified. They should have sufficient seniority to ensure that the mitigation plan is followed through and to identify and request additional resources that may be required. The table (below) provides an indication of authority of managers to act on risks. They may seek further advice from specialist advisors see Appendix A.

| Rating | Risk Level | Responsibility | Frequency of Review | Register | Recommended Action |
|---|---|---|---|---|---|
| 1-6 | Manageable (Low/ moderate) | Ward or department manager. | At Least biannually | Local Risk Register | Managers are encouraged to take action on low risks, particularly when these can be easily minimised or eliminated. These risks will be actioned within the service and entered as a unit risk on the Local Risk Register.<br>Low/Moderate risks are considered as acceptable risks to the Trust, and require no immediate action but must be monitored regularly by the service E.g. annually or when circumstances change to provide assurance that controls continue to be effective.<br>These will not be routinely monitored by the Divisional Governance Managers. |
| 8-12 | Severe (High) | Clinical Directors / Associate Directors/ Heads of Operations and /or Nursing and Heads of Department | At Least Quarterly | Divisional Risk register | High Risk – not acceptable unless an informed decision is taken by the executive management team and clear documentation of the decision evidenced to provide a corporate memory.<br><br>Where appropriate, the service should firstly consider the risk and agree an action plan. These risks will be actioned locally and entered as a Divisional Risk on the Divisional Risk Register. The Division will monitor the application of the action plan and review the risk grading and, if required, adjust.<br><br>The Executive Risk Oversight Committee will monitor the application of any such action plans and review the evidence provided to reduce the risk grading. |
| 15-25 | Critical (Extreme) | Clinical Directors<br>Executive Directors | Monthly | Corporate Risk Register | Extreme Risk – not acceptable unless the Board makes an informed decision. These risks will be entered on the Divisional and Corporate Risk Register. Appropriate actions will be developed and implemented. The Executive Risk Oversight Committee will consider escalation to the Board Assurance Framework should it be assessed that the risk has the potential to adversely affect the delivery of one or more corporate objectives, and will monitor the application of any such action plans, review the evidence provided to reduce the risk grading.<br>The Corporate Risk Register (including all critical risks will be presented at Executive Management Committee quarterly. The Board will receive the Board Assurance Framework for discussion quarterly or more frequently if needed. |

Risks scoring 15 or more (critical/red RAG) or risks identified as having trust-wide (corporate) implications are discussed at the Executive Risk Oversight Committee and assimilated onto the Corporate Risk Register if considered appropriate.

## Section 3 – Risk Management Framework

### 3.1 Overview

Through a process of simple and effective risk identification, assessment and control the Trust will maintain an accurate and contemporaneous Risk Register that will in turn inform the Board Assurance Framework and thereby provide confidence to both the Board and the

community it serves that The Trust effectively recognises and manages issues of risk and operates within a safe environment.

This section details how risk is identified, assimilated into the Risk Registers and reported, monitored and escalated throughout the division and corporate governance structures.

### 3.2 Risk Management Process

There are five steps to the risk management process which form a continuous cycle:

i. Identify the hazard and its risk;
ii. Risk assess;
iii. Identify controls and their effectiveness;
iv. Risk management;
v. Monitor, report and communicate the risk.

### 3.3 Identification of Risk

Risk identification involves a systematic review of all current and planned activities to achieve the Trust objectives, from the perspective of all stakeholders at all levels in the organization. It is this principle of embedding such reviews in all processes that drives a mature risk management culture (whether for an individual patient's care or trust wide risk assessment for specific safety requirement). When identifying risks consideration should be given to what could pose a potential threat to the achievement of objectives within the context of the organisation.

All risks, whether under the control of the Trust or not, should be included at this stage. The aim is to generate an informed list of events that might occur. Key resources that will inform this exercise include:

- Compliance requirements with regulators and stakeholders such as the CQC, Monitor, the Clinical Commissioning Groups (CCGs) and NHS Improvement;
- Recommendations from recent internal/ external audit reports;
- Root cause analysis of incidents, inquiries, complaints or claims;
- Care pathway analysis;
- Performance data;
- Evaluation reports;
- Trend and forecasting analyses;
- Risks associated with the achievement of corporate objectives;
- Other methods of horizon scanning.

Key questions staff should always address are:

- What could possibly go wrong; and at what point during the activity?
- How could it happen and why?
- What could be the effect?
- Who could be affected?


Risks and issues often get confused and a useful way of remembering the difference is;

- Risks are things that might happen and stop us achieving objectives, or otherwise impact on the success of the organisation.

- Issues are things that have happened were not planned and require management action.

The following are a list of activities among many others which may be used to identify potential risks requiring a risk assessment:

### 3.3.1 Proactive Identification and Management of Risk (i.e. before the event)

**Risk Analysis** – a risk analysis is carried out as part of the development of the Trust's Annual Plan. A risk plan will be developed to contain details of each action required to treat the identified principal risks, and will be set out in the Board Assurance Framework.

**Business processes** – review of Business and Service Delivery Plans in order to minimise the risk relating to the Trust fulfilling its statutory and contractual responsibilities, including achieving key performance standards and within any business case presented thereafter.

**Transformation Plans** - are fully assessed for any impact on the quality of services delivered as well as for financial impact and deliverability. Each proposing manager presents a 'project outline document' setting out the detail of the plan and including a rated assessment for impact on quality of services and deliverability. All plans are reviewed and signed off by Executive Directors.

**Business Continuity** – the Trust has in place Emergency Preparedness and Major Incident plan, as well as a range of plans and other associated documents that are designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the Trust. These plans are tested on a regular basis, and risk identified from the learning is communicated back to the relevant groups to ensure processes are refined.

**Clinical guidelines** – the Trust has mechanisms in place to review and implement the latest guidance / recommendations from national best practice (e.g. NICE), identifying clinical risk of non-achievement of the standards.

**External Visits, Accreditation Schemes, regulation and guidance** – the Trust will need to assess its compliance against standards and policy directives and recommendations issued by various national bodies and regulators.

**Audit activity** - (local and national clinical audit, internal and external) – there is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back to appropriate members of staff, with risks identified and reports made to the appropriate groups.

**Reports to Management Team/ Trust Board on key Trust priorities** - regular reports are made identifying potential risks to the corporate objectives. The Trust scorecard covers a number of key targets, linked to strategic priorities. Triggers linked to these targets result in remedial risk management action when performance is below acceptable level.

**Horizon scanning and learning from others** - all areas within the Trust complete horizon scanning at least annually to identify risks to service delivery. Horizon scanning takes various formats from review of national audit reports, local / national initiatives and reviews of regulatory reports within the public domain. Learning lessons from others can enable early identification of risk.

**Central Alert Systems (CAS)** - this is the national method of communication of essential information which needs to be brought to the urgent attention of NHS bodies for review and appropriate action within the required timescale.

### 3.3.2 Reactive Identification and Management of Risk (i.e. after the event)

If this policy is to be effective and the Trust is to continue to develop and improve its approach to risk management, it is not sufficient to proactively assess and record its risks. Part of the culture of change must involve a commitment by all, at every level in the Trust, to review incidents and 'near misses', claims, complaints, and patient / staff feedback, to investigate where necessary and, most importantly, to learn and implement change as a result.

**Adverse events/incidents**
Individual Adverse incidents or thematic reviews from which it is apparent that there is an on-going risk that needs to be assessed and managed.

**Complaints, Claims, Clinical Audit and PALS**
As well as incidents, the Trust will continue to use information highlighted by complaints, claims, clinical audit and patient contact with PALS as opportunities to learn, develop and wherever possible put in place preventative or remedial measures to help improve the quality of the service provided.

**Organisational Learning and Sharing**
No risk management strategy will be complete or effective unless there is organisational learning and sharing of the lessons learned from the identification and management of risks. The Trust continues to report adverse events to national bodies where indicated (e.g. National Reporting & Learning System (NRLS); Health & Safety Executive (HSE); and Medicines & Healthcare products Regulatory Agency (MRHA) and will use the feedback from these organisations from national data as opportunities to identify potential risks and take action.

### 3.4 Statement of Risk (Risk Description)

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

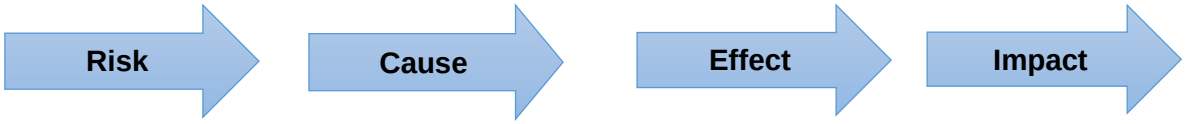
A marker of a good quality risk statement is that it can answer the following questions:

- What could happen?
- Why could it happen?
- Why do we care?

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 …."

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 the organisations strategic objectives.
- The **Cause** is the problems 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.

### 3.5 Assessment and Rating

It is vital that all risks are assessed in an objective and consistent manner if they are to be managed, and to guide operational, project and programme planning and resource allocation. A risk assessment form has been developed to assist in documenting the risk, controls, assurances and actions for each risk. This form should be used as an input document prior to recording on the electronic risk register. (See appendix for template)

#### 3.5.1 Risk Assessment (for Health and Safety risks refer to appendix D)

Once identified, the risk needs to be described clearly to ensure that there is a common understanding by stakeholders of the risk.

Risks will be assessed either using a bespoke risk assessment or using a designated risk assessment tool as identified in individual Trust documents, for example:

In drawing up and reviewing annual and strategic business plans, the Trust will use other recognised risk assessment tools such as SWOT (strengths, weaknesses, opportunities, threats) and PEST (political, economic, social and technical) analyses.

The Trust has a designated process for the compilation and consideration of business cases relating to service developments. A submission pro-forma and a due diligence check list provide the framework for the risks to be identified and assessed and can be accessed from the intranet. Business Cases will be informed by risk assessments.

Clinical Risk Assessment (e.g. falls, tissue viability and infection control) available on the intranet and should be used to assess clinical risk and aid care planning for individual patients.

Within Health and Safety at Work Regulations there are a number of supplementary regulations which include a specific requirement for risk assessment. Separate policies have been developed for these regulations, and are available on intranet.
It is important that managers only complete assessments that are relevant to their area; for example only complete new and expectant mothers risk assessment, when there is one in the area. Generic 'catch all' risk assessments are not beneficial.

For those bespoke assessments the recommended form for risk descriptions is to identify the cause, the effect and the impact. The system then uses descriptive scales to determine what would happen (impact) should the risk occur and the probability (likelihood of the risk materialising); this is referred to as the risk matrix. To use these scales it is important to use and document any information available from both internal and external benchmarking data to understand the risk and the potential impact should it occur.

A simple example would be a young and/or newly qualified car driver where statistically they are more likely to be involved in an accident than any other group and therefore would be assessed as high risk. It is important not to over complicate the process by addressing multiple risks in one assessment and as such in this scenario above a risk assessment for all

car drivers would not be beneficial in terms of risk management and the ability to add controls to influence behaviour.
Undertaking this baseline measure is useful when re-assessing risk for the impact of any subsequent controls that have been put in place.

Once a risk assessment has been completed it should be summarized using the standard template provided and once approved entered on Datix. A simple one-page guide to the information required for Datix is included in appendix C and an A3 template is available on the intranet.

### 3.5.2 Risk Rating

There is a single methodology for risk rating to ensure consistency of approach. The Trust uses the simple guide provided by the former NPSA 'Risk Matrix for Risk Managers'. It provides a guide to assist the assessment process and offers examples across nine different domains. Risk rating must take into account the control measures currently in place and be realistic when estimating the likelihood.

It is important to define the current controls to a) assess their effectiveness and b) to identify further controls / actions that can be taken to reduce the risk further or eliminate. Current controls may be physical (physical separation of people from the risk e.g. isolation for infection control); procedural (procedural methods which are understood and effectively implemented, e.g. safe systems of work, information, training, instruction and standard operating procedures) or protection of individuals (e.g. PPE and clinical risk management).

The risk rating is calculated by assessed consequence x assessed likelihood. The table below is an easy reference guide, with the RAG rating providing a schematic for low, moderate, high and extreme risk.

| | | CONSEQUENCE | | | | |
|---|---|---|---|---|---|---|
| | | 1 Insignificant | 2 Minor | 3 Moderate | 4 Major | 5 Extreme |
| LIKELIHOOD | **1 – Rare** - Not expected to occur | 1 LOW | 2 LOW | 3 LOW | 4 MODERATE | 5 MODERATE |
| | **2 – Unlikely** – Occurs infrequently | 2 LOW | 4 MODERATE | 6 MODERATE | 8 HIGH | 10 HIGH |
| | **3 – Possible** – Once or twice a year | 3 LOW | 6 MODERATE | 9 HIGH | 12 HIGH | 15 EXTREME |
| | **4 – Likely** – Hazard will occur but is not persistent. There are no issues of custom and practice | 4 MODERATE | 8 HIGH | 12 HIGH | 16 EXTREME | 20 EXTREME |
| | **5 – Certain –** Constant threat is custom and practice | 5 MODERATE | 10 HIGH | 15 EXTREME | 20 EXTREME | 25 EXTREME |

The NPSA 5X5 risk matrix and subsequent red, amber, yellow, green RAGs identify the level at which identified risks will be managed within the level of authority for risk management.

### 3.4.3 The consequence(s)

Recorded on a scale of 1 - 5 should the risk occur (be realized). It is important to record the context of the risk, and available evidence base from internal and external information (e.g. incident reporting, legal claims, peer review articles, NICE etc.) before calculating the score for consequence. This score is based on what the impact if the risk would be in most circumstances within your environment and what is reasonably foreseeable. Also by quantifying the consequence in terms of a tangible measure (cost / harm to patient / negative media exposure / targets missed etc.) it aids the identification and description of the benefits realization from proposed risk reduction strategies.

E.g. assessing the risk of patient harm resulting from drug administration error - evidence shows that the majority of drug administration errors are 'low or no harm' incidents, therefore would be scored as a consequence '1'. However, if the risk assessment focused on particular group of drugs e.g. controlled drugs the consequence of an error may be significantly greater in consequence scoring.

The table is taken from the NPSA's guidance 'Risk Matrix for Risk Managers' and is provided as a guide.

| | **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.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |

| | Consequence score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Quality/complaints/audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Low performance rating<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |
| **Human resources/ organisational 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<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>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<br><br>Reduced performance rating if unresolved | Single breech in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breeches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breeches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>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)<br><br>Total loss of public confidence |

| | Consequence score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br><br>Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

### 3.4.4 The Likelihood

Recorded on a scale of 1 - 5 the likelihood of hazard / adverse event occurring (given the current controls/precautions in place). Again it is important to record the context of the risk, and available evidence base before calculating the score for likelihood.

E.g. Assessing the likelihood of a drug administration error occurring - evidence shows that the majority of drug administration errors occur with the administration of routine medicines and probably on a daily basis, therefore would be scored as a '3'. However if the risk assessment focused on particular group of drugs e.g. controlled drugs the likelihood of an error may be significantly reduced due to heightened awareness and increased checking procedures scoring '2'.

| LIKELIHOOD | DESCRIPTION |
|---|---|
| 1 | **Rare** – not expected to occur, may occur only in exceptional circumstances i.e. 0 - 5 % probability |
| 2 | **Unlikely** – not expected but conceivable could occur at some time i.e. 5 - 20 % probability |
| 3 | **Possible** –might occur at some time i.e. 20 - 50 % probability |
| 4 | **Likely** – will occur in most circumstances i.e. 50 - 75 % probability |
| 5 | **Highly likely** – is expected to occur in most circumstances i.e. 75 - 100% probability |

### 3.4.5 Classification of Risks

In line with current guidance and best practice, risks are classified as either Strategic or Operational, defined as follows:

Strategic risks are those that represent major threats to achieving the trust's strategic objectives or to its continued existence. Strategic risks also include key operational failures. For example, failure to meet key targets or the provision of sub-optimal standards of care would be very damaging to the Trust meeting its strategic objectives. Being clear about strategic risk allows the Board to ensure that the information it receives is pertinent to achievement of objectives and facilitates a clearer starting point for mitigation and control as well as business planning. These risks form the core content of the Corporate Risk Register and Board Assurance Framework.

Operational risks occur as a product of the day to day running of a Trust and include a broad spectrum of risks including clinical risks, fraud risk, and financial risk, legal risks arising from employment law or health and safety legislation and risks of damage to assets or systems failures. In this context they include any risk that has the ability to stop the Trust achieving agreed targets or may have such an impact on delivery of Trust services that service delivery becomes in breach of contract with commissioners or spreads across more than one Speciality. They are the responsibility of line management and should be identified and managed by the Divisions. These risks are reported to the Board only where they are risk scored as critical (high) ≥ 15, therefore escalated to the Corporate Risk Register and Board Assurance Framework.

### 3.4.6 Risk Proximity

Risks are also assessed in terms of proximity i.e. when the risk would occur. Estimating when a risk would occur helps prioritise the risk. The proximity scale used in the Trust is:

| Descriptor | Proximity |
|---|---|
| zero to three months | High |
| three to six months | |
| six to nine months | Moderate |
| nine to twelve months | |
| twelve months plus | Low |

## 3.5 Control Identification

Once the assessment of the current risk threat has been undertaken an action plan to address the identified problems must be developed to mitigate the risk being realized and to reduce or eliminate the risk. This plan is expressed as further controls within the risk summary. This should seek to address the root cause of the risk and should be SMART (Specific, Measurable, Achievable, Realistic and Timed). As with assessment of the initial risk it is important to quantify the expected reduction and where possible the cost of implementing the further controls, as this will aid decisions regarding risk acceptability – through a risk/benefit analysis approach and alignment with the Trust statement of risk appetite. Control measures must take into account any relevant legal requirements which establish the minimum levels of risk control.

Controls are identified measures that are intended to minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

In designing further controls consideration should be given to:

- Can the risk/hazard be removed altogether?
- If not, what controls need to be in place so that the consequence, should the risk be realized and the likelihood (chance) of the risk occurring can be eliminated or reduced as far as is reasonably practicable?
- When additional controls are likely to become effective (target date)?
- What assurance will I be able to get as to whether the controls are working?
- What is the amount of managerial effort required to maintain the control?
- What the predicted (residual) risk rating, both from reduction in consequence and likelihood once all the controls are in place (target risk rating)?
- Where will the delivery plan be monitor?

When the further control measures have been identified and agreed they must be prioritised, placed into an action plan and implemented. Where full implementation of the control measures identified cannot be achieved rapidly steps may need to be taken in the interim to minimise the risk.

The implementation of the action plan must be monitored and subsequently reviewed to ensure that the remedial actions identified have been, and continue to be, adequate, appropriate and implemented.

### 3.6 Assurance of Control Effectiveness

It is the policy within the Trust for assessors to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively. These assurances are obtained from a variety of sources, such as:

- management reports,
- internal and external audit
- other external assessors such as the Care Quality Commission and the NHS Resolution

Both positive and negative assurances must be explained, which means that a clear description of what would be seen, known, understood if the controls were effective or not effective in mitigating the risk. This is explained in further detail in the Definition document (see appendix).

Ward, departmental, corporate and divisional managers must ensure that any gaps in the assurances are clearly identified, and that appropriate actions are taken to identify any gaps in the assurance processes. There is an expectation that managers will ensure that actions to control assurance gaps are delivered within the same timescale as closing gaps in controls.

### 3.7 Tolerated risks

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the significance of the risk that remains is understood and the organisation in accordance with the levels of authority for risk management confirms that it is prepared to accept that level of risk. This is known as the residual risk.

As an easy reference guide:

| | | | |
|---|---|---|---|
| 1 - 3 | Low | Likely to be acceptable | Acceptable unless there are practicable and affordable solutions which improves the risk or working environment. |
| 4 - 6 | Moderate | May be acceptable | If suitable controls are in place. |
| 8 – 12 | High | Likely to be unacceptable | High risk may be acceptable in situations where the consequences are potentially high but the likelihood of incidence is low and controls have been improved. |
| 15 - 25 | Extreme | Unacceptable | Executive ownership and action to be taken to reduce / eliminate the risk. |

### 3.7.1 Approval of Tolerated Risks

Approval of tolerated risks is the responsibility for the Divisional board members and will be overseen through the key controls report at the Executive Risk Oversight Committee. Committee members are to be assured that the risk can be tolerated within the scope of the mitigations in place.

## 3.8 Recording of Risks

Many of the risk assessments that are carried out on a day to basis form part of individual work plans; employment records and/or clinical care plans. As such they are applicable only to those directly in involved and are an integral part of those records. For these risk assessments there is no requirement to report this on the Datix system. However, the risk mitigation plans must be communicated and readily accessible to, employees and others as appropriate.

For other risks identified, this policy mandates the use of Datix summary with a full copy of the detail risk analysis being retained on the Datix record.

As a minimum a risk register must contain:

- risk reference;
- risk owner;
- risk description;
- ratings of likelihood and impact, for both current and after actions;
- risk proximity;
- action plans;
- action owner for each action; and
- completion date for each action.

It is recommended good practice to also include:

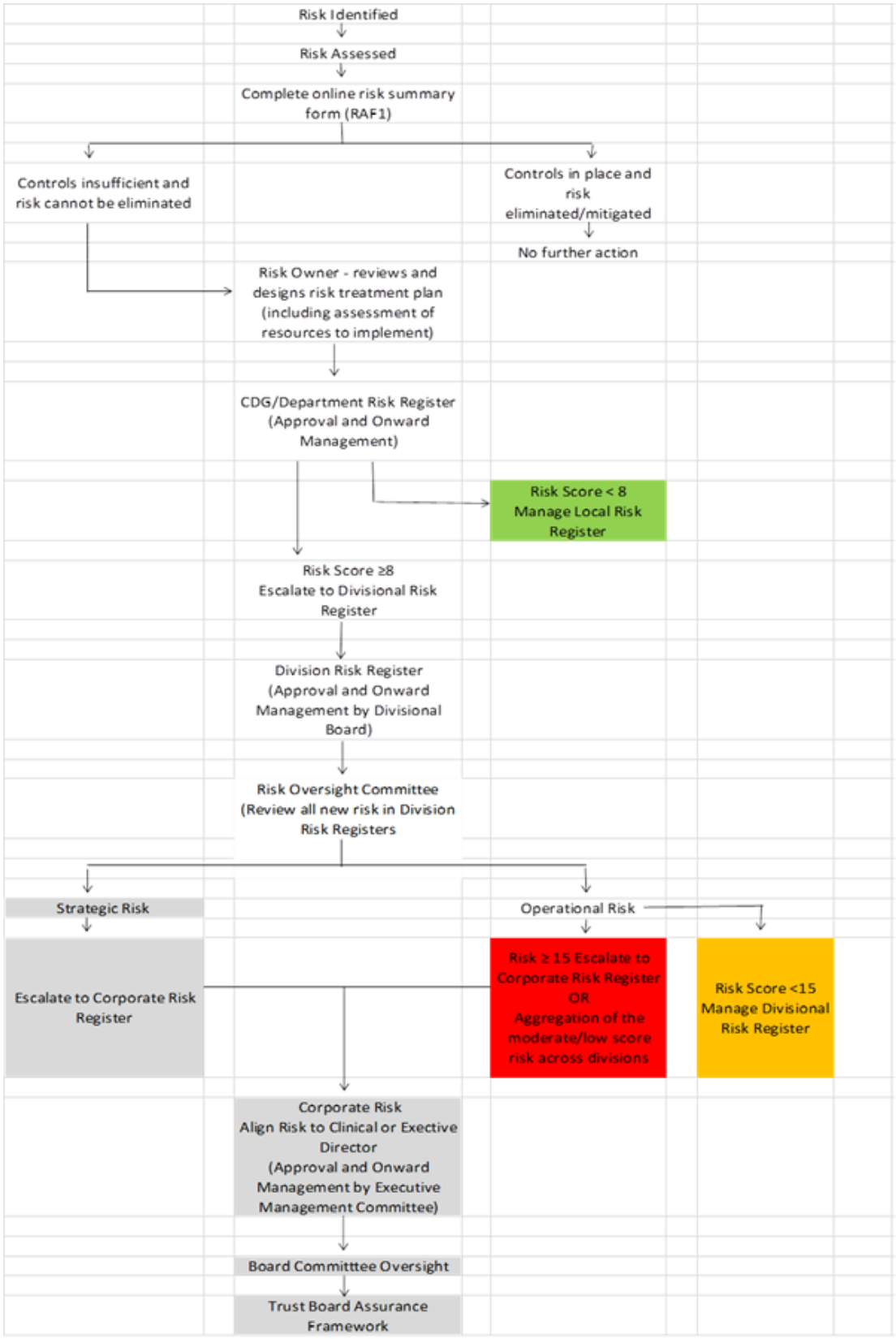
- trend analysis; and
- sources of assurance (management, internal and/or external).

Risk assessments and associated documents must be kept for a minimum period of 4 years from the date which they are superseded as they may be required in the event of a litigation claim for compensation. And some risks assessments (e.g. related to use of substances) may need to be kept for 40 years, in order to trace exposure to substances which are known to have ill health effects e.g. asbestos.

All risks should be allocated a risk owner (the person responsible for overseeing the actions to mitigate the risk). They should understand the risk and monitor it through its lifetime and ensure the appropriate controls are enacted. They are required to review and update the management actions as per the review schedule set for the risk.

When a member of staff is leaving or taking a leave of absence from their current role within the organisation, consideration should be given to reallocation of the risks assigned to the individual and should form part of the exit checks.

### 3.9 Approval Process for Risks



### 3.10 Reporting and Escalating Risks

#### 3.10.1 Escalating Risks

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 the Divisional risk register to the Corporate Risk Register. Risks will be escalated or de-escalated within the defined tolerances and authority to act for each level.

#### 3.10.2 Monitoring and Re-assessment

All risks on the Risk Register will have a review date recorded. The implementation of the action plan and the level of risk must be kept under regular review by the risk owner and where implementation of actions is not producing the anticipated results, the risk should be reassessed and a revised action plan agreed.

As actions are completed and further controls are established, the risk should be re-assessed. Reassessment should also be undertaken in such circumstances as:

- Change in legislation;
- Contractual requirement;
- Change in trust policy
- Objective setting
- Changes to physical environment
- Changes to use of area / room
- Refresh of business / service plans (at least annually as part of business planning)

#### 3.10.3 Divisional Risk Registers

Where a risk is assessed with a high or above rating it is assigned to one of the four Division Risk Registers; and as such has a line of accountability to a Division Management Team and a line of accountability to a member of the senior leadership team (Clinical or Executive Director).

- Each Division has a monthly meeting at which the Division's Risk Register is reviewed by the senior team. The Governance Managers are responsible for preparing a report for the board to enable efficient review of the risk register. This report should include the following:

- A check that all risks have been reviewed in line with specified review date; to enable the board to take immediate action to rectify any gaps (this enables a failsafe to identify and temporarily reallocate risks where a staff member may be off work for a period of time e.g.
- maternity leave);

- Report on proposed changes to risk ratings, with evidence underpinning the change to enable divisional approval;

- Report on new risks for approval and inclusion on the divisional risk register. The Governance Manager should provide the detailed risk assessment, the action plan and the cost implications of the proposed risk reduction strategies provided by the risk assessor;

- Report on all extreme risk with attention to any assurance received on the effectiveness of the current controls;
- Highlight actions across the risk register that are overdue to enable action to be taken; and

- Include a request to all board members to highlight any emergent risks to enable to the board to allocate resource to undertake a full risk assessment.

- Following the meeting the Divisional Governance Managers are responsible for:

- Updating the Datix records in that actions arising from the meeting are entered and assigned to the relevant person via the Datix system. This method of communication will enable the risk owners to easily access the risk summary via the link in the email and update accordingly and provide an audit trail to these communications; and

- Submitting the Division's Risk Oversight Report to the Executive Risk Oversight Committee when scheduled.

At the performance review meetings, the divisions will be expected to report on their top risks and be held to account for performance against the Accountability Framework metrics.

### 3.10.4 Corporate Risk Register

The Trust has a corporate risk register, which is an integral part of the system of internal control and defines the highest priority risks which may impact on our ability to deliver our objectives. The corporate risk register enables the Board of Directors and Audit Committee to be assured of the management of these risks. The Executive Management Committee manages these risks and the register is maintained overall by the Director of Governance.

The risk register is a live document that can be added to or amended anytime. Any risk scoring 15 and above will be reviewed by the Executive Risk Oversight Committee for consideration of escalation to the Corporate Risk Register. Escalation is based on the risk meeting the criteria of a strategic risk and / or on the basis of risk score being critical for an operational risk.

De-escalation of a risk from the corporate risk register is based on the risk no longer meeting the criteria of a strategic risk, scoring less than 15, and the Board of Directors being satisfied by the levels of assurance and mitigations in place.

The Risk Manager is responsible for preparing a report for the Executive Management Committee to enable efficient oversight of the corporate risk register. This report should include the following:

- Confirmation that all risks have been reviewed in line with specified review date; where there are gaps what action is being taken to address the issue.

- Report on risks where ratings have changed, with evidence underpinning the change.

- Report on new risks identified and approved by the Executive Risk Oversight Committee;

- Report on all extreme risk with attention to any assurance received on the effectiveness of the current controls;

- Risks within the Corporate Risk Register will be considered when agenda setting for the Executive Management Committee.

- Following the Executive Management Committee meeting the Risk Manager is responsible for:

- Submitting the corporate risks to the relevant Board Committee for oversight. This practice enables the detail provided to the Board of Directors within the Assurance Framework to have received an appropriate level of probity.

### 3.10.5 Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust with a simple but comprehensive method for the effective and focused review of risk. Through the BAF the Board gains assurance from the Board Committees that strategic and critical operational risks are being appropriately managed.

The BAF identifies through the review of assurances provided which of the Trust's objectives may be at risk because of inadequacies in the operation of controls. It also highlights areas where there is insufficient assurance. This allows the Board to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care.

In terms of evaluating the effectiveness of agreed controls and assurances applied to the risks included in the BAF, the RAG rating system is also used. A guide to types of assurances is provided in appendix. The Board Committees will ensure review of the risks when setting agendas.
The Board of Directors will also receive the Board Assurance Framework in its entirety at the beginning of each financial year and quarterly thereafter. In the intervening months the Board will receive updates through board committee escalations on critical risks.

### 3.10.6 Reporting Schedule

| | |
|---|---|
| Divisional Boards | All risks monthly |
| Executive Risk Oversight Committee: | All >15 and new risks (monthly) All 'corporate' risks (quarterly)<br>Divisional oversight reports (quarterly) |
| Executive Management Committee: | All >15 and new corporate risk (monthly) Full Corporate Risk Register (quarterly) |
| Quality and Patient Safety Committee: | All BAF and >15 'corporate' operational risks associated with quality: patient safety; patient experience & clinical effectiveness or healthcare regulations (bimonthly) |
| Performance Committee | All BAF and >15 'corporate' operational risks associated with performance (bimonthly) |
| People and Organisational Development Committee | All BAF and >15 'corporate' operational risks associated with workforce and education<br>(bimonthly) |
| Innovations Committee | All BAF and >15 'corporate' operational risks associated with large scale programmes / projects with a value over £1m.<br>(quarterly) |
| Board of Directors | BAF and CRR >15 operational risks reported quarterly.<br>Any previous escalated operational critical risk rescored <15 will be reported prior to being removed from reporting schedule. |
| Audit and Risk Assurance Committee | A report on risk management system key controls will be presented to each Audit Committee meeting. |

### 3.10.7 Project Risk Management

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 risk to programmes or projects as part of project documentation.

Each project should have a minimum of one overarching risk on the risk register (recorded on Datix) which describes the potential impact to the organisational strategic objectives should the project not deliver its identified objectives and outputs. Within each project risk, the project manager will be responsible for managing a RAID (risks, assumptions, issues and decisions) log and maintaining a current version, which is monitored through the programme/ project governance meetings.

Approval or reviews of each project risk register entry is monitored through the programme board on a regular basis. Refer to the Risk Management Policy for the criteria for reporting committees dependent or risk type and/or score.

Reports can be developed via Datix for the Time Matters Board and each individual programme board showing the level of the risk to the organisation; these can be designed and run from each programme manager's dashboard.

A training package will be developed for project managers to explain the process for managing risks relating to projects and ongoing support is available from the Trust Risk Manager.

**RAID log:**

- Risks: This log should capture the key elements about risks related to the project for further management by the project team. It should document all project risks, their potential impact and the mitigations and actions put in place by the project.
- Assumptions: This log should consolidate all assumptions from various project meetings.
- Issues: This is used to track any issues related to the project. This is not intended to be used for technical product-related issues (for example, issues with resourcing, vendors, etc.).
- Decisions: This log captures all of the decisions that were taken or made during the project. Decisions that are on the table and taken (and their impact on the project) need to be documented for future learning on other projects.

## Section 4 - Training and Education

To support the implementation and embedding of the risk management policy and procedures training and awareness is provided through a variety of mediums to ensure staff receive training appropriate to their role and reinforce the main elements of this policy:

- an 'Introduction to risk management' will be made available to all staff through the Essential Training Handbook;

- Bespoke advanced risk management training will be available to governance managers and risk register owners, tailored to their specific needs. This could include advice and guidance on the management of risk in their area, peer reviews and / or support with development of risk registers.
- Induction procedures cover basic Health and Safety, Security, Personal Safety and Fire Safety information. Detailed induction training takes place within each department and is based on a training needs analysis; and

- Staff will receive information, instruction and training regarding all hazards within their workplace and the control measures and safe systems of work involved to minimise risk.

- The process for recording attendance and following up non-attendance is in accordance with the Trust Policy.

- Governance and Risk training is also available via the Training and Education for Operational and Leadership teams.

## Section 5 – Development and Implementation including Dissemination

5.1 The Risk and Compliance Team will be responsible for assuring the delivery of the implementation of the policy and procedures

5.2 This Policy will be made widely available, both internally and to our external stakeholders, via a wide range of communication modes including:

- Cascade through the Divisional meetings to senior professionals, managers, ward sisters/charge nurses and first line managers. It is the responsibility of individual managers to ensure that the policy is properly communicated to their staff.
- The Trust Intranet
- Mandatory training handbook.
- Risk related study days.

## Section 6 – Monitoring Compliance and Effectiveness

The overall compliance of this Policy will be monitored by the Executive Risk Oversight Committee. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.

- A monthly risk management key controls report to Executive Risk Oversight Committee (and to each Audit Committee);

- Annual review of compliance with terms of reference of those committees and groups making up the risk management structure;

- Internal Audit annual review to provide an independent assessment of the risk management policy and procedures; and

- Annual risk maturity assessment (internal benchmark)

## Section 7 – Control of Documents including Archiving Arrangements

7.1 Once ratified by the Board of Directors the Responsible Officer will forward this guideline to the Information Governance Department for a document index registration number to be assigned and for the guideline to be recorded onto the central hospital master index and central document library of current documentation.

7.2 In order that this document adheres to the Records Management Policy, the Responsible Officer will arrange for staff to be advised when this document is superseded and for arranging for this version to be removed from the hospital's intranet. The Responsible Officer will also advise the Information Governance

Department who will ensure that this document is removed from the current index and library, archived and retained for 10 years from the archive date.

## Appendix A – Specific Maternity Risk Management Reporting Processes

The Datix incident reporting system is used throughout the Trust. Maternity uses the incident reporting system for reporting common complications of pregnancy and birth which usually have no long term outcomes. However, some of these incidents can result in significant harm which is not immediately apparent and a claim being made against the Trust. Summary reporting tools are used to assess incidents such as postpartum haemorrhage, shoulder dystocia, admission of babies to the neonatal unit at term and prolonged second stage. These provide the opportunity to identify trends and analysis of a number of incidents over a period of time as part of audits.

In addition to standard incident reporting processes outlined in Trust policies, the Maternity services have a duty to report certain incidents to other national confidential enquiries and reporting platforms.

All maternal deaths (deaths in pregnancy, labour, or up to a year after the birth of a baby), baby losses from 22 weeks of pregnancy, stillbirths, and neonatal deaths (deaths in the first 4 weeks of life) should be reported to Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries (MBRRACE) within 30 days of the death occurring. All baby losses from 22 weeks, stillbirths and neonatal deaths should be reviewed using the MBRRACE perinatal mortality review tool which is uploaded to the reporting framework.

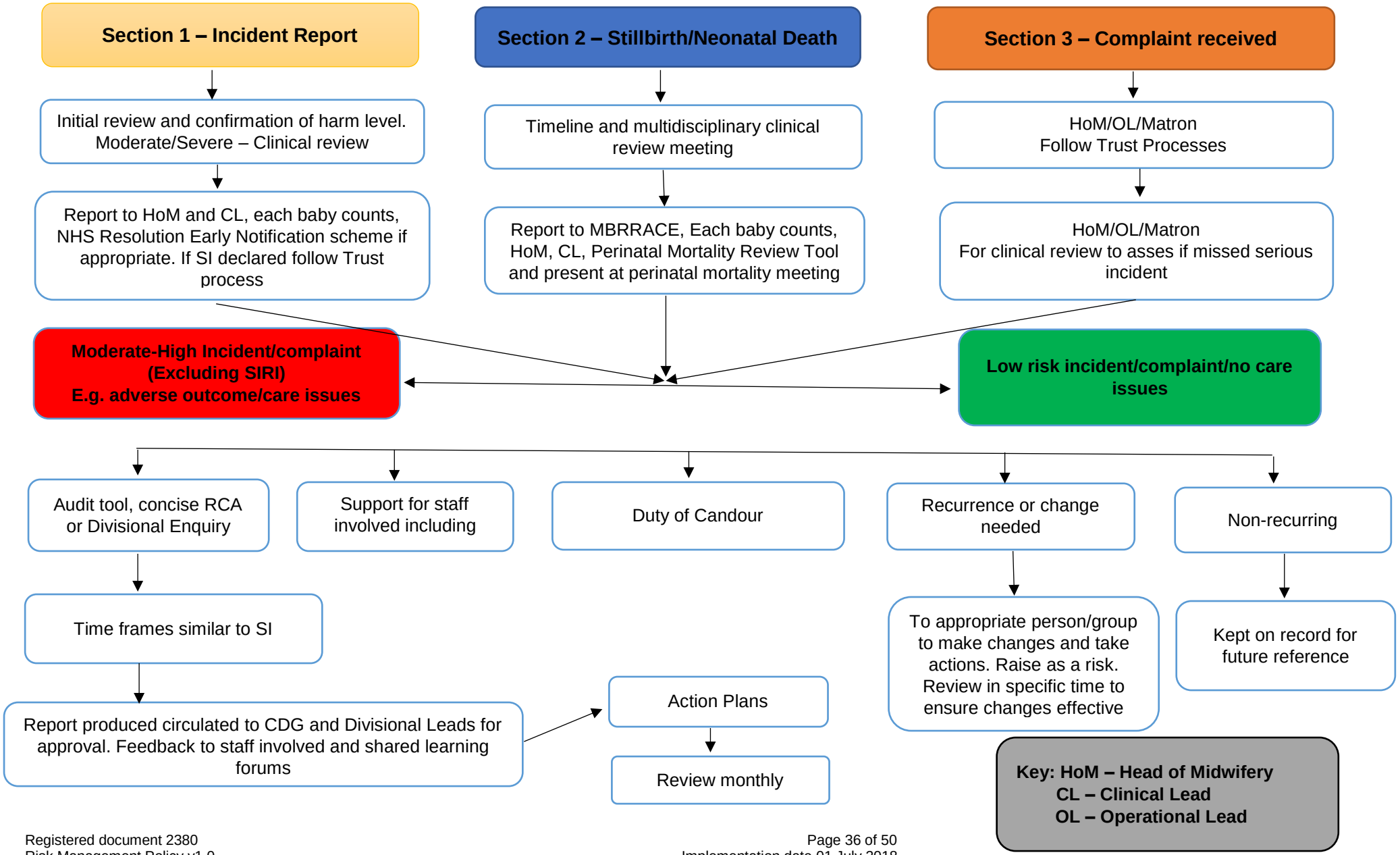
All perinatal deaths require a clinical review to ascertain whether there were missed opportunities, care and service delivery problems and lessons to learn. These may be investigated using a concise RCA, Divisional Enquiry or a SIRI if the reporting criteria is met. The mother of the baby is asked to contribute to these reviews. In the near future, external panels will be undertaking reviews of all stillbirths and neonatal deaths to ensure these are investigated fairly, equitably with sharing of lessons learned and organisational actions from learning.

MBRRACE produce an annual report of all perinatal deaths assessing whether the nature and number of losses within the Trust are consistent with Trusts of similar demographics and level of neonatal care. They also undertake confidential enquires into specific areas of obstetric and maternity care and Trusts are required to provide information and anonymised records to help to facilitate these enquiries.

In addition, all cases of term intrapartum stillbirth, term neonatal deaths and babies who are suspected as having hypoxic ischaemic encephalopathy, will be reported to Each Baby Counts. This is a national reporting framework which requires robust investigation reports to be undertaken looking at contributory factors and root causes. Cases of suspected hypoxic injury are also (with parental permission), to the NHS Resolution Early Notification Scheme.

These specific reporting processes are summarised in the flow chart below.

## Maternity Risk Management Pathways



**Guide to Reporting Maternity Risk Management Issues - Examples**

**Clinical Issues**
3rd/4th degree perineal tears
Apgar score of <7 at 5 minutes
Unexpected admission to NNU
Postpartum haemorrhage >1000mls
(lesser amount if affecting health)
High dependency/intensive care
Eclampsia
Prolonged 1st stage >15hrs
Prolonged 2nd stage >3hrs
Failed Instrumental deliveries
2nd stage CS
Delivery using more than 1 instrument
Medication errors
Ruptured uterus
Shoulder dystocia
Erbs Palsy

**Any unexpected injuries/trauma**
Undiagnosed breech presentation
Stillbirth/neonatal death
Unexpected readmission/admissions mother/baby BBA
Unexpected return to theatre/surgical procedure
Retained swab or instrument
Urinary retention
Needle-stick injuries

**Organisational Issues**

Insufficient equipment
Insufficient staff for workload
Transfers out of Unit
Problems with lifts
Slips, trips, falls
Shortage of beds available
Delay in treatment/discharge

**Record Keeping Issues**

No record of investigation results
No recorded management plan
Missing records/results

**Communication Issues:**

Communication affecting care
Verbal abuse

**Any other incidents where you think there has been an adverse event or near miss or you feel that the standard of care is below that which would be expected**

## Appendix B – Risk Appetite Statement

The below statements are a reflection of the Trust's current position in relation to the primary risk groupings as set by the Good Governance Institute (2012)1. This position will be reviewed on an annual basis (unless required to do sooner) to ensure that the position remains constant for all Trust staff, and to accurately reflect the manner in which the Trust Board and all staff undertake business in a consistent manner.

### Financial

The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential and is prepared to make bold, but not reckless, decisions, minimising the potential for financial loss by managing risks to a tolerable level. For other financial decisions, the Trust takes a cautious position, with VFM as the primary concern. However, the Trust is willing to consider other benefits or constraints and will consider value and benefits, not just the cheapest price. Resources are allocated in order to capitalise on opportunities.

### Compliance/Regulatory

The Board has a cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so and the gain will outweigh the adverse consequences.

### Innovation

The Board has an open view of innovation that supports quality, patient safety and operational effectiveness. This means that it is eager to pursue innovation and challenge current working practices, and views new technologies as a key enabler of operational delivery. However, decision making authority will be carefully managed to ensure that prioritization and focus is on the identification and delivery of innovations with transformative potential and will only be devolved on the basis of earnt autonomy.

### Quality

The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation actions are strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.

### Infrastructure

The board will take a cautious approach when investing in building and equipment maintenance and replacement, based on informed analysis and assessment of risk but may take informed risks if there are identifiable mitigations that can provide reasonable alternative protection.

### Workforce

The board has a flexible view to Workforce and is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward.

**Reputation**
The Board's view over the management of the Trust's reputation is open and is willing to take high to significant risks and is willing to take decisions that are likely to bring scrutiny to the organisation where the potential benefits outweigh the risks and sees new ideas as potentially enhancing the reputation of the organisation.

**Commercial**
The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature, taking a balanced view of risk and reward and on the basis of earned autonomy.

| Key Elements | Avoid | Minimal | Cautious | Flexible | Open |
|---|---|---|---|---|---|
| Quality | | | | | |
| Workforce | | | | | |
| Compliance/ regulatory | | | | | |
| Financial/VFM | | | | | |
| Innovation | | | | | |
| Infrastructure | | | | | |
| Reputation | | | | | |
| Commercial | | | | | |

## Appendix C – Risk assessment form

| **Appendix C – Risk assessment form**<br><br>**Ward/ Dept./ Other** | **Service Area** | **Division** |
|---|---|---|
| | | |

| **Risk Description** | |
|---|---|
| Risk title (task/activity) | |
| Summary of Risks/Hazards<br><br>Please describe risk as following:<br><br>*Caused by ...*<br>*Effect ...*<br>*Impact (May lead to) ...* | |
| Individual inputting risk | |
| Accountable Manager | |
| Manager/Director responsible for risk | |
| **Existing/Current Controls**<br>*Please list the current controls which have been implemented to reduce the risk (task/activity/system/arrangement)* | |
| | |
| | |
| | |
| | |
| | |
| **Controls to be developed**<br>*Please identify any potential gaps in the controls which have not been put in to place* | |
| | |
| | |
| | |
| | |
| | |
| **Positive assurance**<br>*What evidence has there been that control is in place and working effectively?* | |
| | |
| | |
| | |

| **Negative assurance**<br>*What evidence has there been that the control is not being managed/reduced appropriately?* | |
|---|---|
| | |
| | |
| | |
| **Actions**<br>*List all actions which have been put in to place to reduce the risk or implement/maintain a control*<br>*All actions must have a due date.* | **Due Date** |
| | |
| | |
| | |

| **Risk Rating** | | | |
|---|---|---|---|
| **Level of Risk**<br>*Please contact the Trust Risk Manager if this risk is required for the Corporate Risk Register* | Ward | Service | Division |
| | | | |

| **Risk Rating - *Refer to Appendix 1 (Likelihood x Impact = Risk Score i.e. 3 x 2 = 6)*** | |
|---|---|
| **Original Risk Score**<br>*(Original risk rating, before your actions/controls have been put in place)* | |
| **Current Risk Score**<br>*(Current risk rating, where you are now)* | |
| **Target Risk Score**<br>*(Target risk rating, where you aim to be)* | |

| **Risk Review dates** | |
|---|---|
| **Date Identified (dd/mm/yyyy)** | |
| **Next Review Date (dd/mm/yyyy)**<br>Risk Rating: Low /Moderate — Review Period: Bi-annually<br>Risk Rating: High — Review Period: Quarterly<br>Risk Rating: Extreme — Review Period: Monthly | |
| **Target Risk Date (dd/mm/yyyy)** | |
| **Cost of Further Controls** | |

| **Approval** | | | |
|---|---|---|---|
| | **Name** | **Signature** | **Date** |
| **Line Manager Approval** | | | |
| **Governance Manager/Coordinator or Trust Risk Manager Approval** | | | |

**Please ensure that Risk is approved at Divisional Governance Meeting**

## Appendix D - Health and Safety Risk Assessment Form

Division: Dept. /Ward:
Task/Activity:

Summary of Risks/Hazards including People at Risk:
Cause:
Effect:
Impact:

| Existing Controls: |
|---|

| Current Risk Rating: Likelihood x Impact or severity = Risk Rating<br>(Use Matrix overleaf) |
|---|

| Action Plan Summary<br>*(It is important to consider the hierarchy of measures in relation to the 5x5 matrix on page 2 when planning the elimination and/or reduction of risks)* | | |
|---|---|---|
| | Target Date | Completion Date |
| | | |
| Manager Responsible for Action: Signature:<br><br>Designation:<br><br>Review Date: | | |
| **Risk Rating if Actions Completed**<br>**(Use Matrix below)**<br><br>**Likelihood x Impact or severity = Risk Rating** | | |

## Risk Matrix

| | | Likelihood of a recurrence | | | | |
|---|---|---|---|---|---|---|
| | | Remote 1 | Unlikely 2 | Possible 3 | Likely 4 | Almost Certain 5 |
| Severity of Incident | Insignificant 1 | | | | | |
| | Minor 2 | | | | | |
| | Moderate 3 | | | | | |
| | Major 4 | | | | | |
| | Extreme 5 | | | | | |

**Risk Ratings – Action Required**

**Low Risk (Green) (1-6)**
Acceptable risk requiring no immediate action, review annually and place on Service/Departmental Risk Register

**Moderate Risk (Yellow) (8-12)**
Action planned within one month to reduce risk, commenced within 3 months and place on Service/Departmental Risk Register

**High Risk (Orange) (15-16)**
Actions planned immediately, review Monthly and place on Service/Departmental Risk Register.

**Extreme Risk (Red) (20 - 25)**
Immediate Actions required details to be forwarded to Associate Director who will then report to Director of Operations or Director of Nursing & Patient Experience. Review weekly, (or as deemed necessary by the action plan). Place on Trust section of the Risk Register

**Impact of Risk:** **Service Area (local)** ☐ **Division Risk (local)** ☐ **Trust Risk** ☐

**Source of Risk:** _____ **(e.g. Complaint, Incident, Patient Feedback)**

**Type of Risk:**

| | | | |
|---|---|---|---|
| **Clinical** | ☐ | **Health & Safety** | ☐ |
| **Business Development & Contracting** | ☐ | **Information Management & Technology** | ☐ |
| **External Risks** | ☐ | **Operational** | ☐ |
| **Facilities Management** | ☐ | **Staff Related** | ☐ |
| **Financial** | ☐ | | |

**Risk Assessors Name:** **Signature:**

**Designation:** **Date:**

**Assessment and Action Plan accepted by Line Manager and review date agreed: Yes ☐ No ☐**

**Proposed Costs:**
**Manager's Name:** **Signature:**

**Designation:** **Date:**

**Transferred to Risk Register(s)** **Yes ☐** **No ☐**

**Date:** **Datix Input ID No:**
**Name of Inputter:**

| | | |
|---|---|---|
| ***This assessment is to be reviewed - any change to people/process/equipment, after any relevant incident or as required by the risk rating for all Trust General Risks.*** | | |
| **Reviewed By:** _____ | | **Date:** |
| **Any changes?** | **Yes/No** | **Signature:** |

## Appendix E - Risk Summary Form (RAF1) Guide

| Section | Comments |
|---|---|
| ID | A number which allows the risk to be uniquely identified: this will inserted, once the risk is placed on the register. |
| Date Entered | The date the risk was first placed onto the Register |
| Risk Assessor | This is the person who is completing the Risk Assessment Form |
| Risk Owner | This is usually the service manager / matron<br>With exception of strategic risks and those operational risks ≥15 where this is the Director who is responsible for overseeing the actions to mitigate this risk. They should understand the risk and monitor it through its lifetime and ensure the appropriate controls are enacted.<br>They are required to update the management actions as pre the review schedule. |
| Division | This is the Division who has responsibility for mitigating the risk – It is not always the Division that reports the risk. |
| Sub Risk Register | This the sub risk register that is held locally to monitor the actions within the Division |
| Specialty | Area affected by the risk. |
| Type | This is strategic or operational risk |
| Sub Type | This is the sub type of the main risk e.g. clinical and equipment |
| Risk Title | This is a Brief description of what the risk is. |
| Risk Description | A statement that provides a short, unambiguous and workable description, which enables the risk to be clearly understood, analysed and controlled. This should be no more than 1024 characters. (should include cause, effect and impact) |
| Current Controls | Details of any actual controls already in place i.e. factors that are exerting material influence over the risk's likelihood and impact: the risk rating. E.g. policies, guidelines, safe practices.<br>An effective control is one that is properly designed and delivers the intended objective / mitigates the risk |
| Initial Risk Rating | The rating determined by likelihood x consequence using the 5 x 5 matrix<br>Consequence: the impact should the risk occur - this score should take into account the existing controls<br>Likelihood: the likelihood of the risk happening - this score should take into account the existing controls |
| Further Controls / Actions | Further action(s) required to be taken in order to eliminate, mitigate or control the risk |
| Cost to implement | The cost of the actions to eliminate, mitigate or control the risk |
| Target Risk | The risk rating after the further actions have been implemented: expressed as the product of the likelihood x the consequence |
| Risk treatment | This is for the ownership manager to advise on tolerate risk, eliminate reduce or transfer the risk. |
| Verified By | This by signed off by a Clinical Lead, Director or HON/HOP |
| Corporate objectives | This reflects corporate objective this risk impacts. |
| Date of next review | The date of when the risk will be reviewed. |

| Section | Comments |
|---|---|
| Current Risk Rating | This will initially be the same as the initial risk rating<br>As time progresses, the current risk rating should decrease (if your controls are appropriate and effective) and move closer to the predicted residual risk rating |
| Approval Status | This to be given final approval by the ownership manager to finally approve. |

## Appendix F - List of Specialist Advisors

Advice, support and information about training are always available from the Risk Manager or other Specialist Advisors across the Trust.

| Title | Available Advice |
|---|---|
| **Risk Management** | |
| Risk Manager<br>CAS Liaison Officer | All aspects of risk management and associated policies and procedures, the risk register, CAS Alerts and Assurance Framework. |
| Risk Database Analyst | All aspects of incident reporting, Datix database system and risk management training |
| **Claims** | |
| Legal Services Officer | All aspects of claims management and medico-legal issues |
| **Complaints** | |
| Complaints and PALs Manager | All aspects of formal complaints handling, monitoring and training |
| **Clinical Audit** | |
| Clinical Audit Co-ordinators | All aspects of clinical audit |
| **Other Specialist Advisors** | |
| Senior Infection Control Nurse | All aspects of control of infection: operational and strategic |
| Fire Safety Manager | All aspects of fire safety |
| Health & Safety Manager | All aspects of health & safety |
| Security Manager | All aspects of security to persons and property |
| Information Governance | All aspects of information governance, data protection and patient confidentiality |
| Manual Handling Advisor | All aspects of manual handling and back-care issues. |
| Head of Professional Development | All aspects of nursing and Allied health Professionals training including competency in the use of medical devices |
| Chief Pharmacist | All aspects of medication management |
| Radiation Protection | All aspects of radiation protection |
| Resuscitation Officers | All aspects of cardiopulmonary resuscitation |
| Counter Fraud | All aspects of counter fraud |
| Blood Transfusion Nurse | All aspects of blood handling and transfusion |
| Occupational Health Advisors | All aspects of staff health and concerns |

## Appendix G - Types of Assurance

### Internal

- Key Performance Indicators (including quality indicators, contract measures, national targets and ward heat maps)
- Patient Satisfaction Surveys
- Staff Survey Results
- Committee Chair's escalation reports
- Division Quality & Performance Meetings
- Internal Audit Reports
- Local Counter Fraud Reports
- Safeguarding Serious Case Reviews
- Internal Management Reviews
- Self-assessment against the Care Quality Commission outcomes
- Quality Accounts
- Serious Incidents Requiring Investigation
- Clinical Audit
- Specialty Reviews
- Clinical Presentations
- Incident, Complaints, Litigation and PALs reports
- Compliments
- Policies and Procedures – monitoring of compliance
- Annual Reports from all Trust Committees
- PLACE Inspections

### External assessments, reviews and benchmarking

- National Patient Satisfaction Surveys (Inpatient, Outpatient, Emergency)
- CQINS (Commissioning for Quality and Innovation)
- CQC assessments and Intelligent Monitoring Report
- Announced and unannounced inspection of clinical areas by Clinical Commissioning Groups (CCG's)
- Health and Safety Inspections
- External Audit Reports
- PROMS (Patient Related Outcome measures)
- Counter Fraud and Security Management Service
- United Kingdom Accreditation Service (UKAS)Dr Foster
- Independent Reviews
- Information Centre for Health & Social Care
- Information Governance Toolkit
- Peer Reviews (e.g. cancer)
- National Audits (e.g. TARN, LUCADA, MINAP)
- PEAT Inspections
- National Staff Surveys
- Quality Intelligence East (QIE)
- Patient Choices
- Specialist external reviews e.g. confidential enquiries
- National Patient Safety Agency (NPSA) - National Reporting and learning System (NRLS) reports

**Appendix H - Divisional Report Template**

## Report to Executive Risk Oversight Committee
## [Add Division]

### 1 Introduction

1.1 The purpose of this report is to provide an overview of all risks contained within [add Division] risk register where the risk scores are ≥12 (both new and current).

1.2 Across [add Division] there are currently [add number] active risks covering the division's clinical delivery groups of [add name the CDGs]. Within this risk profile there are [add number] risks scoring 12 or above.

1.3 The Committee is asked to provide oversight to:

New risk entries with a risk score ≥ 12 and escalate as appropriate in line with the Risk Management Policy.

All risks score 15 + to ensure that actions to improve mitigations are being implemented in a timely manner. Further to review the assurances that the current controls are being effective and note any gaps in assurance.

### 2 Risk Overview

2.1 Risk Trend chart – all risks scored ≥ 12

| Risk | Dept. | Description | Initial | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

[Add to table above if needed]

2.2 Risk Management Key Controls

A review has been undertaken and the [add division] reports that all risks have been reviewed in line with the risk management policy.
OR
A review has been undertaken and the [add division] reports that all risks have not been reviewed in line with the risk management policy. [Add detail of the issue and actions being taken to rectify].
OR
All the risks assigned post-merger to the XX Directorate have been reviewed. It is worth noting that a number of the risks had limited information available within the Datix system which is now being established and added to the files. The entries will be tidied by the [date] enabling a data extract to be meaningful.

A review has been undertaken and the [add division] reports that all risks have been reviewed in line with the risk management policy.

Or, a review has been undertaken and the [add division] reports that all risks have not been reviewed in line with the risk management policy. [Add detail of the issue and actions being taken to rectify].

2.3 New risks within the reporting period risk scoring ≥ 12

[Add number] new risks were added within the reporting period:

Risk [ID number] [Title]. This was added to the register on [date] following review by the divisional [add meeting] and identified from [add detail e.g. clinical audit outcome etc.]. The detail of this risk is provided in appendix 1 and is presented in full within the appendix. (Add risk template for all new risks as an appendix)

[Repeat above as needed]

2.4 Changes to Risk Score for risks scoring ≥ 12 at last reporting

There were no changes to risks scores within the reporting period.

Or, the following changes to risk scores where approved by the divisions within the reporting period:

Risk [ID number] [Title]. The risk score has been [increased / decreased] [add rationale – based on evidence / analysis]. [State whether this has increase to threshold for inclusion in the corporate risk register or that it remains at a level appropriate for management by the Division].

2.5 Assurances received

The following controls have been tested within the reporting period, with the following assurances for note by the Committee:

| Risk ID | Control | Assurance | Positive / Negative |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 3 Recommendation

The Committee is asked to provide oversight to:

- New risk entries with a risk score ≥ 12 and escalate as appropriate in line with the Risk Management Policy.
- All risks score 15 + to ensure that actions to improve mitigations are being implemented in a timely manner. Further to review the assurances that the current controls are being effective and note any gaps in assurance.