Report to:	**Public Board of Directors**	**Agenda item No:**	**20**
Date of Meeting:	**6 July 2022**		

Title of Report:	**Strategic Framework for Risk Management Update**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Adewale Kadiri, Head of Corporate Governance**
Appendices	**Appendix A: Strategic Framework for Risk Management**

1.	**Purpose for the Report**			
For Information	N	For Assurance	N
For Review and Discussions	Y	For Approval/Agreement	Y

2. Key Recommendation(s) (Note, Approve, Discuss,)

The Board of Directors is asked to discuss and approve the updated Strategic Framework for Risk Management. The Audit Committee has considered the Framework in detail and has approved it for ratification.

3. Legal / Regulatory Implications or NHS Provider Licence Compliance

It is a legal requirement for trusts to comply with the Health and Social Care Act 2008 Regulated Activities Regulations 2014 (Part 3). Regulations 12 and 17 set out the requirement for providers to provide safe care and treatment for service users and doing all that is reasonably practicable to mitigate any such risks.

4. Relevant CQC Domain Compliance Link

Safe	Effective	Caring	Responsive	Well Led
				☒

5. Strategic Priority

Quality: Zero Avoidable Harm

6. Risk (Threats or opportunities link to a risk on the Risk Register, Board Assurance Framework etc)

A failure to effectively identify and manage risks will impact on the delivery of patient care and could risk the Trust's registration with the Care Quality Commission (CQC).

7. Resources Implications (Financial / staffing)

The management of risks requires commitment from all managers to ensure that all risks to the Trust are identified, captured on the Risk Register, action plans developed and risks are monitored as part of their business as usual.

The costs of compliance with the CQC fundamental standards are embedded within operational delivery costs.

8. Equality and Diversity

None identified.

9. References to previous reports

None

10. Publication

Public

Strategic Framework for Risk Management Executive Summary

1 Background

1.1 The Trust's Strategic Framework for Risk Management had been due to be updated initially in October 2021, but this had been delayed as the Head of Risk and Assurance took on frontline duties during the pandemic. In the meantime, the most recent internal audit review of Risk Management and the Board Assurance Framework provided an overall assurance rating of "Partial Assurance with improvement required", in large part because the framework was out of date.

1.2 A draft updated version was presented and discussed at the Audit Committee on 16th June 2022. The Audit Committee approved the updated framework and agreed that it should be presented to the Board of Directors for final approval.

2 Discussion

2.1 The Strategic Framework for Risk Management has now been updated to better describe the role of the BAF not just as a tool for the management of strategic risk, but also as a key part of the Trust's overall governance. Detail on how it is managed has been included (pages 15, 17, 21) and links to the management of the Risk Register established. In addition, attempts have been made to improve the overall quality of the drafting and some key elements have been updated, taking into account that the original document dates back to November 2017. The document has also been updated to address recommendations from the previous Grant Thornton Risk Management Review, including the requirement for all identified risks to be managed through the Trust's Risk Management Database, Datix, and the addition of a section on the Trust's Risk Appetite which was discussed and agreed at the Board seminar in March 2022.

2.2 Account has also been taken of the recommendations from the more recent KPMG review. These include provision of detail on how risk management will be conducted (Page 25), although reference to the Trust's five strategic priorities has not been included as these are shortly to be updated.

3 Recommendations

3.1 The Board of Directors is asked to approve the updated Strategic Framework for Risk Management.

Royal United Hospitals Bath
NHS Foundation Trust

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Strategic Framework for Risk Management

Reference Number:	210
Policy Authors & Title:	Fiona Barnard Head of Risk and Assurance Adewale Kadiri Head of Corporate Governance
Responsible Director:	Chief Nurse
Review Date:	July 2022 ~~October 2021~~
Ratified by:	Board of Directors
Date Ratified:	
Version:	

Related Procedural documents	• Incident Reporting and Management Policy and Procedure; including the management of Serious Incidents • Major Incident Response Plan • Infection Prevention and Control Surveillance • Information Governance Policy • Complaints Policy and Procedure • Claims Policy and Procedure • Health and Safety Policy • FREEDOM TO SPEAK UP: Raising Concerns Policy

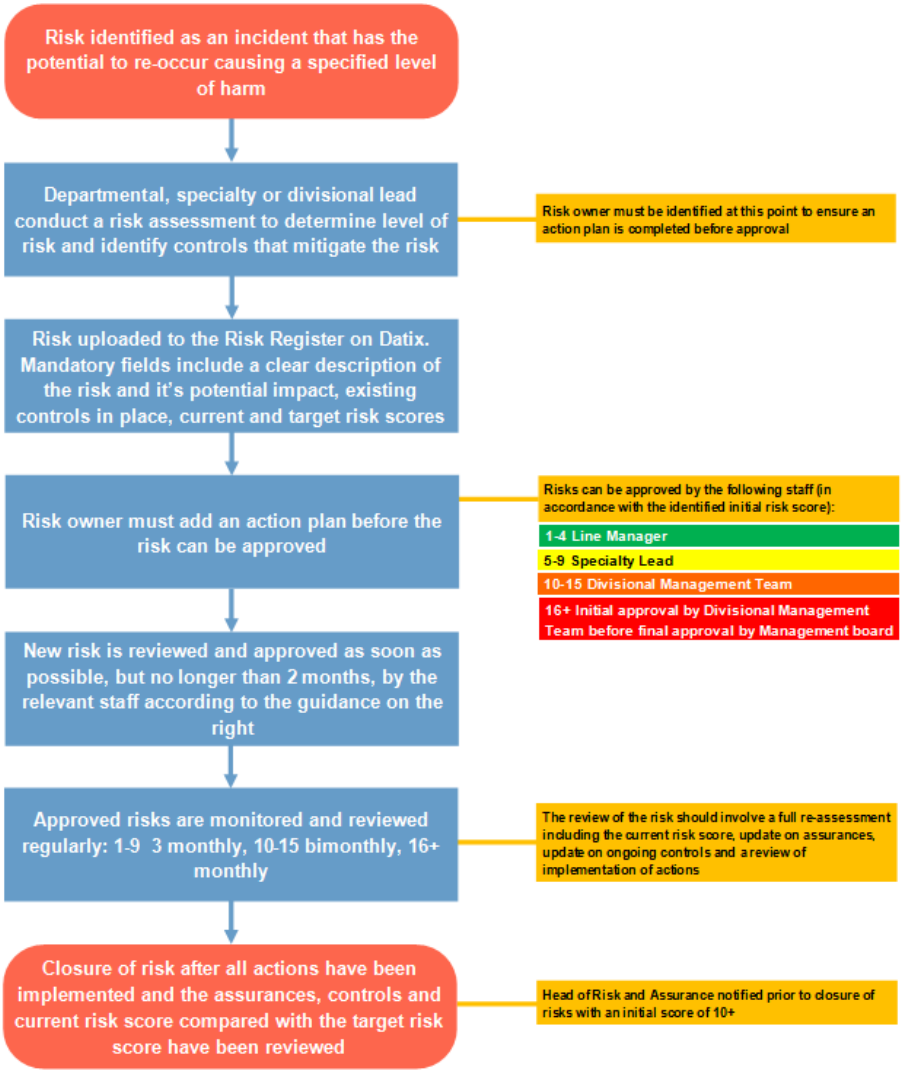
Index:

Amendment History

Issue	Status	Date	Reason for Change	Authorised
7.0	Approved	October 2015	Planned Review (approval documented in the Minutes of the Meeting Oct 2015)	Trust Board of Directors
8.0	Approved	December 2016	Planned Review	Board of Directors
9.0	Approved	October 2017	Planned Review	Board of Directors
10.0		March 2022	Planned Review	Board of Directors

Summary Diagram

~~The Risk Management Strategy~~



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1 Introduction

The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to meeting Trust objectives.

Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should be reviewed at regular intervals to ensure appropriate mitigations are maintained.

An effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces adverse outcomes and can result in 'upside risk' with benefits from the uncertain possibility of gain.

The Trust acknowledges its legal duty to safeguard staff, patients 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 and in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation, statutory legal action and adverse or unwanted publicity.

Risk Management is an integral part of good 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 therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks. The Trust recognises that complete risk control and/or avoidance is impossible, but that risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Board level of risk appetite and tolerance.

This document and related policies clearly set out the processes by which all risks are identified and controlled, including the roles and responsibilities of all staff across the Trust.

2 Objectives for Managing Risk

The Trust is committed to working in partnership with all its staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. This risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

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The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads direct and control the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission, and its strategic objectives and to communicate the Trusts statement of risk appetite and tolerance levels. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board

Primarily the strategy is to identify and manage risks that may prevent achievement of Trust objectives. Robust systems and processes are essential-to support a continuous programme of embedding Risk Management into daily activities and to support decision making through clear understanding of risks and potential impact.

The key objectives of the risk management strategy are to:

- Support a culture where risk management is integrated into all Trust business; including risk management issues when writing reports and considering decisions.
- Ensur~~e~~ing that all staff are adequately trained and competent to execute their duties in respect of risk management.
- Reinforc~~e~~ing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust.
- Ensure that appropriate structures are in place to manage risks, with clear escalation levels and processes;
- Create a system which is user friendly and allows the prompt assessment and mitigation of risk;
- Clearly describe the risk appetite of the organisation;
- Reduce risks to patients, carers, staff, sub-contractors, members of the public, visitors, etc., to an acceptable level;
- Maximise resources available for patient services and care, while m~~M~~inimising~~e~~ financial liability;
- Maintain~~ing~~ a comprehensive register of risks (clinical and non-clinical) and reviewing these on a periodic basis.
- Ensure controls are in place to effectively mitigate ~~the~~ risks and that these are understood by those expected to apply them.
- Ensure gaps in controls are rectified and assurances are reviewed and acted upon in a timely manner.
- Provide a system which integrates into the planning and performance management frameworks to minimise duplication whilst adding value.
- Ensuring adequate monitoring arrangements are in place and continually seeking improvement.

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3 Definitions

3.1 Assurance

- The confidence the Trust has, based on sufficient evidence that controls are in place, operating effectively and its objectives are being monitored and achieved.

3.2 Board Assurance Framework

- The Board Assurance Framework is a tool by which risks to the achievement of the Trust's strategic objectives are identified, managed and reported to the Board. ~~high level management assessment process and record of the primary risks relating to the delivery of strategic objectives and the strength of internal control to prevent risks occurring.~~

3.3 Consequence

- The outcome or potential outcome of an event, sometimes referred to as 'impact' or 'severity'.

3.4 Control

A measure in place to mitigate a risk.

3.5 Current score

What the risk score is assessed as with controls in place.

3.6 Governance

The systems and processes by which the Trust leads, directs and controls its functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.

3.7 Inherent score

Assessment of the risk prior to any mitigation and controls being applied. This is the "unmitigated" risk.

3.8 Internal controls

Trust policies, procedures, practices, behaviours or organisational structures to manage risks and achieve objectives.

3.9 Likelihood

The probability that the consequence will actually happen.

3.10 Operational risks

By-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the Division which is responsible for delivering services.

3.11 Project risks

Risks relating specifically to the delivery of a particular project. They are often run

alongside project 'issue' logs (issues being events that are currently occurring).

3.12 Risk

The threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence. An 'affect' may be positive, negative or a deviation from the expected position.

3.13 Risk Appetite

~~The level of risk that an organization is willing to accept while pursuing its objectives, and before any action is determined to be necessary in order to reduce the risk. Relates to the longer term strategy of what needs to be achieved and the resources available to achieve it.~~

~~Risk appetite can be defined as '~~T~~t~~he amount and type of risk that the Trust~~an organisation~~ is willing to take in order to meet its~~heir~~ strategic objectives. The Trust has different ~~Organisations will have different~~ risk appetites for different types of risk. These are reviewed annually by the Board, and will change over time depending on the Trust's priorities, challenges and the wider risk environment. ~~depending on their sector, culture and objectives. A range of appetites exist for different risks and these may change over time.~~

3.14 Risk Assessor

The person who conducts the risk assessment.

3.15 Risk Assessment

A systematic process of assessing the likelihood of something happening (Frequency or probability) and the consequence if the risk actually happens (impact or consequence).

3.16 Risk Management

The Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.

3.17 Risk Owner

The person responsible for ensuring the risk is adequately managed.

3.18 Risk Tolerance (or Capacity)

The level of risk that an organisation can accept per individual risk. Differentiating between those risks that are acceptable or unacceptable in line with the Trust risk appetite. Maintain boundaries of risk taking outside of which the organisation is not prepared to venture in pursuit of its objectives.

3.19 Strategic risks

The~~e~~se are risks that represent a threat to achieving the Trust's strategic

objectives or to its continued existence. They also include risks that are widespread beyond the local area and ~~risks~~ for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of Directors and included on the Board Assurance Framework, and should be managed at executive level, directly or by close supervision.

3.20 Strategic Objectives

The objectives, ~~known as the Board Assurance Framework~~, set by the Board of Directors as part of ~~in~~ the annual planning process, that specify the standards, outcomes, achievements and targets for the various aspects ~~reas~~ of the Trust's operations

3.21 Risk Registers

Repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk registers are available at different organisational levels across the Trust and will include Board Assurance Framework managed risks. The Risk Register formulates the principle tool the Trust uses for managing its risk assessment systems and processes

3.22 Target Score

An assessment of anticipated risk after the planned actions have been applied.

The Risk Management Process Map

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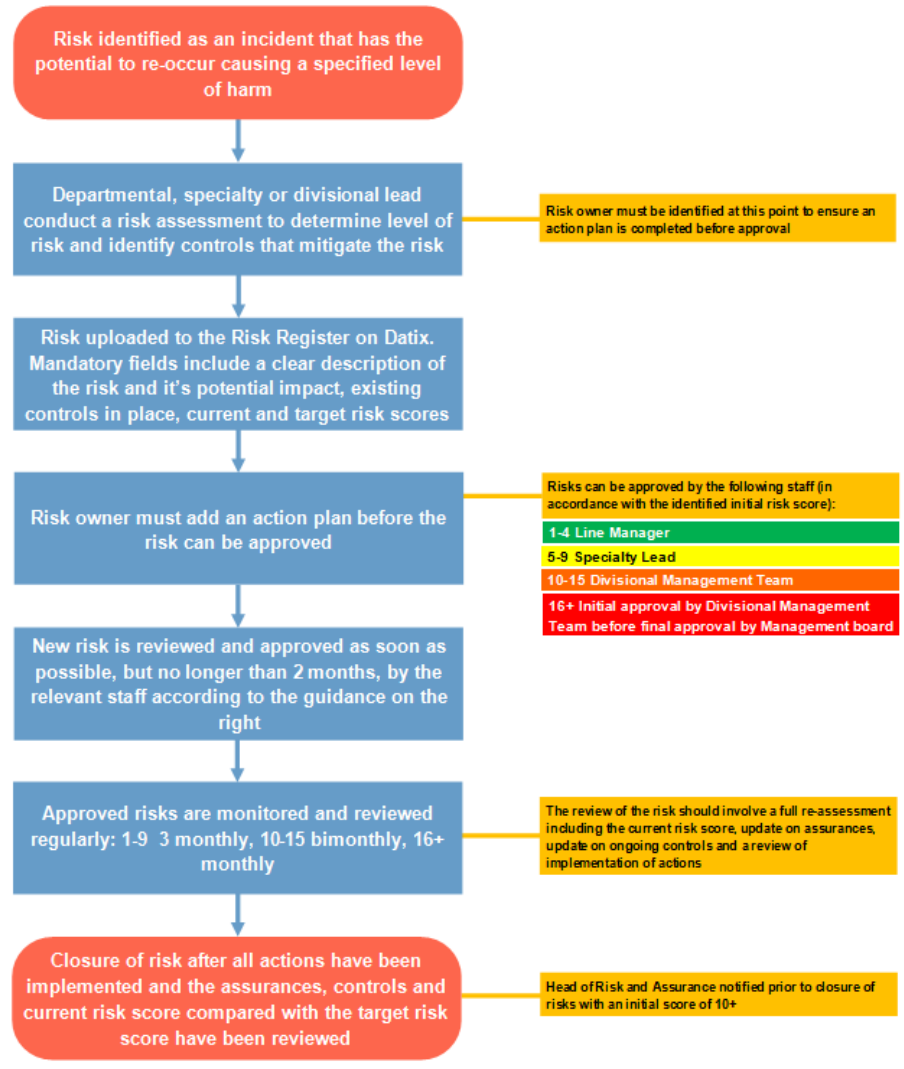

4 Risk Appetite

~~We need to know about~~ R~~r~~isk appetite is important because:

- Failure to agree the Trust's ~~If we do not know what our organisation's~~ collective appetite for risk is and the reasons for it, ~~then this~~ may lead to erratic or inopportune risk taking, exposing the organisation to ~~a~~ risks it cannot tolerate. On the other hand, ~~;~~ ~~or~~ an overly cautious approach ~~which~~ may stifle growth and innovation.~~development~~

- A lack of knowledge among leadership of ~~If our leaders do not know~~ the levels of risk that are legitimate for them to take, or a failure to ~~do not~~ take advantage of important opportunities when they arise, could compromise ~~then~~ service improvements and affect ~~may be compromised and~~ patient and user outcomes affected.

- ~~The Board of Directors have determined the Trusts risk appetite as an 'XXXX' one. (In practice this means that a level of risk taking is encouraged in order for the Trust to maintain a progressive approach to the delivery of services, where assurance can be sought that any associated risks can be mitigated to a tolerable level.) (Taken from UHB&Weston as an example)~~

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5 Risk Appetite Statement

5.1 The Board of Directors have established the Trust risk appetite as being defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, and in some areas our risk tolerance will be cautious, while in others, we are open/hungry for risk and are willing to carry risk in the pursuit of important objectives. We will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this must be highlighted through appropriate governance mechanisms.

Specifically;

5.2 Patient Safety ~~and Experience~~ risks: We have adopted a cautious stance for incident management ~~and patient experience~~ risks. The Board will receive ongoing assurance from testing of compliance requirements.

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5.3 Patient Experience risks: We have adopted an open stance for patient experience risks, willing to consider all options to ensure that patients receive a good experience of care, and choosing the one most likely to result in successful delivery.

~~5.2~~ 5.4 Patient Effectiveness risks: We have adopted an open stance for patient effectiveness risks, willing to consider all options to ensure that medication, treatments and processes are effective, and choosing those that are most likely to provide the most benefit to patients.

5.5 Reputational risks: The Board of Directors accepts that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence. We have adopted an open- ~~cautious~~ stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, thereby enhancing our reputation for delivering high quality, cost-effective services to the public.

~~5.3~~ 5.6 Stakeholder risks: We have adopted an open stance to stakeholder risks, willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit in relation to levels of effective engagement with the organisation's different stakeholder groups.

5.7 Financial risks: We have adopted a cautious stance for financial risks with reference to core running costs and critical safety-related infrastructure, seeking safe delivery options with little residual risk that only yield some upside opportunities. We will adopt a cautious stance in relation to our approach to financial management. However, we will take a more open approach with regard to spending to support patient safety, clinical effectiveness and good patient experience. The Board will receive ongoing assurance through the annual governance statement that policies and procedures are in place in line with HMT guidance.

~~5.4~~5.8 Information risks: We have adopted a varied stance to information risk, to reflect the sensitivity of information as defined by NHS England. We will adopt a cautious approach to the storage of the data in our possession, but will take a more open approach to the use of data, willing consider all options that will maximise the benefits to patients. The Board will receive an annual assurance that guidance and procedures are in place and training undertaken by staff.

~~5.5~~5.9 Cyber risks: We have adopted a cautious stance for cyber risks. The Board will have independent assurance, on service entry and in-life, on the risk of fraud and inadvertent or malicious corruption or modification of data on its IT systems.

~~5.6~~5.10 Business: We have adopted cautious and open stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options that have a cautious residual risk. This means that we use solutions for purchase, rental, disposal, construction, and refurbishment that ensure we

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protect stakeholders from as much risk as possible, producing good value for money whilst fully meeting organisational requirements.

5.11 Legal/Regulatory compliance risks: We have adopted a cautious stance for compliance, seeking a preference for adhering to responsibilities, and safe delivery options with little residual risk. The Board will have annual assurance that compliance regimes are in place.

~~5.7~~ Workforce risks: We have adopted an open stance to workforce related risks, seeking innovation and value for money in relation to the identification of new routes to training, recruiting and retaining both clinical and non-clinical staff. However, we have adopted a cautious stance to the maintenance of staff health and wellbeing.

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6 Risk Tolerance

Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can actually cope with and thresholds at which it is willing to 'accept' a specific risk. The following tables define the risk scores, above which risks may not be 'accepted' and must be actively mitigated.

The Tolerance level applies to the 'Target' score of 'Action Required' risks and the 'Current' (and Target) score of 'Accepted' risks.

Risk Domain	Definition	Accepted Risk Score	Risk Level
Safety	Impact on the safety of patients, staff or public	1-6	Moderate
Quality	Impact on the quality of our services and patient experience.	1-6	Moderate
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels, competence and training.	1-8	High
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	1-8	High

Commented [BF1]: Can we discuss the accepted scores? This is reflective of UHBristol & Weston so we might wish to amend in line with RUH historic tolerance levels

Reputation	Impact upon our reputation through adverse publicity.	1-~~9~~12	High
Business	Impact upon our business and project objectives. Service and business interruption.	1-12~~9~~	High
Finance	Impact upon our finances.	1-12~~9~~	High
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	1-8	High

Tolerance levels of Safety & Quality risks 1-6 (Below the black line)

Commented [BF2]: Should all risks have the same tolerance level or would it be different according to domain? These 3 tables suggest different tolerance levels as an example.

Commented [KA3]: Please see my suggested changes to the risk tolerance levels above.

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

Example: Tolerance levels of Workforce, Statutory and Environmental 1-8 (Below the black line)

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

Example: Tolerance levels of Reputation, Business & Finance Risks 1-9 (Below the black line)

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

7 Monitoring Compliance

The Head of Risk and Assurance will ~~shall~~ monitor the processes for managing risk locally to ensure they are being complied with as per this Strategy and the Risk Management Policy and Procedure.

A review of the risk management process will be presented on an annual basis to the Audit and Risk Committee. The review will formulate an overview of the current systems and processes in place for risk management. The overall implementation of this strategy shall be monitored through internal audit review undertaken in line with the Trust internal audit programme.

8 Compliance and Assurance

- The NHSI 'Single Oversight Framework' enables Trusts to demonstrate that they are performing within their agreed provider licence. The oversight framework is built around five national themes reflecting the NHS Long Term Plan and apply across trusts, commissioners and ICSs: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

- The Board Assurance Framework identifies the principal risks to the achievement of the trust's strategic objectives, as well as the components of the system of internal control that are in place to manage those risks. The Framework is populated with a combination of high scoring operational risks identified from within the Risk Register which potentially impact achievement of the Trust's strategy, and risks that have been assessed by the Board as potentially having that impact, notwithstanding the possibility that they might not be included on the Risk Register.

- The BAF process is managed by the Head of Corporate Governance in conjunction with the Executive Team. The full BAF is presented for review on a quarterly basis

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to the Board of Directors, with the aim of ensuring that the controls that are in place to manage and/or mitigate these risks remain effective, and that progress is being made to fill any gaps in control. The Board will also ensure that the risks as set out are the correct ones, and will suggest any additional or alternative risks as they see fit. It is also important that the BAF influences the Board agenda. Each BAF risk has a lead Board committee, and the relevant subset of the BAF is presented for review at each meeting. The Committee is able to interrogate each risk in more detail than at Board meetings, they are able to scrutinise actions being taken to mitigate the risk and where challenge the risk ratings. ~~is made up of two parts, the first is the monitoring of the achievement of the Trust Strategic Priorities and Corporate Objectives, and the second is the compilation of a strategic risk register, identifying the significant risks to the achievement of the priorities. These reports provide the Trust Board with a means of satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of objectives is at risk due to a gap in control and/or assurance.~~

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9 Monitoring through External Standards

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- All NHS bodies are required to prepare and sign a full Annual Governance Statement (AGS) as part of their Annual Report and must have the evidence to support this Statement. ~~The Annual Report brings together this evidence.~~

- All governance committee papers are submitted with an accompanying summary sheet, which highlights to the committee membership the purpose of the report/document, the related National standard and any identified risks either currently identified on the Risk Register and/or BAF, or those that require recording.

- Internal A~~a~~udit reports and any resulting action plan to address recommendations are~~is~~ presented ~~submitted~~ to the Audit and Risk Committee for approval and they help inform~~s~~ the statement on internal control, which is contained within the Trust's annual financial statements. The findings from individual audits also inform the Head of Internal Audit Opinion which is also a key piece of evidence around the adequacy of the Trust's control environment.

- ~~The Audit and Risk Committee will review progress against identified elements of the audit report action plan until completion.~~

10 Risk Management Policy

11 Policy Statement

An effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces the likelihood of adverse outcomes and can result in a culture with a proactive approach to risk and the possibility of gain.

The management of risks is a key factor in good governance and achieving the provision of the highest quality care to the Trust's ~~our~~ patients. Of equal importance is the legal duty of the Trust to control and limit any potential risks to staff and the general public, as well as safeguarding the assets of the Trust. It is the responsibility of all staff to be involved in the identification and reduction of risks.

All staff are responsible for the health and safety of staff, patients, visitors and others who access Trust Services. The purpose of this Policy and associated Procedure (section 15) is to assist staff in understanding and implementing the Trust's Strategic Framework for Risk Management.

12 Roles and Responsibilities

The Trust recognises that the Board collectively and individually, and some individual colleagues ~~employees~~ carry responsibility for ensuring the successful implementation and application of ~~a~~the risk management framework:

12.1 The **Chief Executive** has overall accountability for all risk, health and safety issues and for providing the Trust with the necessary organisation and resources to produce, implement and manage effective policies and ~~y~~actions to realistically minimise risk to the lowest level possible within available resources.

12.2 The **Chief Nurse** is the designated director with responsibility for risk management. This post holder is responsible for ensuring that the Trust's overall duty for risk management is discharged appropriately and for ensuring that effective operational arrangements are in place throughout the Trust. Achievement of this will be through the Management Board and the Board of Directors.

~~This post has responsibility for ensuring that the necessary systems and resources are in place to help the organisation assess and control risk.~~

12.3 The **Medical Director** is ~~nominated to support the corporate clinical risk management function by acting as~~ the Medical Risk Lead, and among other things, provides support ~~for the Trust in supporting the Head of Risk and Assurance~~ on matters requiring medical staff collaboration and/or advice and perspective. This role also ~~e post~~ has responsibility for ensuring that clinical risk is included ~~pursued~~ as part of the clinical governance agenda at specialty level. The Medical Director also ~~shall~~ fulfils the role of Caldicott Guardian and ~~will~~ plays a key role in ~~helping to~~ ensuring~~e~~ that the Trust meets ~~satisfies~~ the highest ~~practical~~ standards for managing information governance risks in relation to patient records and

information. ~~The Caldicott Guardian will act as the conscience of the organisation in this respect, and will actively support work to manage such risks.~~

~~12.3~~12.4

~~12.4~~12.5 The **Director of Finance** h~~H~~as delegated responsibility and accountability for financial risk. As Senior Information Risk Officer (SIRO) they are ~~is~~ the designated director ~~with~~ responsible ~~ility~~ for ensuring that there is a framework in place for the management of information governance risk across the organisation.

~~12.5 Director of Human Resources is the designated director with responsibility for ensuring that there is a framework in place for the management of non-clinical risk across the organisation.~~

12.6 The **Director of Estates and Facilities** is responsible for Health and Safety and is responsible for ensuring effective ~~physical and human~~ systems and precautions are in place to control health and safety risks.

~~**12.7** Caldicott Guardian The Medical Director shall fulfil the role of Caldicott Guardian and will play a key role in helping to ensure that the Trust satisfies the highest practical standards for managing information governance risks. The Caldicott Guardian will act as the conscience of the organisation in this respect, and will actively support work to manage such risks.~~

~~12.8~~12.7 The **Head of Corporate Governance** is responsible for organising the Board of Directors' Annual Cycle, making provision for the discussion of all new significant risks entered on to the Risk Register and that the Board of Directors undertakes at least one annual review and discussion of all risks. ~~The Head of Corporate Governance should make sure, through the Chairman, that the Board of Directors give due consideration to risk when considering the business on their agenda~~. The Head of Corporate Governance is also responsible for managing and updating the BAF in conjunction with the Executive Team~~the Board Assurance Fra - mework~~, ensuring that it effectively and on an ongoing basis identifies and reports on the management of those risks that could prevent the organisation from achieving its strategic objectives. The postholder will liaise regularly with the Head of Risk and Assurance to ensure alignment as appropriate between the Risk Register and the BAF.

~~**12.9** The~~ **Head of Risk and Assurance** ~~The Head of Risk and Assurance~~ is responsible for the overview of risk activity in the Trust, for the purpose of providing the Board of Directors with assurance.

The postholder ~~Head of Risk and Assurance has~~ is responsible ~~ility~~ for:

- advising on and co-ordinating risk management activities at all levels of the organisation;
- maintaining and updating the ~~risk management~~ tools and systems for assessing risk, and reporting and investigating incidents;

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- maintaining the risk management database used for collating and analysing incident information and risks;
- raising line managers' awareness of their ~~the~~ risk management responsibilities ~~to line managers~~, by providing them with information, advice and support ~~with risk management activities~~;
- advising and supporting colleagues on updating the Risk Register ~~upon receipt of related information~~;
- supporting the ~~Trust and Divisions in reviewing the content of the Risk Register to~~ identification of ~~y~~ themes and trends in risk reporting amongst Specialties/Directorates;
- reviewing risk scoring to ensure consistency across the Trust ~~by risk 'owners',~~ by ensuring the application of ~~the~~ guidance on~~for~~ determining the consequence/severity and likelihood of risks;
- ~~ensuring that the duplication of risks on the Trust wide risk register is minimised;~~
- providing or commissioning ~~offering~~ risk management training ~~to senior staff~~ as required.

~~The Head of Risk and Assurance will attend relevant committee or Board meetings at the request of the Chief Nurse.~~

~~12.10~~ The **Health & Safety manager** is responsible for advising and co-ordinating non-clinical risk management activities at all levels of the organisation. The postholder

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~~The Health & Safety Manager~~ is responsible for:

- ~~Assisting with~~ the assessment of ~~areas of~~ non-clinical risk, in partnership with identified experts~~, both internal and external;~~ and reporting and investigating non-clinical incidents;
- Ensuring that line managers are aware of and supported in the discharge of their responsibilities ~~and are supported in risk management activities by providing them with information and advice or training~~;
- Advising the Head of Risk and Assurance of any risk assessment scored at 16 or above;
- Reporting and investigating non-clinical incidents, and providing information to external stakeholders where appropriate.

~~12.11~~12.8 **All Executive and Non-Executive Directors** ~~(all)~~ are ultimately accountable for the Trust's achievement of integrated risk and governance. All risks with a score of ≥12 should have an identified Executive Lead, enabling a greater degree of accountability.

~~12.12~~ Directors of Division must understand and implement the Trust's risk management strategy and its underlying policies.

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They are responsible for:

- ~~Ensuring they have adequate knowledge and/or access to all legislation relevant to their areas and, as advised by appropriate experts, ensuring that compliance to legislation is maintained;~~
- Ensuring that ~~the~~ guidance around~~bout~~ governance and risk management is implemented in their specialties/departments and that all staff are alert to the risks within their work environment and of their individual responsibilities;
- Ensuring that all staff have access to 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, contractors, members of the public and visitors;
- Ensuring all employees attend mandatory training, as identified in the Trust's Electronic Staff Record (ESR) ~~in the Training Matrix~~, and that appropriate mandatory updates are maintained;
- Ensuring adequate resources are available and procedures are in place to identify clinical and health and safety risks to all ~~our~~ patients and staff, and that risk assessments are carried out within their respective are of responsibility;
- ~~The on-going maintenance and review of their risks recorded on the Risk Register in Datix. Where significant risks have been identified and where local control mechanisms are considered to be inadequate they are responsible for ensuring that these issues are raised at the appropriate Divisional/Directorate governance groups, in accordance with the risk escalation pathway;~~
- Ensuring that risks identified through local/divisional/directorate risk assessments are considered as sources for service improvement/development and fed into ~~the Operational plan;~~the business planning process.
- Ensuring financial probity and accountable use of resources within their remit area(s) and reporting risks to financial balance to their line manager;

The **Divisional Directors** are responsible for supporting the governance of risk as a core function in each department. Guidance for the responsibilities of these groups is attached at Appendix 2. ~~; communicate the outcomes of Management Board discussions to the relevant risk 'owner'.~~

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~~12.13~~12.9 Divisional Governance/Quality/Patient Safety Leads are responsible for:

- Facilitating divisional and departmental risk process' in accordance with this policy and ensuring that the escalation of risks occurs in timely manner to the divisional board;
- Facilitating the preparation of monthly exception reports of any divisional risks of 12 or above, to be received by the central risk team no less than 10 days before the Management Board meeting.

~~12.14~~12.10 The **risk 'owner'** is responsible for the management and overview of the risk and the plan for mitigation, even when responsibility for the action plan ~~responsibility~~ has been wholly or partially devolved;

Is responsible for the review of the action plan created to mitigate the risk, in line with the timescales given in the action plans and according to the risk level that any progress is recorded within the entry, to provide an accurate record of the management of the risk to the Management Board, Board of Directors and external bodies.

~~12.15~~12.11 All staff (including Honorary Contract holders, locum and agency staff and 5.16contractors)

Notwithstanding the identification of the above key personnel, the Trust recognises that organisational risk management is the responsibility of all members of staff. Every member of staff (including clinicians, temporary staff, contractors and volunteers) are responsible for ensuring that their own actions contribute to the wellbeing of patients, staff, visitors and the Trust.

All staff are required to ~~Key personnel responsibilities are~~:

- Report incidents or events, using the Trust's approved incident reporting mechanism (Datix), as required by the Management of Health and Safety at Work Regulations 1999.
- ~~The Trust has point of reporting for all types of incident; whether clinical, non-clinical (including health and safety), financial, corporate or information incidents. This information will inform the nominated leads of related risks;~~
- A~~ll staff are required to a~~ttend and follow individual essential training requirements and not to use equipment, adopt practices or processes which deviate from mandatory or statutory requirements and procedures for the purposes of health and safety. Staff ~~They~~ are expected to locate, observe and comply with all relevant policies and procedures that have been made available within the Trust.
- ~~All staff must~~ C~~c~~ontribute to the identification, management, reporting and assessment of risks and to take positive action to manage them appropriately. This is an essential part of managing risks locally and is a statutory requirement.
- In addition, staff must ~~have a responsibility for~~ tak~~e~~ing steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Freedom to Speak up Policy.

13 Committee responsibilities

13.1 The Board of Directors has ultimate responsibility and accountability for the quality and safety of services provided by the Trust. Risk management in the overarching framework of governance is therefore the princip~~l~~a~~le~~ role of the Board.

The Board of Directors undertakes a four monthly review and discussion of the Risk Register, to review any impact upon the Board Assurance Framework and review the organisation's risk appetite.

13.2 The **Audit and Risk Committee** hasve responsibility for assuring the Board of Directors that safe and effective healthcare is being delivered and that the Trust is meeting its statutory duties, including the assessment of the Trust's compliance with the Health and Social Care Act 2008 Regulated Activities, Regulations 2014 (part 3). A review of the risk management process is conducted ~~will be presented~~ on an annual basis by ~~to~~ the ~~Audit and Risk~~ Committee with a view to gaining ~~. The review will formulate~~ an overview of the adequacy of the ~~current~~ systems and processes in place for risk management. The Committee also carries out a review of the BAF to provide assurance to the Board that the processes for its development and maintenance are effective, and that the other Board Committees are using it appropriately.

13.3 The **Management Board** is accountable to the Board of Directors for the operational management of the Trust and the delivery of objectives set by the Board of Directors. The Management Board is the key operational decision~~-~~making body within the ~~taking sub-committee of the Board of Directors in the~~ Trust and sup;ports the Chief Executive and the Executive Team to run the organisation. ~~has responsibility for the operational success of the Trust.~~ The Management Board meets monthly and meetings are ~~will be~~ conducted in line with its ~~their~~ Terms of Reference, its~~-~~ work programme, and the current ~~of the key~~ risks facing the ~~to the~~ organisation;

As such, it is responsible for:

- monitoring the structures, processes and responsibilities for identifying and managing key risks facing the organisation, ~~prior to discussion at the Board of Directors meetings;~~
- the final approval of all risks added to the Risk Register with a score of ≥ 16, to assess whether the scoring and proposed action plans are appropriate;
- the monthly review of all current risks on the Risk Register with a current score of ≥ 16, monitoring progress against the action plan agreed to mitigate the risk, or identifying actions necessary to achieve completion of the action plan;
- ~~the monthly review of all current risks on the Risk Register with a current score of 10 – 15, in order to ensure that the lower scoring risks with the potential to have a significant impact are not overlooked and their effect on the Board Assurance Framework can also be appropriately assessed~~;
- the monthly notification of all Risk Register entries that remain unapproved after two months;
- monitoring all risk related disclosure statements, in particular the Aannual Governance Statement and declarations of compliance with ~~the~~ Care Quality Commission regulations, prior to approval by the Board of Directors;
- Ensuring that any ~~all~~ actions arising from ~~identified in all~~ audits and reviews of Risk Management are addressed and completed ~~to achieve the requirement of the Strategic Framework for Risk management~~.

As the committee responsible for managing and balancing all operational issues including, finance, performance and managing risk, the Management Board will

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approve all business cases with a financial cost within limits set out in the Standing Financial Instructions.

~~13.4~~ The **Divisional Boards** support the work of ~~underpin~~ the Management Board, in being overseeing ~~responsible for~~ the day to day delivery of health care and related services. The Standing Orders and Standing Financial Instructions, provide appropriate levels of ~~increase the~~ autonomy and decision m~~t~~aking by providing a framework for the delegation of powers and authority. ~~of the Divisions by reducing bureaucracy and increasing self-management. The development of service line reporting allows the Management Board to focus on performance, risk management, corporate operational issues and strategic developments~~. Divisional Board ~~The~~ meetings take place monthly and are ~~meetings will be~~ conducted in line with their Terms of Reference. They are

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~~The Divisional Boards are~~ responsible for:

- ensuring systematic risk assessment and effective risk management takes place across the areas within their sphere of responsibility;
- ensuring that risks that are brought to their attention a~~r~~end either managed through ~~with~~ the allocation of appropriate resources, or escalated where appropriate to the Management Board~~, for the identification of resources or acceptance of the risk~~;
- the monthly review of all current risks on the Risk Register with a current score of ≥ 10, monitoring progress against the action plan agreed to mitigate the risk, or identifying actions necessary to achieve completion of the action plan.

~~13.5~~13.4 **Programme and Project Boards** oversee ~~a~~ specific programmes or projects, for example the acquisition of a service provider. These groups are required to manage the risks associated with the defined project and ensure that they are assessed and appropriate action plans developed.

They are required to maintain an independent risk register which links to the Trust-Wide Risk register, through a single overarching risk which covers the whole programme or project. See **section 23**.

~~13.6 Specialty and Service Management meetings~~ **Specialty and Service management teams** oversee the delivery of specific services, reporting to the Divisional Directors through existing line management structures. They are

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~~The Local Specialty/Service management team is~~ responsible for:

- Proactively identifying ~~predicting and undertaking resolution planning of~~ risks within their areas of work; and
- ~~Reviewing and~~ Uupdating their Divisional Boards on progress against action plans for mitigating identified service risk(s).

~~13.7~~13.5 ~~The Divisional Governance Groups~~ In recognition of the significant ~~large~~ operational and clinical governance agendas to be delivered within the clinical Divisions, each Divisional Board has delegated responsibility and authority for clinical governance to a **Divisional Clinical Governance Group**. The Divisional

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Clinical Governance group deals with clinical governance and associated risk issues on behalf of the Divisional Board.

Each Divisional Governance group has responsibility for:

- Ensuring each speciality/department within their remit holds local governance/risk meetings;
- Reviewing incidents, claims and complaints data, in order to identify themes and trends, key risks to the organisation and implement actions to learn, reduce and prevent reoccurrence;
- ~~Ensuring every Specialty/Department is involved in a local Governance/risk meeting;~~
- Proactively predicting and undertakinge resolution planning of clinical risks;
- Escalatinge clinical risks to the Divisional/Directorate Board (see Appendix 2);
- Reviewing and updatinge the Divisional/Directorate Board on progress against action plans for mitigating identified risk(s).

~~13.8~~13.6 The **Specialty Governance group**'s smaller specialties or departments may decide to participate in a larger overarching governance groups within their Division.

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The departmental governance meeting chair must ensure the minutes of these meetings are submitted to the relevant Divisional Governance Group.

The Local Specialty Governance Team is responsible for:

- ensuring that incident trends are monitored to identify themes, trends and risks to patient safety and delivery of the service, escalating these for inclusion on ~~to~~ the Risk Register where the risks are not amenable to local resolution;
- Proactively predicting and undertakinge resolution planning of clinical risks;
- Reviewing and updatinge the Divisional Board on progress against action plans for mitigating identified risk(s).

~~13.9~~13.7 Ward/department management meetings

Ward and Department Managers must:

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- ensure~~ing~~ that risk assessments are completed locally, recorded and shared with the Risk Management or Health and safety Departments, where necessary;
- ensure~~ing~~ that identified risks are incorporated into the Trust-Wide Risk Register in Datix and through the Division/Directorate, where the risks are not amenable to local resolution;
- ensure~~ing~~ that incident trends are monitored to identify local themes and trends and risks to patient safety and delivery of the service, escalating these for inclusion on ~~to~~ the Risk Register where the risks are not amenable to local resolution;
- Review and update the Divisional Board on progress against action plans for mitigating identified risk(s).

~~13.10~~13.8 The **Health & Safety Committee** acts as the operational committee for supporting the management of health and safety risks. The Health & Safety Committee facilitates the resolution of Trust-wide non-clinical (health and safety) risk issues amenable to control by policy and procedural change at a corporate-wide level and recommends action to the Non-Clinical Governance Committee and thence to the Board of Directors, where there is a financial implication for the resolution of the risk.

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Strategic risks identified outside the remit of these committees/groups will be entered onto the Risk Register upon the decision of the relevant Executive Director.

14 Education and Training

The Trust will continue to develop training that will ensure all staff are alert to potential risk areas and are aware of the systems, processes and resources to assess and manage risks appropriately.

Senior managers who are members of the Board of Directors and Management Board will receive risk awareness training as required.

Managers are responsible for ensuring all their staff receive the type of initial and refresher training that is commensurate with their role(s).

Staff must refer to STAR available on the intranet to identify what mandatory training is relevant for their role. Further information is available on the statutory and mandatory training web pages about each subject, the required frequency of update and the available training opportunities.

15 The Risk Management Process

16 Assessment

Risk may be identified through a variety of external and internal sources:

The requirement and timescales for the assessment of specifically identified areas of risk (i.e. health & safety, security, stress, hazardous substances, violence abuse and harassment etc.) are clearly identified within the dedicated procedural documents.

Risk will be assessed and prioritised using a risk assessment matrix (Appendix 3), which enables the organisation to assess the level of risk based upon measurement of the likelihood and consequence of the occurrence. This prioritisation tool is based upon the National Patient Safety Agency guidance and the Australian and New Zealand Risk Management Standard (AS/NZ 4360:2004). This matrix will be used to evaluate the level of risk and determine the risk category (i.e. severity and likelihood scores) for each risk identified. Risk assessment guidance can be found at Appendix 4.

17 Managing the risk

Once a risk has been assessed at a local level, or added directly on to the Risk register (Datix); if all the actions for resolution can be achieved at a local level, progress against these will remain the remit of the specialty or department. If not all of the actions for resolution can be achieved, the risks must be escalated to the Divisional Board for agreement on treatment or acceptance of the identified risk(s). The group agreement on the decision to treat or accept the risk(s) must be clearly documented in the minutes of the meeting.

The Divisions will maintain a register of risks on Datix, comprised of all the risks identified but unresolved at specialty or department level, as well as those identified Division wide. This Divisional risk register will be part of the Trust-Wide Risk Register, maintained in the Datix database.

Where mitigation of the risk(s) is not achievable or resolution cannot be achieved within the Division, the risk must be escalated to the Management Board.

All risk reviews and progress must be documented in progress notes on Datix to enable a clear audit trail of communication and actions taken to ensure mitigations are implemented or escalated if not effective.

18 Monitoring, review and updating

The Division is responsible for monitoring progress against the identified actions to reduce the risks scoring ≥ 10 identified within their areas of responsibility and the updating of the Risk Register, following every review. The frequency of monitoring of progress against the actions identified to reduce the risk will depend upon the initial risk score and the anticipated duration of the action plan. The risk 'owner' is required to update the Risk Register, following any review and assessment of progress, in accordance with the timescales identified in Appendix 3.

The Management Board is presented with all new risks scoring ≥ 16 entered on to the Risk Register since their previous meeting, in order to approve the scoring and validity of the proposed action plan to mitigate the risk. The Management Board decision to treat or accept a risk must be clearly documented in the minutes of the meeting.

At each meeting, the Management Board will be presented with a summary report detailing significant Trust-wide risks on the Risk Register scoring ≥ 10, in order to monitor and review progress against the agreed action plans and challenge, if necessary, progress against the agreed action plan deadlines. The definition of Trust-wide risks has been agreed as:

Risks identified on the Trust-wide Risk Register (the Risk Register) that threaten to prevent the organisation's ability to continue to deliver an acceptable quality of healthcare services, whether collectively or in isolation~~, including (but not limited to):~~

~~property damage;~~

~~laboratory services;~~

~~availability of a staff group;~~
~~administrative processes/services;~~
~~service bids;~~
~~Contracts and commissioning.~~

What will be monitored	Monitoring/ Audit method	Monitoring responsibility *(individual/group/ committee)*	Monitoring Frequency	Reporting arrangements	Actions to improve & learn where monitoring has identified issues
Risk Register Compliance	Risk review at escalation levels Collection of data from electronic risk reports	Management Board Board of Directors Risk and Audit Committee	Monthly report Four monthly report Annual Review	Risk Register Report to Management Board Four monthly risk report to Board of directors Annual Risk register audit report	Action plan progress update. Review acceptance status at monthly reviews or as per level of risk in accordance with policy Close risks that are now resolved Identify tolerable risks and agree process of review

19 Completion

The Management Board decision to accept or close a risk will be clearly documented in the minutes of the meeting. This decision will be communicated to the risk 'owner', via the Divisional Directors. The Head of Risk and Assurance is also notified of such decisions, in order to ensure the Risk Register remains accurate.

The Board of Directors will review all current risks on a four month basis, to monitor progress on resolution, recommend action, or formally minute acceptance of high and extreme risks at their current level.

Significant or extreme risks are those that are potentially damaging to the organisation's objectives and it is these that will be addressed by the Board of Directors. The Board of Directors has ultimate responsibility and accountability for decisions regarding actions to be taken on extreme risks. The Board of Directors may choose to:

- return the risk to local, divisional or executive team level for further clarification or resolution;
- accept the risk as adequately, whilst not optimally, controlled, by existing risk reductions measures;
- accept the risk as not amenable to resolution in the existing financial climate;
- transfer the risk in full or in part to another organisation;
- adopt actions to reduce the likelihood only;
- adopt actions to reduce the consequences only;

- adopt actions to reduce the likelihood and consequences;
- avoid the risk by eliminating the service.

The Board of Directors' decisions to treat or accept the risk(s) will be clearly documented in the minutes of the meeting and communicated to the Head of Risk and Assurance by the Trust Secretary, in order to ensure the Risk Register is updated accordingly.

All decisions to 'accept' a risk not amenable to resolution in the existing financial climate will be reviewed by the Board of Directors on an annual basis, to confirm the decision, or review the treatment plan. Any decision to treat the risk(s) must be clearly documented in the minutes of the meeting and communicated to the risk owner by the nominated Director.

A summary of this process is available at Appendix 2.

20 Acceptable Levels of Authority for Resolving Risks

The responsibility invested in wards departments and specialties for resolving risks is defined by what they can do locally to create safer systems of work and by the risk rating applied for the specific risk assessed. Risks that have been given a 'green' (insignificant) or yellow (low) rating (Appendix 3) can usually be resolved locally, through ward or department actions.

Once a risk extends beyond the parameters of department service provision OR if it has been assessed and given an 'orange' (moderate) or 'red' (high) rating, it will further review by the relevant Divisional Directors to identify the appropriate action plan to treat or accept the identified risk(s).

Risks extending beyond the sphere of responsibility of one Division or if it has been assessed and given a 'red' (high) rating will need to be discussed at the Management Board to identify the appropriate actions to treat or accept the identified risk(s) or assign multidivisional actions.

If the Management Board is unable to resolve the issue, the risk will be escalated to the Trust Board of Directors for a decision to achieve resolution or other disposal as described in **section 3**. The Board of Directors will look at all the potential consequences of carrying the risk and decide whether investing in a solution is justified or alternatively accepting the risk. This is shown diagrammatically in figure 2.

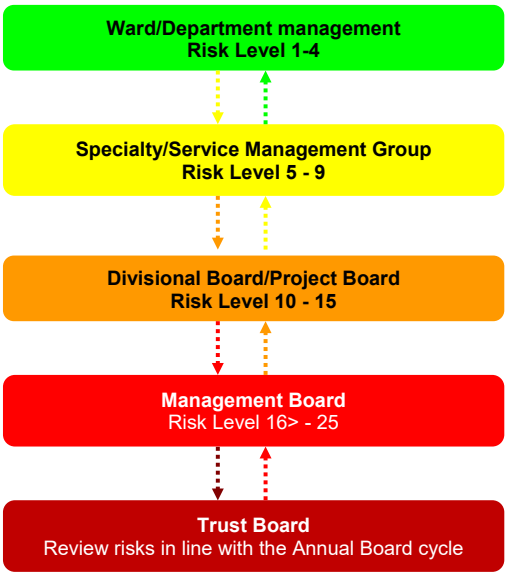


Figure 2. Acceptable levels of authority for resolving risks

If the Board of Directors decide the risk is externally driven or its resolution is limited by available funding, there may be reason to take the discussion to the Trust partners e.g. Clinical Commissioning Group (CCG) or NHS Improvement (NHSI).

21 Risk Management and the Trust Planning Process

Risks that are key to the delivery of the Trusts organisational objectives are highlighted within the annual report. ~~The development of the Trust's three year strategy, the contracts with the commissioners and any business plans must~~and will include an assessment of the risks to the Trust.

~~The risk management approaches adopted by the Trust are equally applicable in all areas and are built into all future planning and development. In particular, the methodologies for identifying, assessing and prioritising risk will be used by the relevant Directors, or their nominated deputy, to undertake risk assessments in the following areas:~~

- ~~Capital planning, and in particular the National Development Plan;~~
- ~~Procurement;~~
- ~~Service Planning;~~
- ~~Re-organisation and re-structuring.~~

~~The planning process and integral risk assessment must include an awareness of our stakeholders, with regard to the way in which their behaviour affects the organisation and the way in which the behaviour of the Trust affects them. 'Stakeholders' include patients, local health community partners, public interests, and service user interests.~~

The Board of Directors is required to sign a statement, as part of the annual report, which states that they have confidence in the system within the Trust for managing risk. This statement reflects the risks ~~flowing~~ from the contracts with the commissioners and the Chief Executive's objectives.

~~The Standards for Quality and Safety, upon which the Board of Directors sign off their assurance, as part of the annual report, are concerned with the management and minimisation of risks. The Board will provide adequate resources to Risk Governance and the achievement of regulatory compliance.~~

The Trust is resolved to subscribe to the National Health Service Resolution, in order to meet its insurance cover against clinical and non-clinical claims.

22 Projects and Strategic Policy Decisions

23 Programme or Project Risk(s)

These relate to risk(s) relating to a Programme or Project which may impact on the delivery of the project.

A project may be defined as the process of carrying out work to achieve a clear objective, usually bringing about a change. A project will normally have a set of characteristics:

- Agreed, well defined documented set of objectives and end products;
- A start point and an endpoint which brings about change;
- A definition which sets out what is included and excluded from the project;
- A plan which takes account of timescales, costs and quality;
- A defined set of tasks – which will often be inter-related and can be grouped into phases or work areas;
- An agreed set of staff and resources – who should have an agreed dedicated level of time to carry out the tasks;
- Access to a wider community of interested parties;
- A well-defined plan, with constraints issues and risks communicated and managed;
- A prescribed set of benefits and outcomes which can be measured – before and after the project, leading to a successful conclusion on time to budget and meeting expectations.

All discrete and significant projects or strategic policy decisions within the Trust must be risk assessed using the agreed risk assessment process. Each Project Manager within the Trust must undertake risk assessments of their designated projects at the beginning of the project.

All risks must be subjected to the same risk assessment process, using the agreed process (Appendices 3 - 4), to ensure consistency. Each project is required to have a separate risk register. The Project Manager will review the risks at regular intervals and maintain an active project register of risk.

The management of the project's risk register must be a standing agenda item at all Project Board (or equivalent) meetings, where risks must be reviewed and updated as necessary. Any changes identified and agreed by the project team must be reported to the overarching Committee with responsibility for reviewing the project.

One overarching risk should then be added to the Trust-Wide Risk Register, which covers the whole programme or project. The identified reporting process will report significant risks to the Management Board via the Trust-wide Risk Register.

Where the Trust is involved in projects which are managed through third parties with contractual commitments to utilise a different project methodology, a clear protocol will be established which identifies how risks held in the project format or system will be escalated to the Risk Register.

There may be projects that require formal project methodology which is fully documented within a Project Initiation Document, detailing all project risks which are known and are included in any associated Business Case. A formal project approach using or based upon a recognised project methodology will reduce the associated risks within a project.

24 Partnership Risk(s)

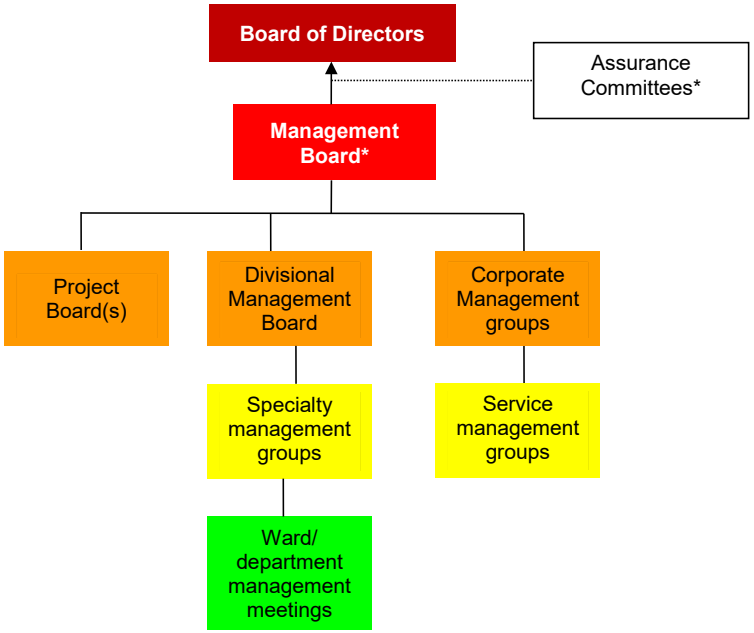
A risk relating to joint working arrangements with other NHS and Non-NHS organisations may be identified as part of the planning process. Elements of these risks maybe outside of the control of the Trust and therefore appropriate assurances should be sought from the partner organisation, by the relevant Director, and clearly documented as part of the planning and continuing risk assessment/management process.

Appendix 1: Consultation Schedule

Committee name	Date reviewed
Management Board membership	
Board of Directors	

Appendix 2: Governance Framework

Commented [BF4]: I think we need to keep a structure in but does this reflect the position today?



Please note: This is a representation of the Governance Structure of the Trust. For an accurate picture please refer to the Governance Structure published on the intranet at www.ruh.nhs.uk

Legend

Insignificant risk (1 -4): Low risk (5 – 9): Medium risk (10 – 15):

High risk (16 – 24): Extreme risk (25):

* High Level Risk Committees

Appendix 3: Risk Assessment Matrix

Acceptable Risk
Risk is tolerable as long as it is well managed and controlled. In addition to identified hazards, all incidents claims and complaints will be risk assessed according to the following process and investigated according to the severity or the consequence and likelihood of (re)occurrence.

All Risk Assessments within the Trust will identify:

I. The hazards within the Task/ area being assessed inherent in the work undertaken
II. who and how many people would be affected
III. how often specific events are likely to happen (may be based on frequency of previous occurrence)
IV. how severe the effect or consequence would be
V. how controllable the hazards are

Acceptable risk will be determined using the following traffic light system:
Severity/consequence
Given the (in)adequacy of the control measures, how serious the consequences are likely to be for the group, patient or Trust if the risk does occur (using the matrix).

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

		Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	independent review Low performance rating Critical report	Inquest/ombudsman inquiry 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 Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff or very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

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

Likelihood

Given the (in)adequacy of the control measures for each risk, decide how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for very likely.

Score	Descriptor	Description
1	**Rare**	Extremely unlikely to happen/recur – may occur only in exceptional circumstances – has never happened before and don't think it will happen (again)
2	**Unlikely**	Unlikely to occur/reoccur but possible. Rarely occurred before, less than once per year. Could happen at some time
3	**Possible**	May occur/reoccur. But not definitely. Happened before but only occasionally - once or twice a year
4	**Likely**	Will probably occur/reoccur. Has happened before but irregularly – several times a month
5	**Very Likely**	Continuous exposure to risk. Has happened before regularly and frequently – is expected to happen in most circumstances. Occurs on a daily basis

Risk Score is determined by Severity x Likelihood

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

Tolerance Level

Action to be taken following identification of a risk score

1 – 4 Insignificant	5 – 9 Low	10 – 15 Medium risk	16 – 24 High	25 Extreme
Action may be long term. Risks subject to aggregate review, use for trend analysis	The majority of control measures are in place. Risk subject to regular review should be reduced as part of directorate long term goals	There is moderate probability of major harm of high probability of minor harm, if control measures are not implemented. Prioritised action plan required with timescales. To be monitored and reviewed six monthly	Significant probability that major harm will occur if control measures are not implemented. Urgent action is required. Consider stopping procedures. Actions to be audited until in control. Review monthly	Where appropriate and in discussion with the lead clinician/manager stop all action IMMEDIATELY. Controls to be implemented immediately and audited until risk score reduced. Review weekly

Appendix 4: Easy steps to the Risk Assessment Process

A risk assessment is a systematic and measured examination of any **risk** identified, i.e. what, in your work, could cause harm to:

- **people** - including yourself, patients and their friends or relatives, carers, staff (permanent, temporary and independently contracted), visitors, etc.

  or

- **the organisation** – including day to day tasks, operations, our environment, services, etc.

It will assist you to decide whether or not you have taken enough precautions to prevent harm or loss or should do more.

The following words will assist in clearly stating the risk:

As a result of…

There is a risk that…

Which may result in…

Please refer to a copy of the Trust Risk Assessment Form (Appendix 4), this is available on the intranet.

N.B. This form should not be used to carry out specialist risk assessments such as COSHH, Patient Handling, DSE, etc.

Remember, a Risk Assessment should provide a means of communicating the hazards or threats identified and control measures available to minimise risks. The risk assessment should be explicit, enabling anyone who doesn't yet know of the issue, to understand it. Abbreviations should not be used, only facts (not opinion) and staff titles/roles (not names).

Follow the steps below in order to complete a Risk Assessment.

Step 1 **Identify the Department** – including the Responsible Manager, Assessor and Date of Assessment.

Step 2 **Hazard/Threat:** Describe the hazard or threat, so that anyone will understand the issue.

Step 3 **Associated Risks:** Describe the risks associated with the Hazard/Threat, who might be injured, what might happen to that person (including, patients, relatives, carers, staff, visitors, etc.), property or project and why/how.

Step 4 **Existing Control Measures:** – assess the measures currently in place to control the hazard and thereby reduce the risk (there may or may not be measures already in place to minimise the risk). If there are no Current Control Measures in place, simply record this fact.

Remember, the Trust is committed to an open and fair culture, recognising that many important lessons are learnt through an open and transparent approach, which would not otherwise be learned where blame is apportioned, or staff feel under threat through risk assessment. The Trust promotes a just, fair and responsible culture that fosters learning and improvement, whilst encouraging accountability.

Step 5 **Current Risk Score:** – identify the Risk Score with existing Current Control Measures in place; this will help you to:

- Understand the value of your Current Control Measures in place (sometimes, Current Control Measures in place actually increase risk).
- Recognise the risk level potential if any of your Control Measures fail.

Use the Risk Scoring Matrix (**Appendix 3**) to assess the Risk Score as follows:

1. Select the most appropriate ***severity/consequence*** of the Hazard/Threat and subsequent risk occurring
(e.g. Negligible, Minor, Moderate, Major or Catastrophic)

and

2. Select the most appropriate ***Likelihood*** of the Hazard/Threat and subsequent risk occurring
(e.g. Rare, Unlikely, Possible, Likely or very likely)

then

3. Cross-reference the chosen *severity scores* and *Likelihood score* to produce a Risk Score, e.g. if you decide that the Impact is 'Major' (4) and the Likelihood of the risk occurring is 'Unlikely' (2), then the Risk Score is Moderate (8).

N.B. Use the statements around potential impact on people and the organisation on the Risk Scoring Matrix as a guide, but remember, Risk Scoring is subjective not exact. It is designed only to assist in thinking systematically around an identified risk.

Remember, you should try to consider the Risk Score in terms of the **organisation as a whole**; for example:

1. An isolated issue such as a lack of available shelving within a room resulting in items being stored inappropriately on the floor and damaged, may feel as though it has a Risk Score of 20 to the room user, but in the context of all other risks faced across the organisation as a whole, it is more realistically a 'Negligible' *Impact* (1) x a 'Certain' *Likelihood* (5), producing a Risk Score that is Low (5).
2. A non-slip floor that could cause a patient or other person to fall, resulting in semi-permanent harm, reflected as a 'Moderate' *Impact* (3) x a 'Possible' *Likelihood* (3), producing a Risk Score that is Moderate (9).

N.B. If the **current risk score is 16 or above**, please discuss with your department manager immediately on completion of the risk assessment; they may adjust your score or confirm your assessment and notify the Head of Risk and Assurance or Health & Safety Manager.

Step 6 Identify the Control Measures Required (best case scenario)**:** consider whether the Current Control Measures in place (if any) tackle the root cause of the problem, or just the symptoms of the problem. Decide upon the best case scenario course of action and describe the Control Measures Required to minimise the risks as far as possible. Identify the Control Measures/actions required to be taken in order of priority.

Control Measures fit into a '**Hierarchy of Controls**', as follows:

1. Elimination:
Always the first choice

- By substitution with a less dangerous alternative, e.g. using a safer substance, or a safer machine
- Avoiding certain processes, e.g. buying in from a sub-contractor
- Redesigning to eliminate the risk altogether

2. Engineering Controls

- Engineering controls, e.g. maintenance, lagging pipes
- Isolate the hazard, e.g. guard the dangerous parts of a machine
- Machinery to reduce risks, e.g. 4 section profiling bed, riser/recliner chair

3. Procedural Controls

- Segregate staff from the hazard, e.g. stand behind a barrier whilst an x-ray is taken
- Safe working procedures, e.g. correct methods of handling toxic waste, permit to work systems
- Time exposure, e.g. reduce time exposed to a chemical
- Warning systems, e.g. using signs to warn of a slippery floor

4. Behavioral Controls
Always the last choice

- Information, Training, Instruction and Supervision, e.g. providing manual handling training relevant to the job
- Personal Protective Equipment (PPE), e.g. use of gloves, visors, safety shoes, etc.

This should be the **LAST RESORT**, as human behavior is not failsafe - for use only where the above measures do not control the risk!

This list indicates an 'order of priority' for Control Measures in any hazardous/threatening situation. The hierarchy reflects the fact that eliminating and controlling risk using engineering and procedural controls is more reliable than relying solely on people changing their behavior, which can never be failsafe, because people will always be prone to error, i.e. through lapses in concentration, distraction, differences in perception and experience. It is a well-documented fact that adverse incidents occurring are usually the result of unanticipated failures within system and process design.

The measures at the top of the Hierarchy of Controls seek to create a safe workplace whilst the measures at the lower end of the Hierarchy attempt to make people safe in a hazardous environment. If you have more than one Required Control Measure, list and number these in order of priority as you record them.

The line Manager should make every effort to implement required Control Measures identified by the Risk Assessment and should ensure that all new and Current Control Measures are made known to their staff and are working.

Step 7 **Target Risk Score** (best case scenario)**:** Identify the **Risk Score** anticipated with the **Required Control Measures** in place. Usually, **Required Control Measures** will reduce the **Risk Score** substantially (although not always, e.g. some risks are occupational, such as lone-working in the community, and although minimised through **Control Measures**, will always exist to some extent).

Adding this **Risk Score** will help you to compare the value of the **Current** risk score (Step 5) and doing nothing to minimise the risk, with the risk once the **Required Control Measures** (Step 7) are in place.

Step 8 Identify the **Target (Completion) Date,** the **Cost** of the **Actions/Control Measures Required** and the **Manager Responsible** (Risk 'owner').

Step 9 Present the completed risk assessment to your line Manager for discussion. Your line Manager will review the assessment and may make adjustments, e.g. to the risk score, because of their over-arching perspective on the score, or to the actions/control measures required, suggesting other solutions.

Your line Manager will arrange for the risk assessment to be entered onto The Trust-wide Risk Register (in Datix), for regular review and monitoring by the specialty/department; being used to inform departmental business

planning through allocation of resources in order to minimise the risks identified therein.

Your line manager may not have the resources, authority or means to action all control measures identified by the risk assessment, e.g. purchase of equipment, change to strategy or premises, but is now formally informed of the Hazard/Threat and risk, in order to work towards the required control measures.

Step 10 Depending upon the initial score, your line manager will arrange for the risk a to be reviewed by the Specialty/Divisional/Directorate Management Board, for either regular monitoring of progress against the action plan, or agreement on the decision for the appropriate course of action in managing the risk.

Document Control Information

Ratification Assurance Statement

Dear Alison

Please review the following information to support the ratification of the below named document.

Name of document: Strategic Framework for Risk Management

Name of author: Fiona Barnard

Job Title: Head of Risk and Assurance

I, the above named author confirm that:

- The procedural document presented for ratification meets all legislative, best practice and other guidance issued and known to me at the time of development of the document;
- I am not aware of any omissions to the document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known;
- The procedural document meets the requirements as outlined in the document entitled Trust-wide Policy for the Development and Management of Policies;
- I have undertaken appropriate consultation on this document;
- I will send the document and signed ratification checklist to the Policy Co-ordinator, for publication at my earliest opportunity following ratification;
- I will keep this document under review and ensure that it is reviewed prior to the review date

Signature of Author: Fiona Barnard **Date:** 1 March 2022~~03 February 2020~~

Name of Person Ratifying this policy: Alison Ryan

Job Title: Chair~~man~~

Signature: **Date:** March 2022~~February 2020~~

To the person approving this policy:

Please ensure this page has been completed correctly, then print, sign and **post this page only** to: Director's Office, Wolfson Centre, (D1), Royal United Hospital
The **whole policy** must be sent electronically to: ruh-tr.policies@nhs.net