### RISK MANAGEMENT POLICY AND PROCEDURES

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<td>Chair of PRAMG</td>
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<td>Associate Director Governance and Risk</td>
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The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This Policy has therefore been equality impact assessed by the (Quality Governance Steering Group) to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.
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1.0 **Introduction**

1.1 The Trust’s Risk Management Policy and Procedures have been primarily developed to set out the Trust’s key aims and objectives for risk management.

1.2 They have also been developed for the following reasons:

- To comply with legal & statutory requirements and to comply with the requirements of external regulators and other relevant bodies;
- As guidance to assist with proactive risk management and risk mitigation;
- To support the organisation in its approach to ensuring the safety of staff, patients, visitors and others affected by the Trust’s activities.

1.3 University Hospital Southampton NHS Foundation Trust (UHS) recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all activities which involve a certain degree of risk. These risks are present on a day-to-day basis throughout the Trust.

1.4 The continued delivery of high quality healthcare requires the identification, management and minimisation of events or activities, which could result in unnecessary risks to patients, staff, visitors and members of the public. The management of risk is a key organisational responsibility of all staff employed by the Trust.

1.5 The Trust acknowledges its legal duty to safeguard staff, patients, visitors and members of the public. There are also sound moral, financial and good practice reasons for identifying and managing risks. Failure to manage risks effectively can lead to harm/loss/damage in terms of both personal injury but also in terms of loss or damage to the Trust’s reputation; financial loss; potential for complaints; litigation and adverse or unwanted publicity.

1.6 Risk Management is a systematic process by which potential risks are identified, assessed, managed and monitored. It is an integral part of good Clinical and Corporate Governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial. Risk Management is also embedded within the Trust’s overall Performance Management Framework and links with business planning and investment.

1.7 It is recognised that the delivery of healthcare will always involve a degree of potential risk, due to the complex interactions of people, skills, technologies and drugs. However, it is recognised that a significant amount of patient safety incidents could have been avoided if lessons from previous incidents had been learnt or potential risks mitigated earlier.

1.8 This policy and procedures aims to clarify roles and responsibilities of Trust staff and provide clarity on the risk management process to enable the organisation to continuously improve.

1.9 The challenge faced by the Trust is to identify and minimise so far as is reasonably practicable the potential for such risks to materialise by being pro-active and to ensure where required that organisational learning takes place.

1.10 Comprehensive guidance on the process for the management of risk locally is contained in Appendix A.

2.0 **Scope**

This policy and procedures applies to all Trust staff.
3.0 Aims and Objectives

3.1 The Trust is committed to providing high standards of patient centred care in all settings. All services are required to focus on patient safety and quality of care whilst acting with responsibility within the financial and performance framework of the Trust.

3.2 Our overall aim is to achieve a culture where risk management and safety is everyone’s business, there is open and honest reporting of incidents, a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised.

3.3 When things go wrong it is important that the response is one of openness and learning with a drive to reduce future risk. The Trust accepts that “honest failures” may occur and believes that risk and safety activities can and will inform and improve practice.

3.4 Through a coordinated approach to the management of risk and quality governance within this healthcare organisation the aim is to:

- Improve quality of care and patient experience;
- Maintain a safe environment free of unnecessary risks for patients, employees and visitors;
- Ensure the provision of a robust system for reporting and analysis of incidents with timely learning for all staff;
- Ensure that there are effective risk management systems, processes and arrangements in place and that these are monitored on an ongoing basis;
- Create an open and fair approach to incident identification and investigation, supported by a learning culture;
- Develop activity to support population of the Trust’s Board Assurance Framework through ongoing review of local and corporate risk registers;
- To support the achievement of the Trust’s objectives as set out in the Annual Plan, the Integrated Business Plan and the Trust’s 20/20 Vision;
- To ensure staff are aware of the process for the management of risk locally, divisionally and corporately and of the committee structure supporting risk management within the organisation;
- To ensure staff are aware of their duties in relation to risk management, that there are clearly defined roles and responsibilities for the management of risk and that management levels of authority in relation to risk are clear;
- To use risk assessments and intelligent risk information i.e. Risk Registers and data sources, to inform the overall business planning/investment process in the Trust as well as other components of governance i.e. clinical effectiveness, audit and education and training;
- To identify the process through which the Board and high level committees will review, scrutinise and monitor the Corporate Risk Register and Board Assurance Framework.

4.0 Outcomes

- The Trust will meet its statutory duties and comply with all appropriate regulations, assessments, accreditation and external reporting requirements;
- Trust staff will be aware of their duties and responsibilities in relation to risk management and will manage and escalate risks accordingly;
- Through effective risk management the Trust will meet its objectives, including improved quality and safety and best use of resources for all patients, staff, visitors and the community served.
5.0 Other Related Strategies, Policies and Procedures

- Clinical Effectiveness/Outcomes Strategy
- Concerns and Complaints Policy & Procedures
- Consent Policy
- External Agency Visits, Inspections and Accreditations Policy
- Health and Safety Policies
- Incident Management Policy
- Incident Reporting Policy
- Litigation and Insurance Policy
- Maternity Risk Policy
- Patient Experience Strategy
- Patient Safety Strategy
- Quality Governance Strategy

The above and further useful policies and procedures can be found on the Trust’s Staffnet.

6.0 Implementation of the Policy and Procedures

The implementation of this policy and related procedures will be achieved through:

- Developing robust arrangements in all Divisions, Care Groups and departments for managing risk;
- Ensuring clearly defined roles and responsibilities for the management of risk are agreed and understood across the Trust;
- Providing risk management training and support to designated individuals including senior managers to enable them to manage risk as part of normal line management responsibilities;
- Undertaking risk assessments (clinical; organisational; financial etc) using a common methodology to identify, control and minimise risks;
- Recording the results of risk assessments onto the relevant Trust Risk Register;
- Maintenance of the risk register database (RAFT) containing a record of all UHS risks. It is a dynamic database reflecting the nature of our risks and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made on actions to mitigate risks where applicable;
- Ensuring that all high level risks (risk score 16-25) are escalated, if appropriate, to the Trust Executive Committee via the Executive Risk Scrutiny Group;
- Encouraging an open and fair culture of in terms of reporting and learning from incidents from both staff and patients;
- Implementing the recommendations from the National Reporting and Learning System (NRLS), Health & Safety Executive (HSE), MHRA and other Alert Notices and communicating resultant changes to all staff across the Trust;
- Ensuring compliance with the Health and Social Care Act 2008 and other relevant regulatory requirements.

7.0 Accountability and Responsibility

7.1 Corporate

Trust Board
The Trust Board is collectively accountable for risk management and has a collective responsibility to ensure that the Board provide review and challenge to support the management of risk. The Board is made up of both Executive and Non-Executive Directors.
Chief Executive
The Chief Executive has overall accountability for risk management, delegating discrete responsibility to the appropriate Executive Director according to their portfolio.

Executive Directors
Each Executive Director is responsible for reporting to the Executive Risk Scrutiny Group on the development and progress of risk management within their directorate and for ensuring that related policies and procedures are implemented and evaluated effectively.

Director of Nursing
The Director of Nursing has delegated responsibility for the strategic and operational management of risk.

Associate Director of Governance & Risk
The Associate Director of Governance and Risk has responsibility for overseeing the strategic and operational development and management of risk across the organisation.

Trust Governance & Risk Manager
The Trust Governance and Risk Manager is responsible for supporting the Associate Director of Governance and Risk with the implementation of the strategic and operational aspects of risk management across the organisation, including management of the Board Assurance Framework and Corporate Risk Register and drafting the Annual Governance Statement.

Corporate Safety Teams (Patient and Health & Safety)
The Safety teams have responsibility for facilitating the delivery of the Integrated Safety Strategy and its key work streams. The teams are responsible for supporting and facilitating Divisional incident reporting and for mitigating, overseeing and ensuring the management of Adverse Incidents, Serious Incidents Requiring Investigation (SIRI) and Never Events and ensuring learning is disseminated.

Managers and Clinical Leads
Managers and Clinical Leaders are responsible for identifying actual and potential risks and managing them, where appropriate, at local level within their designated areas. They should refer to the Care Group Management Team and/or the Divisional Management Team for help in responding to significant risks and/or where the risk has wider organisational impact.

Authority of managers with regard to managing risk
All managers have responsibility and authority to manage risk according to their level of authority and responsibility, as outlined in Standing Financial Instructions, Scheme of Delegation, Trust policies and their individual job descriptions. Further detail of risk management levels of responsibility are given in Table 4 in Appendix C.

7.2 Divisional
Each of the Divisional Clinical Directors (DCD) has responsibility for ensuring that this Policy is understood and followed by their Division. The DCDs, Divisional Director of Operations and Divisional Heads of Nursing and Professions (DHN/P) have joint accountability and responsibility to ensure effective management and communication of the risk management processes throughout their Division, with the DHN/Ps taking the lead role in executing these responsibilities. It is the Divisional Management Team’s responsibility to ensure that all staff are aware of this and other relevant policies and procedures and their role and responsibility in identifying and addressing all risk and safety issues.
Line Managers and Clinical Leaders are responsible for identifying actual and potential risks and managing them where appropriate at local level within their designated areas. All staff should be made aware of the risks within their work environment. They should refer to the Care Group Management Team and/or the Divisional Management Team for help in managing significant risks and/or where the risk has wider organisational impact.

The Divisional Management Team will:

- Ensure that all relevant Trust policies and procedures are communicated to and followed by all staff;
- Ensure all staff are made aware of the risks within their work environment;
- Ensure risk assessments are undertaken and reviewed, recorded on risk registers as appropriate and any decision to accept/transfer risk is taken and recorded appropriately;
- Analyse data to identify and highlight any trends from assessments or incidents and where appropriate escalate them to the risk register;
- Ensure the Care Group and Divisional risk registers are reviewed and updated on a regular basis and that risks are escalated as per this policy;
- Have clear arrangements for monitoring performance through the Care Group/Divisional Governance Group/s and via the monthly Divisional Performance Reviews;
- Ensure appropriate training and support is available to line managers to enable them to manage risk as part of their normal line management responsibilities;
- Ensure all staff understand their responsibility through appraisal;
- Ensure all staff receive appropriate risk management training as identified in the Trust’s Training Needs Analysis;
- Utilise the range of information and assistance available through the claims, complaints, audit, safety and governance departments and any other relevant source to improve practice, risk management and safety;
- Within Trust financial standing orders and the agreed Divisional budget consider the allocation of funding where required to deal with identified risks as part of the normal planning process based on a risk assessment approach;
- Ensure the National Patient Safety Agency root cause analysis tool is used to investigate incidents and facilitate trust-wide learning.

Divisional Governance Managers (DGM)

The DGMs collaborate in partnership with both the Governance & Risk and the Corporate Safety Teams and Care Group leads for the Division to ensure the delivery and achievement of good risk management and health and safety practices advising on actions required, including developing plans and monitoring performance. This includes regular review of the Division’s and Care Group’s Risk Registers.

Through the Divisional structures, DGMs support Divisional staff, such as Matrons, Clinical Leads and Ward/Department Managers with undertaking effective risk assessments and management of risk in their areas. DGMs provide support to Divisional staff in the identification, investigation (using Root Cause Analysis), reporting and learning from incidents (including SIRIs and Coroners Inquests). They also assist in ensuring staff are offered the appropriate support and debriefing when necessary.

7.3 Trust Staff

All staff have a responsibility for identifying actual or potential hazards and risks and reporting/escalating issues in accordance with this Risk Management Policy and Procedures and the Trust Incident Reporting, Analysis, Investigation and Management Policy.
8.0 Organisational Risk Management Structure

Appendix F outlines the Trusts risk management structure detailing all the Committees/Groups which have some responsibility for risk and how they interface to ensure an integrated, embedded approach to sound governance and risk management. The responsibilities of these Committees/Groups are detailed below.

Terms of Reference for Committees/Groups with responsibility for managing risk are regularly reviewed and monitored by the relevant committee chair and are available from the Trust Governance and Risk Manager. As a minimum these will include:

- Duties;
- Reporting arrangements to the board;
- Membership, including nominated deputy where appropriate;
- Required frequency of attendance by members;
- Reporting arrangements into the high level committee(s);
- Requirements for a quorum;
- Frequency of meetings;
- Process for monitoring compliance with all of the above.

The Chief Executive and Trust Board are accountable for ensuring there is a board sub-committee which oversees risk management and ensuring the Board regularly review risk related reports, the Board Assurance Framework and Corporate Risk Register information. Details of the high level framework of committees and groups supporting the Trust Board and effective management of risk and safety are given below:

8.1 The Audit & Assurance Committee reviews, scrutinises and challenges the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical) that support the achievement of the organisation’s objectives. This includes rigorous review of the Corporate Risk Register and Board Assurance Framework on a quarterly basis, providing both assurance and challenge to the Trust Board.

8.2 Trust Executive Committee (TEC), which acts as the overarching Risk Management committee for the Trust, is chaired by the Chief Executive (CEO) and membership consists of Executive Directors, Divisional Clinical Directors, Divisional Directors of Operations, Divisional Head of Nursing and Professions, Head of School of Medicine, Director of Education and Head of Corporate Affairs. TEC advises the CEO on key issues, including risk management, which may affect the safe delivery of services within the Trust and the achievement of Trust objectives. The Committee reports to the Trust Board and is responsible for ensuring:

- Rigorous review of the high level risk registers and Board Assurance Framework on a quarterly basis;
- That there are clear and robust accountability arrangement at all levels of the organisation for risk management, including within the Divisional structure, which are explicit and understood;
- Intelligent information is available to support decision-making and effective operation of the Trust at all levels;
- Arrangements are in place to evidence that organisational learning takes place from incidents, complaints, claims etc. ;
- That the Trust Board receives regular updates and assurance on the management of risk, including the Board Assurance Framework, Corporate Risk Register and other quarterly governance reports.
8.3 Executive Risk Scrutiny Group
The Executive Risk Scrutiny Group provides assurance and a steer to the Trust Executive Committee (TEC) regarding high-level risks on the Board Assurance Framework, Corporate Risk Register and risks escalated by Divisions/Care Groups. The Group ensures that there is appropriate scrutiny and challenge associated with the review of risks prior to their inclusion onto the Trust’s Corporate Risk Register/Board Assurance Framework or de-escalation to a Divisional level. The Group also ensure that adequate support is provided to Divisions through Executive Director sponsorship for each high level risk accepted for entry onto the Corporate Risk Register from the Divisions or corporate functions. Divisional and Trust HQ Risk Review groups report by exception to the ERSG.

8.4 Divisional and Trust HQ Risk Register Scrutiny Groups
Each Division has a Divisional Governance Group into which Care Group governance/risk issues are reported. The Divisional Governance Groups discuss and manage these risks or propose their escalation, via the process below and as illustrated in Appendix F. Trust HQ Departments meet quarterly to review and discuss their risks with their Executive Lead, THQ Governance and Risk Team and Director of Nursing as outlined in Appendix F.

Each Divisional Management Team/relevant THQ department manager meets quarterly with the Director of Nursing and/or Associate Director of Governance & Risk and the Trust Governance & Risk Manager to review the Divisional/Care Group/THQ departmental Risk Register, risk scores and progress with action plans. These meetings may also review learning and actions required from analysis of data arising from incidents, complaints, claims etc. Risks for proposed escalation are identified and referred to the Executive Risk Register Scrutiny Group for consideration of their inclusion on the Corporate Risk Register/Board Assurance Framework. Risks proposed for closure by the Division/Dept are also discussed. If agreed these are entered onto the local risk log for regular review by the Care Groups and Divisions in case they need to be re-escalated onto the appropriate Risk Register in the future.

8.5 Quality Governance Steering Group
This Committee, which reports to TEC, has been established to steer the strategic implementation and oversee the performance of quality governance within the Trust, ensuring the Trust continues to undertake continual quality improvement and achieves compliance with the CQC Fundamental Standards of Care and key issues which may impact on the quality of Patient Experience, Patient Safety, Patient Outcomes and Regulatory Assurance within the Trust. QGSG also:

- Supports operational management teams within the Trust in implementing governance, risk management and safety processes and improvements;
- Provides a level of scrutiny of governance arrangements including compliance with the Care Quality Commission and follow up of external report recommendations;
- Ensures standards are clear and holds Divisions accountable for the delivery of the governance, risk management and safety agendas;
- Ensures the escalation of any areas of concern to the ERSG, Trust Executive Committee and/or the Audit and Assurance Committee, as appropriate.

A number of key committees report to QGSG. These include the Patient Safety Steering Group, Patient Experience Steering Group, Clinical Effectiveness & Outcomes Steering Group, Divisional Governance Groups, Infection Prevention Committee, Corporate Health & Safety, Safeguarding Children & Adults, Major Incident and Education Strategy Groups. These groups are supported by a number of feeder groups. The roles, responsibilities and reporting routes of these groups are contained in the associated policies and Terms of Reference. Full details of these Committees are outlined in Appendix E. Integration of the issues from QGSG and ERSG is achieved through Trust Executive Committee reports and discussions.
9.0 Process for High Level Committee Review of the Corporate Risk Register and Board Assurance Framework

- The Executive Risk Scrutiny Group (ERSG) reviews the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) on a quarterly basis;
- Prior to the quarterly meetings the Executive Directors meet on a 1:1 basis with the Trust Governance and Risk Manager to review and update their risks, risk scores and action plans on the BAF and CRR;
- This information forms part of the papers for discussion at the quarterly ERSG where the rationale for risk closure, increasing or decreasing of risk scores or escalating risks to the BAF is recorded and documented. Risk escalations from Divisional Boards/THQ Depts/Groups for inclusion on the CRR are also considered;
- The BAF and CRR are revised post this meeting and sent with recommendations to the Trust Executive Committee (TEC) for approval prior to being agreed and reviewed by the Audit & Assurance Committee on a quarterly basis. The Trust Board then receives assurance from the AAC and reviews the BAF and corporate risks summary quarterly;
- Risks are also identified through sources such as complaints, claims, incidents and external reports and feed into the risk management process as identified in Appendix A. Data for these issues (excluding external reports) is held on the Safeguard system.

10.0 Process for the Management of Risk Locally

Comprehensive guidance on the process for the management of risks locally, which can be downloaded separately, is contained in Appendix A.

11.0 Education and Training

11.1 There are key education and training subject areas in relation to risk and safety which are required to be included in the Trust’s Training Needs Analysis (TNA) and made available in various ways for all staff, including Board members and senior managers, to access.

11.2 The Trust review the organisation’s TNA in respect of risk management training content annually, in order to ensure that the delivery of education and training continues to match requirements. The TNA is available to all staff on Staffnet.

11.3 All staff are required to ensure that they complete the relevant training and all completed training is captured within their staff training records with any gaps discussed at appraisal.

11.4 Monitoring of compliance will be reported by staff group and Care Groups/THQ directorates and reviewed as part of the 6 monthly Divisional Education Performance Review meetings and by the statutory and mandatory training KPI report to ESG quarterly.

11.5 Risk awareness training for senior managers will be provided as detailed in Appendix G.

12.0 Monitoring Compliance with this Policy

The purpose of monitoring is to provide assurances that the agreed approach is being followed and that we get things right for staff, patients, visitors and members of the public in addition to using resources well and protecting our reputation. Monitoring of this policy will be proportionate, achievable and deal with specifics that can be assessed or measured.

Any identified areas of non-compliance or gaps in assurance identified during the monitoring of this policy will result in recommendations to address these areas and/or embed learning. Monitoring of this Policy and general risk management within the Trust will be reviewed through the groups/committees identified in Appendix F. Additional monitoring will be undertaken as per the matrix below.
<table>
<thead>
<tr>
<th>Reporting arrangements into high level committees and Trust Board reflect those outlined in the Terms of Reference</th>
<th>Quarterly Board Assurance Framework and Corporate Risk Register received by TEC, A&amp;AC and Trust Board</th>
<th>A review of: 4 sets of minutes and papers from Trust Board, TEC and ERSG and one set of A&amp;AC papers</th>
<th>Annual in Q2</th>
<th>Trust Governance &amp; Risk Manager</th>
<th>Policy Ratification and Monitoring Group (PRAM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What aspects of the policy will be monitored</td>
<td>What will be reviewed to evidence this</td>
<td>How will this be done</td>
<td>Frequency</td>
<td>Who will co-ordinate and report the findings</td>
<td>Which group will receive the findings</td>
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<tr>
<td>That the process outlined in this policy for risk assessments is followed</td>
<td>Generic Risk Assessment and Escalation Forms Risk Registers</td>
<td>A review of: 15 risk assessment and escalation forms (3 from each division and 3 from Trust HQ) to ensure the risk assessment process has been followed</td>
<td>Annual in Q2</td>
<td>Trust Governance &amp; Risk Manager</td>
<td>Policy Ratification and Monitoring Group (PRAM)</td>
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<tr>
<td>Process for the management of risk locally (including risk escalation) is being followed</td>
<td>Risk Registers Minutes from Risk Register Scrutiny Groups</td>
<td>A review of: - 4 sets of minutes from Divisional Risk Register Scrutiny Groups (one from each Division) and one THQ Group set of minutes. - all escalations to ERSG, TEC and other relevant groups. - 2 Divisional and 1 THQ Risk Register to ensure risks are current and in line with this Policy.</td>
<td>Annual in Q2</td>
<td>Trust Governance &amp; Risk Manager</td>
<td>Policy Ratification and Monitoring Group (PRAM)</td>
</tr>
<tr>
<td>Trust risk registers include source of risk, description, risk score, action plan, date of review and target risk score and that these registers are monitored as per policy</td>
<td>All Trust Risk Registers</td>
<td>A review of: - Corporate Risk Register. - 2 Divisional Risk Registers. - 2 THQ Risk Registers.</td>
<td>Annual in Q2</td>
<td>Trust Governance &amp; Risk Manager</td>
<td>Policy Ratification and Monitoring Group (PRAM)</td>
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13.0 Dissemination & Communication

This Policy and associated procedures is available on the Intranet and communicated to all staff at Corporate Induction. Revisions to the policy will be notified to staff through Staffnet.

14.0 Next Steps

This Policy and associated procedures provides the framework for the Trust in its approach to risk management. It is recognised that this is a continuous improvement programme, which requires year on year development. The Policy and Procedures will be reviewed on an annual basis and be updated at least every three years to ensure the information contained within them is accurate and up to date.

15.0 References

Health and Safety at Work Act 1974
An Organisation with a Memory (DH, 2000)
Building a Safer Place for Patients (DH, 2001)
Seven Steps to Patient Safety (NPSA, 2004)
Safety First (DH, 2006)
Risk Assessment Programme (NPSA, 2006)
Healthcare Risk Assessment Made Easy (NPSA, 2007)
A Risk Matrix for Risk Managers (NPSA, 2008)
Essential Standards of Quality and Care (CQC, 2011)
Duty of Candour (CQC, 2014)
Risk Assessment Framework (Monitor, 2014)
Appendix A

Risk Identification, Assessment, Risk Registers and Local Risk Management Process

1.0 Risk Identification

1.1 Introduction

The purpose of completing a risk identification exercise is to identify, discuss and document the risks facing the organisation. Managers almost always know what risks the organisation/service is exposed to and must ensure they formally record such risks. These risk identification guidelines aim to assist in ensuring that the Trust manages risk effectively and efficiently.

1.2 Identifying risk

Risk identification is defined as "the process of determining what, where, when, why, and how something could happen". Risk identification is a deliberate and systematic effort to understand and document all of the key risks facing the organisation. The objective of risk identification is to generate a comprehensive list of risks based on those events and circumstances that might enhance, prevent, degrade or delay the achievement of the organisation or service objectives. This list of risks is then used to guide the analysis, evaluation, treatment and monitoring of key risks. The risk identification process must identify unwanted events, undesirable outcomes, emerging threats, as well as existing and emerging opportunities.

1.3 How to perform risk identification

The key steps necessary to effectively identify risks from across the organisation are:

a. Understand what to consider when identifying risks;
b. Gather information from different sources to identify risks (e.g. complaints, claims, incidents, audits, etc.);
c. Apply risk identification tools and techniques;
d. Use risk categories for comprehensiveness;
e. Document the risks;
f. Document the risk identification process;
g. Assess the effectiveness of the risk identification process.

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**Risk Identification**

What is the source of each risk?

What might happen that could:
- Increase or decrease the effective achievement of objectives
- Make the achievement of the objectives more or less efficient (e.g. financial, people, time)
- Cause stakeholders to take action that may influence the achievement of objectives
- Produce additional benefits

Other considerations:
- What would the effect on objectives be?
- When, where, why, how are these risks (both positive and negative) likely to occur?
- Who might be involved or impacted?
- What controls currently exist to treat this risk (maximise positive risks or minimise negative risks)?
- What could cause the control not to have the desired effect on the risk?
Risk identification tools and techniques that could be used for risk identification:

<table>
<thead>
<tr>
<th>Risk Identification: Tools &amp; Techniques</th>
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<tbody>
<tr>
<td>Structures Interviews</td>
</tr>
<tr>
<td>Audit Reports</td>
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<tr>
<td>Checklists</td>
</tr>
<tr>
<td>Surveys and Questionnaires</td>
</tr>
<tr>
<td>Focus Groups</td>
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<tr>
<td>Local and Overseas Experience</td>
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<tr>
<td>Post-event Reports</td>
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<tr>
<td>Strategic and Business Plans</td>
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</tbody>
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Once these steps have been completed Risk Identification leads into Risk Assessment. However, in practice risk identification and risk assessment are often completed in a single step.

2.0 Process for Risk Assessment and Scoring

2.1 Introduction to risk assessment

Risk assessment is a systematic process to quantify or qualify the level of risk associated with a specific threat or event, to enrich the risk intelligence available to the organisation. The main purpose of risk assessment is to help prioritise the organisation’s most important risks.

Risks should be assessed on the basis of the likelihood of the risk occurring and the impact/consequence of its occurrence on the Trust/service objective(s). Consideration should also be given to the controls and assurances in place to manage/mitigate the risk.

The Trust uses a standardised generic risk assessment form across the organisation. The Trust's Generic Risk Assessment and Escalation Form and details of how to use it are included as Appendix B. However, it should be noted that specific risk assessment forms are used in some instances e.g. for clinical assessments such as VTE and some health and safety assessments. Where this occurs the form and process will be outlined in the related policy documents.

2.2 Risk Scoring/Grading Matrix

Once a risk assessment has been completed the risk should be scored using the standard risk scoring/grading matrix tool to help estimate the Likelihood x Consequence of a risk being realised and give a resulting overall risk score. The Trust's Risk Scoring/Grading Matrix and details of how to use it is included as Appendix C.

2.3 Risk assessment forms

Results of risk assessments should be discussed at the relevant Divisional/THQ meeting for agreement of the risk, risk score, controls and assurances. Agreed risks should then be entered onto the register locally or escalated for possible entry onto the Corporate Risk Register, as per this policy (see Appendix A). Risk assessment forms should be retained locally as per record retention requirements.
3.0 Risk Registers

3.1 Introduction to Risk Registers

Managing risk is part of everyday management in the NHS, however due to the time that is required to implement solutions to risks and financial constraints; the concept of Risk Registers has been developed to provide an ongoing log of these risks. Risk Registers are primarily an internal management tool to support Divisions/corporate departments in managing their risks whilst there is an opportunity to raise/escalate particular risks for inclusion onto the Trust's Corporate Risk Register.

A Risk may be anything that affects the strategic objectives/vision of the Trust, such as providing a safe service, providing continuity of service, or not meeting national standards. Multiple risks may exist within a service and across the Trust at the same time. Risk Registers are a means of logging, tracking and prioritising risks and resources. All risks, of all types, should be managed using this process.

In order that a robust system of assurance can be established the following steps are followed:

- Principal objectives are set at strategic and corporate levels and cascaded to divisions, care groups, departments and individuals;
- Risks to the achievement of strategic objectives are identified, scored and recorded on the appropriate registers. High level strategic risks are recorded on the Board Assurance Framework. Relevant strategic risks are also highlighted in the Annual Plan and Integrated Business Plan;
- Key controls intended to manage these risks are identified;
- Assurances related to these objectives and risks are recorded, evaluated and any gaps identified;
- Action plans to address any gaps in controls or assurance are identified, owned and regularly monitored through the Trust’s committee and performance structures.

3.2 Key Principles of Risk Registers

- Risk Registers should be a dynamic management process used by managers to manage risk and prioritise resources across the Trust. Divisions/corporate departments should identify the key risks associated with delivering their services and achieving the Trust’s key objectives. Risk Registers should only be used for risks that cannot be immediately resolved.
- In identifying risks, consideration should be taken of other information from performance monitoring, results of local/national audit programmes or through the reporting of incidents (including PALS, complaints, claims, etc.).
- Risks that cannot be sufficiently managed (and are ‘high-risk’) within a Division/corporate department will be escalated to the Trust Executive Risk Scrutiny Group for review and consideration for inclusion within the Corporate Risk Register.
- The information on the Risk Registers is held on RAFT, which is the Trust’s bespoke system for Risk Registers and Assurance Framework. Access to these registers is via the Trust Governance and Risk Manager, who will authorise appropriate access and ensure training is provided.
- Accuracy of data is essential and when risks are entered onto this system all relevant fields on the form should be completed. The risk register must include source of the risk, description of the risk, the risk score, the action plan, dates of risks review and the target score (this is the residual risk score/risk appetite).
4.0 Process for the Management of Risk Locally

4.1 The Role of Divisions/Care Groups/Corporate Departments

- It is the responsibility of the Care Groups/Division/Corporate Departments to undertake risk assessments, identify and reduce risks as part of routine management practice. This includes using data from the review of incidents, complaints, claims, business cases, external/internal reviews, reports and any other appropriate feedback.
- Care Groups/Divisions/Corporate Departments are responsible for validating, prioritising and identifying solutions to their risks. Where immediate solutions (within one month) are not possible, the risks are rated above 9 and further mitigating actions are possible then these are entered onto the local risk register.
- Risks/hazards which can be addressed through immediate action and/or are low scoring and risks where further mitigating actions are not possible (therefore they are ‘accepted’) will not be entered onto a risk register but will be reviewed and monitored locally as appropriate.
- Care Groups/Divisions/Corporate Departments nominated persons will directly access and update their own Risk Registers via RAFT.
- Care Groups/Divisions/Corporate Departments are responsible for ensuring that action plans are effectively implemented to reduce and mitigate risks and that these are monitored regularly.
- Each Divisional Management Team/relevant THQ department will meet quarterly with the Director of Nursing and/or Associate Director of Governance & Risk and the Trust Governance & Risk Manager (Risk Review Scrutiny Group) to review the Divisional/Care Group/THQ departmental Risk Register, risk scores, controls/assurances and action plans.
- Divisions/Corporate Departments should only escalate risks to the Executive Risk Scrutiny Group and TEC if, after local management action, a residual level of risk remains which is considered above the threshold of acceptance, or if a risk can only be owned and managed at a corporate level. Risks for escalation must be signed off by the Divisional Management Board or relevant Executive Director.
- Divisional/Care Group Governance Groups and Corporate Departments should review their Risk Registers regularly (at least quarterly). The risk registers may also be reviewed at the Divisional Performance Reviews.
- Divisional Boards should scrutinise and validate their risks:
  - before submission of reports to ERSG/TEC
  - at regular intervals to ensure that action plans are being implemented and risks mitigated.
- All senior managers should use their local Risk Register as a management tool and ensure that the risk registers are used to inform the annual business planning process.

4.2 Roles of Specific Individuals

The person identifying a risk has the following responsibilities:

- Assess and grade the risk in order to ascertain priority for action
- Notify and discuss with Care Group Management Team and/or the Divisional or Trust HQ Governance Manager for approval to enter onto the Divisional/Care Group/Dept risk register
- Take local action if possible
- Escalate according to score/grade of risk
5.0 Escalation of Risks

5.1 Risk Control and Action Planning

Managing risks involves identifying the range of options for mitigating the risk, assessing those options, preparing risk management action plans and implementing them. The following risk management options, which are not necessarily mutually exclusive or appropriate in all circumstances, can be applied:

- **Avoid** the risk – deciding not to proceed with the activity likely to generate risk (where this is practicable).
- **Mitigate** the likelihood of the risk materialising – e.g. through contract conditions, audit and compliance programmes, policies and procedures, preventative maintenance, supervision, training etc. Funding of these controls will also need to be considered. Reduce the potential consequences if the risk does materialise e.g. through contingency planning, minimising exposure to the risk, public relations, relocation of activity.
- **Transfer of Risk** – this involves another party bearing or sharing some part of the risk e.g. through the use of contracts, insurance arrangements and organisational structures such as Service Level Agreements (SLAs).
- **Accept** and monitor the risk – after risks have been controlled, reduced or transferred, there may be risks that are retained. Plans should be put in place to manage the consequences of these retained risks. In some cases risks that cannot be reduced or transferred will need to be “accepted" by the Trust/Divisional Board. These retained risks will be reviewed through the processes outlined in this document.

All Trust Risk Registers and the Board Assurance Framework are ‘live’ documents and each change is recorded so that an audit trail of risks and changing risk score is available, therefore all risk scores are current and based on the controls and assurances in place when scoring the risk.

Decisions to accept, reduce or eliminate risks should be clearly documented and made available to stakeholders.

The key controls relating to risks which need to be identified are those which, when taken together, support our staff in the achievement of the organisation's objectives and sound risk management practices and include, for example:

- Management structure and accountabilities
- Policies and procedures
- Governance processes and committees
- Incident reporting and risk management processes
- Complaints and other patient and public feedback procedures
- Staff training and education
- Statutory frameworks, for instance the Standing Orders
- Standing Financial Instructions and associated Scheme of Delegation
- Communications processes
- Internal audit

Independent sources of assurance on the effectiveness of the Trust’s key controls include:

- External audit reports
- Internal Audit reports
- External inspection bodies, e.g. CQC, MHRA, Royal Colleges, HSE, etc.
- National surveys
5.2 **Risks escalated from the Divisions/Corporate Departments** are reviewed by the Executive Risk Scrutiny Group which meets quarterly. The Group reviews each risk submitted and a judgement is made as to what recommendation will be made to the Trust Executive Committee. If a risk arises that requires escalation between these reviews, the Divisional Management Team/Corporate Department should discuss the risk with the lead Executive Director for that area of risk and document any immediate actions agreed/taken. The Chair of ERSG can take an Executive decision to escalate a risk directly to the Trust Executive Committee or Trust Board if necessary.

5.3 **Process for assessing strategic risks**

The Executive Risk Scrutiny Group assess all risks on the CRR and Board Assurance Framework quarterly as well as horizon scanning and considering any new or escalated risks from Divisions/THQ Departments. The ERSG determines which risks are of a strategic or operational nature. Once identified and assessed high level strategic risks are clearly identified on the Corporate Risk Register/Board Assurance Framework. Relevant strategic risks are also highlighted in the Annual Plan and Integrated Business Plan.

*Figure 1* below outlines the risk register process  
*Figure 2* below outlines the risk escalation process  
*Appendix B* contains a downloadable generic risk assessment and escalation form.
Figure 1: Risk Register Process

Possible Risk/Hazard Identified
- risk assessment completed

Risk Assessment Reviewed within Local Department

Manage Risk Locally
- risk assessment filed locally for regular review and update (available for scrutiny on request)
- resubmit to Care Group/THQ Dept if risk score increases or risk cannot be managed locally

Considerations when Managing a Risk Locally
- risk can be swiftly resolved within one month and/or
- risk must have a low risk rating; this may be an ‘accepted’ risk or one that can be ‘mitigated’

Care Group/Dept Specific Risks
- reviewed and updated quarterly

Divisional Risk Register Top Risks
- reviewed at Divisional Governance Groups

Quarterly Divisional/THQ Risk Register Scrutiny Group meetings
- review all risks and determine management

De-escalate to Care Group/Dept Risk Register

Escalate to Executive Risk Scrutiny Group (ERSG)

Manage on Divisional/THQ Risk Register

ERSG Considerations
- appropriate paperwork completed by DGM/THQ Dept
- ERSG determine if risk entered onto Corporate Risk Register or remains at Divisional/THQ level

Risk Entered onto Risk Register (allocated to Care Group/Division/THQ Dept)

Accept Risk and add to appropriate Risk Register

Return to Dept to continue Managing Risk Locally

Escalate to appropriate Care Group/THQ Dept
- risk reviewed and risk score validated

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Figure 2: Corporate Risk Escalation Flow Chart

Risks Identified Through Various Sources
- reports, meetings (including QGSG), inspections etc
- may be fed back for local management or escalated to the ERSG
- ERSG may also delegate other groups to assess, action or monitor risks

Local Management
- review of risk assessments by Care Groups/Divisional Governance Groups/THQ Departments
- where appropriate enter risk and complete all relevant fields on RAFT

Feedback to Divisions for Performance Reviews
Review with Divisions at risk scrutiny meetings

Executive Risk Scrutiny Group
- review Board Assurance Framework and the Corporate Risk Register
- make recommendations to TEC ref acceptance of risk escalations from Divisions/THQ Deps to the Corporate Risk Register or de-escalation of risks for local management

Trust Executive Committee
- quarterly review of Board Assurance Framework and Corporate Risk Register
- agree ERSG recommendations of escalation of Divisional/THQ risks to the Corporate Risk Register or de-escalation to Divisional/THQ Risk Registers

Decision to:
- remove risk from Corporate Risk Register
- add risk to Corporate Risk Register
- agree explicit link to SO/IBP – BAF
- Chairman’s action
- refer back to Division for additional information/business case
- refer back to Division

Audit & Assurance Committee
- scrutiny of Corporate Risk Register/Board Assurance Framework
- rolling programme of review of Divisional/Care Group Risk Registers

Trust Board
- quarterly review of top risks from Board Assurance Framework and Corporate Risk Register

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Appendix B

Generic Risk Assessment and Escalation Form
(see Appendix 1 for additional guidance)

Section 1: Risk Identification

a. Risk Title: *(be clear and concise, include location if relevant)*

b. Risk Description
*(what the actual risk/hazard/problem is and how it could occur)*

c. Potential Consequences
*(what could happen, who could be affected and how they could be affected if the risk is realised)*

d. Source of Risk (select one only)

- Incident Report
- Complaint
- Claim
- Internal Report
- Business Case/CIP
- Other

<table>
<thead>
<tr>
<th>Business/Finance</th>
<th>Capacity &amp; Demand</th>
<th>Education &amp; Training</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, Safety &amp; Welfare</td>
<td>Infection Prevention</td>
<td>Information Governance</td>
<td>Medical Equipment</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Patient Care/Treatment</td>
<td>Premises Safety/Suitability</td>
<td>Process/Procedure</td>
</tr>
<tr>
<td>Regulation &amp; Compliance</td>
<td>Safeguarding</td>
<td>Staffing</td>
<td>Systems Reliability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SO1</th>
<th>SO2</th>
<th>SO3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusted on Quality</td>
<td>Delivering for Taxpayer</td>
<td>Excellence in Healthcare</td>
</tr>
</tbody>
</table>

e. Risk Category (select one only)

f. Strategic Objective (select one only)

Section 2: Risk Assessment

a. Current Controls
*(systems in place to manage the risk, i.e. a policy, procedure, physical control, etc)*

b. Gaps in Control
*(systems which are not yet in place – could be linked to Action Plan)*

c. Current Assurances
*(evidence that the risk is being managed effectively, i.e. audits, accreditations, decrease in incidents, etc)*

d. Gaps in Assurance
*(lack of evidence that current controls are effective - could be linked to Action Plan)*
Section 3: Risk Treatment

a. Risk Action
   - Accept
   - Avoid
   - Mitigate
   - Transfer

b. Target Risk Score
   - 1-3 (Very Low)
   - 4-6 (Low)
   - 8-12 (Moderate)
   - 15-16 (High)

c. Action Plan

<table>
<thead>
<tr>
<th>Action Description</th>
<th>Start Date</th>
<th>Target Date</th>
<th>Lead Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

d. Financial Cost: £

e. Business Case/CIP Completed? Yes No N/A

Section 4: Risk Monitoring/Escalation

a. Risk Held Locally? Yes No

b. Escalate to Risk Register? Yes No

c. Risk Register:
   - Corporate
   - THQ
   - Div A
   - Div B
   - Div C
   - Div D

d. Department/Care Group:

e. Reason for Escalation
   "(include why the risk cannot be managed locally if appropriate)"

f. Agreed where/by whom? "(i.e. Care Group/Divisional meeting, Executive Director etc)"

Section 5: Assessor’s Details

Name: _______________________________ Job Title: _______________________________ Date: _______________________________

Section 6: Next Steps

a. Care Group/Dept Risks: return completed form to your Care Group or Department Manager

b. Divisional Risks: return completed form to your Divisional Governance Manager

c. THQ/Corporate Risks: return completed form to Trust Governance & Risk Manager

Section 7: Outcome

a. Risk Escalated? Yes No

b. Assessor Informed? Yes No

c. Reason if No: _______________________________ d. Date added to Risk Register: _______________________________

e. Name: _______________________________ Job Title: _______________________________ Date: _______________________________
Appendix 1  

Guidance for Completion of Form

General Guidance

- Be clear and concise
- Click on specific guidance within boxes to add text
- Keep text within boxes if possible
- Complete Sections 1 to 6 in full
- Do not include this Appendix with completed form

Section 1: Risk Identification

- Risk Category Descriptions

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business/Finance</td>
<td>Business or finance related, including commercial development, contracting etc</td>
</tr>
<tr>
<td>Capacity &amp; Demand</td>
<td>Lack of facilities/resources to manage current or predicted patient demand</td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>Unavailability of courses/funding or shortage of qualified staff</td>
</tr>
<tr>
<td>Falls</td>
<td>Specifically relating to patient falls</td>
</tr>
<tr>
<td>Health, Safety &amp; Welfare</td>
<td>Health &amp; Safety/Staff welfare related excluding Patient Falls</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>Patient or staff related</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Relating to Information Governance or FOI/Data Protection Acts</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Lack of suitable/serviceable medical equipment/devices</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Relating to the prescription, use or storage of medicines</td>
</tr>
<tr>
<td>Patient Care/Treatment</td>
<td>Relating to the care or treatment of patients not covered by other categories</td>
</tr>
<tr>
<td>Premises Safety/Suitability</td>
<td>Lack of adequate space/facilities for patients or equipment storage</td>
</tr>
<tr>
<td>Process/Procedure</td>
<td>Inadequate processes/procedures resulting in errors/delays etc</td>
</tr>
<tr>
<td>Regulation &amp; Compliance</td>
<td>Failure to achieve local/national targets or conform with legislation</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Risks affecting children or vulnerable adults</td>
</tr>
<tr>
<td>Staffing</td>
<td>Staffing levels below established strength</td>
</tr>
<tr>
<td>Systems Reliability</td>
<td>Inadequate physical, electrical or IM&amp;T systems: lifts, call bells, fire alarms etc</td>
</tr>
</tbody>
</table>

Section 2: Risk Assessment

- See Risk Management Policy & Procedures for more specific guidance and information

Section 3: Risk Treatment

a. Risk Action: majority of actions will be to mitigate the risk, seek advice if unsure
b. Target Risk Score: ideal level of acceptable risk, aim as low as possible but be realistic
c. Action Plan: ensure actions address risk including gaps in control/assurance, target dates are realistic, lead person responsible is aware
d. Financial Cost: total amount required to reduce risk score to target risk score

Section 4: Risk Monitoring/Escalation

a. Risk Held Locally?: generally yes if risks are very low/low and can be effectively managed at local level
b. Escalate to Risk Register?: only if risk cannot be managed locally

Section 5: Assessor’s Details

- Complete in full

Section 6: Next Steps

- Corporate Risks originating at Care Group/Divisional level should be escalated via Divisional Governance Manager

Section 7: Outcome

- To be completed by Care Group/Divisional Governance Team or Trust Governance & Risk Manager
Appendix C: Risk Grading Matrix

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that have/might arise from the event/risk.

2. Use Table 1 to determine the Consequence score $C$, for the actual/potential adverse outcome relevant to the event/risk being evaluated. The highest descriptor appropriate to the event/risk will determine the $C$ score.

3. Use Table 2 to determine the Likelihood score $L$, for those adverse outcomes.

   If possible, score the Likelihood by assigning a predicted frequency of the adverse outcome occurring. If this is not possible then assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project, the patient care episode or the designated timeframe (e.g., annual targets). If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score. Be realistic – the highest descriptor appropriate to the event/risk will determine the $L$ score.

4. Plot your answers using Table 3 to determine the colour banding for the event/risk.

5. Use Table 4 to identify the level at which the event/risk will be investigated/managed in the organisation.
<table>
<thead>
<tr>
<th>Domains</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on the safety of patients, staff or public (physical/psychological harm)</strong></td>
<td><strong>Negligible</strong></td>
<td><strong>Minor</strong></td>
<td><strong>Moderate</strong></td>
<td><strong>Major</strong></td>
<td><strong>Catastrophic</strong></td>
</tr>
<tr>
<td>Minimal injury requiring no/minimal intervention or treatment.</td>
<td>Minor injury or illness, requiring minor intervention</td>
<td>Moderate injury requiring professional intervention</td>
<td>Major injury leading to long-term incapacity/disability</td>
<td>Incident leading to death</td>
<td>Multiple permanent injuries or irreversible health effects</td>
</tr>
<tr>
<td>No time off work</td>
<td>Requiring time off work for &gt;3 days</td>
<td>Requiring time off work for 4-14 days</td>
<td>Requiring time off work for &gt;14 days</td>
<td>Increase in length of hospital stay by 1-3 days</td>
<td>Increase in length of hospital stay by &gt;15 days</td>
</tr>
<tr>
<td></td>
<td>Increase in length of hospital stay by 1-3 days</td>
<td>Increase in length of hospital stay by 4-15 days</td>
<td>Increase in length of hospital stay by &gt;15 days</td>
<td>RIDDOR/agency reportable incident</td>
<td>RIDDOR/agency reportable incident</td>
</tr>
<tr>
<td></td>
<td>An event which impacts on a small number of patients</td>
<td>An event which impacts on a small number of patients</td>
<td>An event which impacts on a small number of patients</td>
<td>An event which impacts on a small number of patients</td>
<td>An event which impacts on a small number of patients</td>
</tr>
<tr>
<td><strong>Quality/complaints/audit</strong></td>
<td><strong>Peripheral element of treatment or service suboptimal</strong></td>
<td><strong>Informal complaint/inquiry</strong></td>
<td>overall treatment or service suboptimal</td>
<td><strong>Formal complaint (stage 1)</strong> complaint</td>
<td><strong>Formal complaint (stage 2)</strong> complaint</td>
</tr>
<tr>
<td></td>
<td>Treatment or service significantly reduced effectiveness</td>
<td>Local resolution</td>
<td>Local resolution (with potential to go to independent review)</td>
<td>Repeated failure to meet internal standards</td>
<td>Major patient safety implications if findings are not acted on</td>
</tr>
<tr>
<td></td>
<td>Minor implications for patient safety if unresolved</td>
<td>Repeated failure to meet internal standards</td>
<td>Critical report</td>
<td>Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>Multiple complaints/ independent review</td>
</tr>
<tr>
<td></td>
<td>Reduced performance rating if unresolved</td>
<td>Reduced performance rating if unresolved</td>
<td>Low performance rating</td>
<td>Critical report</td>
<td>Low performance rating</td>
</tr>
<tr>
<td><strong>Human resources/ organisational development/staffing/ competence</strong></td>
<td>Short-term low staffing level that temporarily reduces service quality (&lt;1 day)</td>
<td>Low staffing level that reduces the service quality</td>
<td>Late delivery of key objective/service due to lack of staff</td>
<td>Uncertain delivery of key objective/service due to lack of staff</td>
<td>Non-delivery of key objective/service due to lack of staff</td>
</tr>
<tr>
<td></td>
<td>Unsafe staffing level or competence (&gt;1 day)</td>
<td>Unsafe staffing level or competence (&gt;1 day)</td>
<td>Loss of key staff</td>
<td>Loss of key staff</td>
<td>Loss of several key staff</td>
</tr>
<tr>
<td></td>
<td>Low staff morale</td>
<td>Low staff morale</td>
<td>Very low staff morale</td>
<td>Very low staff morale</td>
<td>No staff attending mandatory / key training</td>
</tr>
<tr>
<td></td>
<td>Poor staff attendance for mandatory/key training</td>
<td>Poor staff attendance for mandatory/key training</td>
<td>No staff attending mandatory / key training</td>
<td>No staff attending mandatory / key training</td>
<td>No staff attending mandatory / key training</td>
</tr>
</tbody>
</table>

Disclaimer: It is your responsibility to check against Staffnet that this printout is the most recent issue of this document.
<table>
<thead>
<tr>
<th>Statutory duty/ inspections</th>
<th>No or minimal impact or breach of guidance/statutory duty</th>
<th>Breach of statutory legislation Reduced performance rating if unresolved</th>
<th>Single breach in statutory duty Challenging external recommendations/improvement notice</th>
<th>Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report</th>
<th>Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse publicity/ reputation</td>
<td>Rumours Potential for public concern</td>
<td>Local media coverage – short-term reduction in public confidence Elements of public expectation not being met</td>
<td>Local media coverage – long-term reduction in public confidence</td>
<td>National media coverage with &lt;3 days service well below reasonable public expectation</td>
<td>National media coverage with &gt;3 days service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence</td>
</tr>
<tr>
<td>Business objectives/ projects</td>
<td>Insignificant cost increase/schedule slippage</td>
<td>&lt;5 per cent over project budget Schedule slippage</td>
<td>5–10 per cent over project budget Schedule slippage</td>
<td>Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met</td>
<td>Incident leading &gt;25 per cent over project budget Schedule slippage Key objectives not met</td>
</tr>
<tr>
<td>Finance including claims</td>
<td>Small loss Risk of claim remote</td>
<td>Loss of 0.1–0.25 per cent of budget Claim less than £10,000</td>
<td>Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000</td>
<td>Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time</td>
<td>Non-delivery of key objective/Loss of &gt;1 per cent of budget Failure to meet specification/slipage Loss of contract/payment by results Claim(s) &gt;£1 million</td>
</tr>
<tr>
<td>Service/business interruption Environmental impact</td>
<td>Loss/interruption of &gt;1 hour Minimal or no impact on the environment</td>
<td>Loss/interruption of &gt;8 hours Minor impact on environment</td>
<td>Loss/interruption of &gt;1 day Moderate impact on environment</td>
<td>Loss/interruption of &gt;1 week Major impact on environment</td>
<td>Permanent loss of service or facility Catastrophic impact on environment</td>
</tr>
</tbody>
</table>

Table 2: Likelihood Score (L)

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain/certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>This will probably never happen/recur</td>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
<td>Will probably happen/recur but it is not a persisting issue</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
<tr>
<td>Probability</td>
<td>&lt;0.1 per cent</td>
<td>0.1–1 per cent</td>
<td>1–10 per cent</td>
<td>10–50 per cent</td>
<td>&gt;50 per cent</td>
</tr>
</tbody>
</table>
Table 3: Risk Scoring Matrix  \[ R (Risk) = C \times L \] (Consequence) x (Likelihood)

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>1 Negligible</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic/Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td></td>
<td>Green 1</td>
<td>Green 2</td>
<td>Green 3</td>
<td>Yellow 4</td>
<td>Yellow 5</td>
</tr>
<tr>
<td>Unlikely</td>
<td></td>
<td>Green 2</td>
<td>Yellow 4</td>
<td>Yellow 6</td>
<td>Orange 8</td>
<td>Orange 10</td>
</tr>
<tr>
<td>Possible</td>
<td></td>
<td>Green 3</td>
<td>Yellow 6</td>
<td>Orange 9</td>
<td>Orange 12</td>
<td>Red 15</td>
</tr>
<tr>
<td>Likely</td>
<td></td>
<td>Yellow 4</td>
<td>Orange 8</td>
<td>Orange 12</td>
<td>Red 16</td>
<td>Red/Red 20</td>
</tr>
<tr>
<td>Almost Certain/Certain</td>
<td></td>
<td>Yellow 5</td>
<td>Orange 10</td>
<td>Red 15</td>
<td>Red/Red 20</td>
<td>Red/Red 25</td>
</tr>
</tbody>
</table>

Table 4: Management of Risk

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Remedial Action</th>
<th>Decision to accept risk</th>
<th>Risk Register Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green 1-3</td>
<td>Ward/Dept Manager</td>
<td>Ward/Dept Manager</td>
<td>Care Group/Division</td>
</tr>
<tr>
<td>Very Low Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow 4-6</td>
<td>Care Group/Dept Manager</td>
<td>Care Group/Dept Manager</td>
<td>Care Group/Division</td>
</tr>
<tr>
<td>Low Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange 8-12</td>
<td>Care Groups/Divisional Management Team</td>
<td>Care Groups/Divisional Management Team</td>
<td>Care Groups/Division</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red 15</td>
<td>Divisional Management Team</td>
<td>Divisional Management Team</td>
<td>Division</td>
</tr>
<tr>
<td>High Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red 16</td>
<td>DMT/Executive Director</td>
<td>TEC/Trust Board via ERSG</td>
<td>Division or Corporate</td>
</tr>
<tr>
<td>High Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red/Red 20-25</td>
<td>Executive Director/CE</td>
<td>TEC/Trust Board via ERSG</td>
<td>Corporate</td>
</tr>
<tr>
<td>Extreme Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Risk Grading Process

- **No/negligible harm/damage**
- **Low/minor harm/damage**
- **Moderate harm/damage**
- **Severe/major harm/damage**
- **Catastrophic harm/damage/death**

**Step 1:** What is the potential consequence of the event/risk if the event/risk is realised?

**Step 2:** What is the likelihood of this event occurring again or the risk being realised?

**Step 3:** What is the overall risk score (colour category) for this event?

**Step 4:** What controls and assurances are in place to mitigate the risk? Do these reduce the likelihood or consequence of the risk being realised and therefore reduce the risk score?

*The ‘colour category’ & risk score assigned determines the desired level of investigation required & the management accountability level attributable to the event / risk.*
## Appendix D: Risk Management Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance</td>
<td>Confidence, based on sufficient robust evidence, that internal controls are in place, operating effectively and objectives are being achieved e.g. internal and external audits and reviews</td>
</tr>
<tr>
<td>Assurance Committee</td>
<td>A board level committee with overarching responsibility for ensuring appropriate assurance is gained on the management of all principal risks. This may be an existing committee such as a governance, audit or risk committee</td>
</tr>
<tr>
<td>Board Assurance Framework</td>
<td>A structure/document within which boards identify the principal risks to the organisation meeting its principal objectives and map out both the key controls in place to manage them, how they have gained sufficient assurance about their effectiveness and identify any gaps in controls or assurances</td>
</tr>
<tr>
<td>Control</td>
<td>The systems used to manage and govern the organisation e.g. policies and procedures or physical controls</td>
</tr>
<tr>
<td>Current Risk Score</td>
<td>Within a Risk Register - which is a living document – risk scores may fluctuate dependent on many factors therefore a current risk score helps identify if a risk is decreasing or escalating.</td>
</tr>
<tr>
<td>External Assurance/Independent Assurance</td>
<td>Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as External Audit, NHSLA, CQC, MHRA or Royal Colleges for example</td>
</tr>
<tr>
<td>Gap in Assurance</td>
<td>Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively</td>
</tr>
<tr>
<td>Gap in Control</td>
<td>Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives</td>
</tr>
<tr>
<td>Hazard</td>
<td>A potential source of risk e.g. damage or harm</td>
</tr>
<tr>
<td>Integrated risk management</td>
<td>A process through which organisations identify, assess, analyse and manage all risks and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks</td>
</tr>
<tr>
<td>Internal Assurance</td>
<td>Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical Audit or management peer review</td>
</tr>
<tr>
<td>Internal Control</td>
<td>The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected</td>
</tr>
<tr>
<td>Mitigation/treatment of risk</td>
<td>Actions taken to reduce the risk or the negative consequences of the risk</td>
</tr>
<tr>
<td>Negative Assurance</td>
<td>Evidence that shows risks are not being managed and/or controlled effectively e.g. Poor external reviews or serious untoward incidents</td>
</tr>
<tr>
<td>Positive Assurance</td>
<td>Robust evidence that shows risks are being reasonably managed and objectives are being achieved eg external audits, reviews etc</td>
</tr>
<tr>
<td>Principal Objectives</td>
<td>Objectives set at strategic, corporate and directorate (or equivalent) level</td>
</tr>
<tr>
<td>Principal Risk</td>
<td>A risk which threatens the achievement of Principal Objectives</td>
</tr>
<tr>
<td>Prioritisation/Scoring of Risk</td>
<td>A process by which risks are graded/scored based on the likelihood of their occurrence and the impact of their consequences</td>
</tr>
<tr>
<td>Residual Risk</td>
<td>The risk remaining after risk control measures have been taken, often reflected as the current risk score</td>
</tr>
<tr>
<td>Retained Risk</td>
<td>Once the organisation has agreed their risk appetite and risk tolerance this will be <strong>the level of risk they are prepared to accept.</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Risk</td>
<td>The combination of likelihood and consequence of hazards being realised, resulting in some form of loss or damage. The possibility that objectives will not be achieved</td>
</tr>
<tr>
<td>Risk Analysis</td>
<td>The systematic use of information to identify hazards and to estimate risk</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>How much risk the organization wants to take</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>The <strong>identification and analysis of relevant risks</strong> to the achievement of objectives (comprises of risk analysis and risk evaluation)</td>
</tr>
<tr>
<td>Risk Control</td>
<td>The process in which decisions are made and measures implemented by which <strong>risks are reduced</strong> to, or maintained within, specified levels</td>
</tr>
<tr>
<td>Risk Matrix (Risk evaluation/scoring system)</td>
<td>Tool used to help estimate <strong>Likelihood x Consequence</strong> resulting in an <strong>overall risk score</strong></td>
</tr>
<tr>
<td>Risk Management</td>
<td>A systematic process by which potential risks are identified, assessed, managed and monitored</td>
</tr>
<tr>
<td>Risk Management Strategy/Policy</td>
<td>A document outlining how organisations, are and will, do their ‘reasonable best’ to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds</td>
</tr>
<tr>
<td>Risk Register</td>
<td>A central register of the Trust’s key risks that identifies the classification of risks by area, likelihood, consequence etc. The register also identifies who has responsibility for the risk and the actions being taken to manage it.</td>
</tr>
<tr>
<td>Risk Tolerance</td>
<td>How much risk the organisation can feasibly take.</td>
</tr>
<tr>
<td>Annual Governance Statement (AGS)</td>
<td>An annual statement signed by the Accountable Officer on behalf of the Trust Board that forms part of the Annual Financial Statements for the year. The AGS provides public assurances about the effectiveness of the organisation’s system of internal control</td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>An overall goal of the organisation</td>
</tr>
<tr>
<td>System of Internal Control</td>
<td>A system, maintained by the Board, that supports the achievement of the organisation’s objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation’s objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically</td>
</tr>
</tbody>
</table>
Appendix E: Trust Governance Committee Structure

QGSG - is responsible for the ratification of most Trust wide Policies through PRAM

Please Note: Some of the Feeder/sub groups illustrated here have additional working groups or task and finish groups reporting to them.

*Reports/escalations from local mortality monitoring groups.

PATIENT EXPERIENCE STEERING GROUP Chair: J Cox/ J Williams

PATIENT SAFETY STEERING GROUP Chair: J Pearce

CLINICAL EFFECTIVENESS/OUTCOMES STEERING GROUP Chair: Simon Corbett

SAFEGUARDING VULNERABLE ADULTS STEERING GROUP Chair: Gail Byrne

PATIENT SAFETY

FEEDER GROUPS

TRUST EXECUTIVE COMMITTEE

QUALITY GOVERNANCE STEERING GROUP Chair: Judy Gillow/ Michael Marsh

SUB GROUPS

RADIATION PROTECTION COMMITTEE

EDUCATION STRATEGY GROUP

SAFEGUARDING CHILDREN STEERING GROUP

CORPORATE HEALTH & SAFETY COMMITTEE

DIVISIONAL GOVERNANCE GROUPS

INFECTION PREVENTION COMMITTEE

REGULATORY ASSURANCE – REPORTING

POLICY RATIFICATION AND MONITORING GROUP (PRAM)

Updated May 2014

Disclaimer: It is your responsibility to check against Staffnet that this printout is the most recent issue of this document
Appendix F: Committees and Groups with Responsibilities for Risk

Risks identified through risk assessments, incidents complaints, claims, external reports, etc.

- Trust HQ Departments
- Clinical Care Groups
- Clinical Depts & Divisional Depts
- Issues from QGSG Feeder Groups

- Divisional Governance Meetings
- Divisional Management Boards
- Quality Governance Steering Group
- Divisional Risk Scrutiny Groups
- Executive Risk Scrutiny Group
- Trust HQ Risk Scrutiny Group Meetings

- Audit and Assurance Committee
- Trust Executive Committee
- Trust Board
- Trust Board

Disclaimer: It is your responsibility to check against Staffnet that this printout is the most recent issue of this document
Appendix G: Risk Awareness Training for Board Members and Senior Managers

Introduction:
The Trust is required to have an approved documented process for delivering risk management awareness training for all board members and senior managers that is implemented and monitored. This is to ensure compliance with regulatory/best practice and to ensure these senior staff have a clear understanding of risk.

Aim:
To ensure Trust Board (TB) members and Senior Managers have a clear understanding of risk which ensures the review, identification and management of principle and operational risks to support the achievement of the Trust’s strategic objectives.

Definition:
For the purposes of Risk Awareness Training for Senior Managers - senior managers are defined as: Trust Board Executive and Non-Executive members and members of the Trust’s Executive Committee (TEC).

Basic risk awareness training is covered by a range of statutory and mandatory subjects included in the trust training needs analysis (TNA) and the requirements for staff to complete this are defined in the TNA and Education and Learning Policy. Senior Managers are expected to complete this training in line with the policy and TNA requirements.

Types of issues to be covered and method of delivery:
In addition to basic risk awareness training it is recognised that senior managers require a broader awareness of risk related issues than the majority of staff because legislation and regulations could impact on them and/or the wider organisation. To this end, through the Board and TEC meetings and papers, they will be provided with regular updates (no less than annual), progress reports and other relevant information relating to the following issues and any others which may be required to ensure their competence and understanding of risk related issues:

- Corporate Risk Register, Board Assurance Framework and emerging risks
- Incident reporting and risk assessment
- Care Quality Commission requirements
- NHS Litigation Authority requirements, initiatives, actions, etc.
- Monitor requirements, issues, etc.
- Financial governance and Counter fraud
- Corporate manslaughter
- Patient Safety
- Patient Experience
- Clinical Effectiveness/Patient outcomes
- Corporate Governance requirements, issues, etc.
- Information Governance
- Human rights/staffing/employment issues
- White papers/new national guidance/external reports
- Statutory/Mandatory training compliance

Recording required attendance:
Completion of statutory and mandatory training will be recorded by Training and Development on the OLM database and they will generate reports for the Head of Corporate Affairs. Non-attendance will be monitored through the T&D reports sent to the Head of Corporate Affairs who will raise concerns with the relevant line manager for any individual who fails to undertake the required training or regularly attend appropriate TB/TEC meetings. Evidence of the issue being addressed/rectified will be required to be received by the Head of Corporate Affairs within one month.

Briefings, handouts and updates presented to TB/TEC meetings will be sent to any non-attendees.