South London and Maudsley **NHS**
NHS Foundation Trust

Risk Management Strategy

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Information Governance Policy
Incident Policy
Claims Handling Policy
Emergency & Major Incident Policy
SLaM Mandatory Training Policy
AWOL – Missing & Absent Policy
Being Open & Duty of Candour Policy
Clinical Risk Assessment & Management of Harm Framework
Health & Safety Risk Assessment Policy

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Contents

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Section 3: Appendices		
AP1	Board Governance Structure	25
AP2	Assurance Map	26
AP3	Risk Flow Diagram	27
AP4	Risk Evaluation	28
AP5	Risk Matrix & Guidance	30
AP6	Risk Appetite Matrix	34
AP7	Definitions	35
AP8	How to do a risk assessment	36
AP9	Identifying risk	41
AP10	Training	42

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Executive Summary

Risk management is an inherent part of South London & Maudsley NHS Foundation Trust (SLaM) approach to quality improvement and good governance and is a central part of the Trust's strategic and operational management. It is the process whereby the Trust identifies, assesses and analyses the risks inherent to and arising from its activities, whether clinical or non-clinical including strategic, financial, workforce or any other and puts in place robust and effective controls to mitigate those risks.

The aim of risk management is continued improvement and not just to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operations objectives. This strategy describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed at all levels and an effective internal control system is in place. The strategy is a trust wide document, and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation.

The trust recognises the importance of the Boards identification and ownership of risk and this is supported by the governance structure in place. The Board's committees look at different aspect of risk and provide a scrutiny and assurance role that supports the Board in its decision-making. The operational roles of the executive team and CAG's are supported by all levels of staff, from ward to board, whom the trust provides training to.

The trust believes that effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in the business planning process where a more competitive and successful edge and public accountability in delivering health services is required this also involves working closely with its local stakeholders, e.g. through the STPs.

The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the trust and individuals to reduce the incidence and impact of the risks they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of service delivery within the organisation.

The trust is committed to working in partnership with 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 will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective internal control systems and accountability for organisational learning in order to continuously improve the quality of services. As part of this, the trust undertakes to ensure that adequate provision of resources, including financial, personal training and information technology in as far as reasonably practicable is made available.

This strategy is subject to 3 year review, or sooner if circumstances dictate, and approval by the Trust Board.

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1.0 Introduction

1.1 South London and Maudsley NHS Foundation Trust recognises that providing mental health and social care services and the activities associated with employing staff, providing premises and managing finances are an inherently risky business, but that risk, properly managed can bring with it advantages, opportunities and benefits. Understanding what the risks are that the organisation faces and managing them appropriately will enhance the Trusts ability to make better decisions, deliver the objectives and improve performance.

1.2 As risk is an inherent part of the delivery of healthcare, the risk management strategy outlines the Trust's approach to risk management throughout the organisation and identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

1.3 Continuing authorisation as a foundation trust introduces the imperative or strategic business risk management, in addition to risks associated with service delivery. Maintaining foundation trust status is dependent on regular 'self certification' by the Trust Board that clinical services, governance and financial standards are met. In turn, self-certification requires access to high quality risk and assurance reports that are the product of an effective risk management strategy and process and through the right collection, analysis and action of relevant data.

1.4 The Strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels who are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

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

1.6 There is clear responsibility of the Trust Board in response to the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust (2013), and the subsequent Berwick Report (2013) to provide assurance that patient safety and recovery is at the top of the agenda. Lessons learned from the Francis Inquiry, both on a national and local level, demonstrate the importance of an overarching assessment of risk to the Trust. The Trust aims to ensure that patient safety and quality risk assessment continue to follow the consistent risk management process outlined in the strategy. Francis and Berwick also specifically emphasised the importance of Board responsibilities and an open and fair culture to ensure the best possible patient safety principles within Trusts. These are clearly set out within this strategy.

1.7 The Risk Management Strategy confirms the organisational framework for the management of risk within South London and Maudsley NHS Foundation Trust.

2.0 Risk Statement

2.1 This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

2.2 The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an on-going commitment to improving the management of risk throughout the organisation:

2.3 **AWARENESS Staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.**

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- Risk identification – line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

- Accountability – staff will be identified to own the actions to tackle risks.

- Communication – there will be active and frequent communication between staff, stakeholders and partners.

COMPETANCE Staff will be competent at managing risk

- Training – staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.

- Behaviour and culture – senior management will lead change by example, ensuring risks are identified, assessed and managed. Front line staff are encouraged to identify risks.

MANAGEMENT Activities will be controlled using the risk management process and staff are empowered to tackle risks.

- Risk assessment and management – risks will be assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans will be put in place where required.

- Process – the process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.

- Measuring performance – exposure to risk will be measured with the aim of reducing this over time. The culture of risk management will also be measured and improved.

RISK APPETITE AND TOLERANCES The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate.

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

- Risk leadership
- People
- Risk policy and strategy
- Partnerships
- Risk management processes
- Risk handling
- Outcomes

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

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3. Risk Appetite

3.1 Risk appetite statement

3.1.1 The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed;
- The amount of risk to be taken on;
- The desired balance of risk versus reward;

3.1.2 On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

- Risk to patients
- Organisational risk
- Reputational risk
- Opportunistic risk

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

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

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

3.1.6 **Expressing Risk Appetite**

The Trust uses the 5 x 5 matrix (likelihood and consequence) to identify risk ratings. The Trust's risk appetite line is set at 12; any risks rated at or above this level are reported to the relevant Board Sub-Committee and the Board on a quarterly basis. A risk score of 12 or above should therefore be treated as a trigger for a discussion as to whether the trust is willing to accept this level of risk. A residual risk rating should be set for all risks. This residual risk rating is a means of expressing a target for the lowest acceptable (tolerated) level for that risk. When setting residual risk ratings, risk leads should consider what level of tolerated risk they are willing to retain. For some risks, the residual risk rating could be high, especially where the consequences are potentially severe or some elements of the risk lie outside the direct control of the Trust. All risks will have a risk appetite rating which will be derived from the Risk Appetite Matrix for NHS organisations (appendix 6)

4.0 Risk Management Process

The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

1. Clarifying objectives
2. Identifying risks to the objectives
3. Defining and recording risks
4. Completion of the risk registers and identifying actions
5. Escalation and de-escalation of risks

4.1 Governance structures to support risk management

There are different operational levels of risk governance in the Trust:

- Board of Directors
- Assurance Committees
- Senior Management Team
- Risk Scrutiny Committee
- CAG or Corporate Governance Meetings
- Clinical / Corporate Service Unit
- Department/speciality level
- All staff reporting risks

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

The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls. The BAF is used to drive the Board agenda.

The Corporate Risk Register is the high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

The Annual Governance Statement is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

Additionally the Audit Committee and other Board sub-committees (Finance and Performance Sub-Committee, Quality Sub Committee and Remuneration & Nomination) exist to provide assurance of the robustness of risk processes, in doing so take account of risks relevant to their area of activity, and to support the Board of Directors

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

4.2 Horizon Scanning

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

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

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- NHS Improvement
- Care Quality Commission
- NHS requirements on finance
- Legislation
- Government white papers
- Government consultation
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health publication
- Monitor publications
- Local demographics
- STPs and working with other stakeholders
- Seeking stakeholder views e.g. Council of Governors, Commissioners and the population we serve

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

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

5.0. Project and Programme Risk

Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of the programme documentation.

5.1 Project and Programme Risks

Project and programme opportunities and threats are generally identified:

- If a programme, through the escalation of risks from projects within the programme

- During project or programme start up

- By other projects or programmes with dependencies or interdependencies with this project or programme

- By operational areas affected by the project or programme

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

- Identify the owners of a programme and individual projects within the programme

- Identify any additional benefits of adopting risk management within this project or programme

- Identify the nature and level of risk acceptable within the programme and associated projects

- Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level

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- Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects

- Identify how inter-project dependencies will be monitored and managed

- Clarify relationships with associated strategies, policies, and guidelines.

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

5.2 Costing of project and programme risks

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

6.0 Regulatory Framework for Risk Management

6.1 The Trust must ensure that its risk management arrangements meet the requirements of a number of national bodies that are described below:

6.2 Care Quality Commission (CQC)

6.2.1 The CQC includes risk management as part of its essential standards (which cover clinical and non-clinical issues). All healthcare providers, including NHS Trusts, must achieve these minimum standards. The CQC replaced the Quality Risk Profiles (QRPs) with the surveillance model which are a suite of indicators that relate to five key questions the CQC inspection teams ask of all services: are they Safe, Effective, Caring, Responsive to peoples needs and Well Led? Trusts are rated one of four levels: Outstanding, Good, Requires Improvement or Inadequate. Ratings are published to help patients compare services and make choices about providers.

6.3 The NHS Foundation Trust Code of Governance

6.3.1 This strategy will support the continued development of an environment which will enable the trust to demonstrate compliance with the NHS Foundation Trust Code of Governance, and in particular principle F.2 Internal Control:

- **Main principal – F.2:** The Board should maintain a sound system of internal control to safeguard public and private investment, the NHS foundation trust's assets, patient safety and service quality.

- **Code provision – F.2.1:** The Board should conduct, at least annually, a review of the effectiveness of the NHS Foundation Trust's system of internal control and should report to members that they have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems.

6.4 Monitor's Risk Assessment Framework

6.4.1 Monitor uses the information collected and received from Foundation Trusts under the *Risk Assessment Framework* to assess the risk to continuity of services conditions and, for NHS foundation trust's, non-compliance with the NHS foundations trust governance condition. Monitor has two types of assessment ratings:

i)   **continuity of service risk rating**   This represents Monitor's view of the likelihood that a licence holder is, will be, or could be in breach of the continuity of services licence condition 3. A rating will be issued to all licence holders that provide Commissioner Requested Services; and

ii) **governance rating,** for NHS foundation trusts only, setting out Monitor's degree of concern about the governance of the trust, any steps Monitor are taking to investigate this and/or any actions Monitor are taking.

6.4.2 These will be assessed separately using new types of risk categories; each NHS foundation trust will therefore be assigned two ratings.

6.4.3 As part of the Annual Risk Assessment, NHS Improvement requires all Foundation Trusts to declare that all significant risks have been identified, that effective risk management processes are in place and that all issues raised by external audits and assessments have been addressed. This strategy describes the processes that the trust will put in place to achieve this.

6.5 National Health Services Litigation Authority (NHSLA)

6.5.1 The NHSLA provides insurance cover to the NHS for most incidents, both clinical and non-clinical. The NHSLA had previously assessed all NHS Trusts for compliance against a unified set of risk management standards. However, following a change in approach, they no longer carry out assessments. In their place the NHSLA have introduced the 'Safety and Learning Service', which supports Trusts to build a safety and learning culture through their work in learning from claims.

6.5.2 The NHSLA risk management standards however, reflect good risk management practice, and the Trust will continue to use them as a basis to address relevant areas of risk for as long as they apply to the Trust and reflect current processes and practice.

6.6 National Patient Safety Agency (NPSA)

6.6.1 The NPSA functions were transferred to NHS England in 2012. This particular function does not set specific requirements that are assessed. However, it works closely with agencies across the NHS and with Trusts to implement and establish solutions to problems and to support a safety aware culture. For example, the NPSA issue national patient safety alerts and monitor all patient safety incidents via the National Reporting and Learning Service (NRSL).

7.0 Responsibilities and accountabilities for risk management

7.1 Individual Responsibilities

Risk Management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in the day to day of members of staff in many different ways.

The following sections define the organisational expectations of particular roles or groups.

7.1.1 Chief Executive

The Chief Executive is the responsible officer for the South London & Maudsley NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management as outlined below.

7.1.2 Chief Finance Officer

The Chief Finance Officer has responsibility for financial governance and associated financial risk.

7.1.3 Medical Director

The Medical Director has joint responsibility for clinical governance and clinical risk management, including incident management, and has joint responsibility with the Director of Nursing for quality.

7.1.4 Director of Nursing

The Director of Nursing has responsibility for patient safety and patient experience, and has joint responsibility with the Medical Director of quality and clinical risk management.

7.1.5 Chief Operating Officer

The Chief Operating Officer (COO) has responsibility for ensuring that effective operational arrangements are in place throughout the Trust and across all sites, this includes performance management and the management of operational risks. The COO has particular responsibility for Health and Safety.

7.1.6 Trust Secretary

The Trust Secretary leads on the management of strategic risk within the organisation and the Board Assurance Framework.

7.1.7 Executive Directors

Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

7.1.8 CAG Directors

CAG Directors are accountable for ensuring that appropriate and effective risk management processes are in place within the CAGs, and that all staff are aware of the risks within their work environment, together with their personal responsibilities.

They must ensure that risks are identified, assessed, and acted upon. They must ensure that where appropriate captured on local risk registers, ensuring that risks are reviewed by an appropriate divisional group at least quarterly as part of performance monitoring, to consider and plan actions being taken. They must ensure appropriate escalation of risks from service or directorates to

divisional level within the defined tolerances. Divisional Directors have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this strategy and related documentation.

The Divisional Directors are responsible for ensuring that staff receive the relevant elements of risk management training and then non-attendance is followed up.

7.1.9 Clinical Directors

Clinical Directors are responsible for ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk register; and ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.

7.1.10 Senior Managers

Senior managers that lead on risk management and set the example through visible leadership of their staff. Senior staff are expected to be aware of and adhere to the risk management best practice.

7.1.11 Health and Safety Risk Manager

The Health and Safety Risk Manager advises the Trust on Health and Safety, including statutory compliance requirements; responsible for ensuring that there are systems in place to ensure that safety alerts are disseminated, implemented and monitored.

7.1.12 All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow the Whistleblowing Policy incorporating guidance on raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

7i.2 Committee Duties and Responsibilities

8.2.1 Board of Directors

The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has be delegated by the Board to the following interrelating committees:

- Audit Committee
- Finance and Performance Sub-Committee
- Quality Sub-Committee

Specific responsibilities for the management of risk and assurance on its effectiveness is delegated as follows:

8.2.2 The Audit Committee

The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system for internal control by means of independent and objective reviews of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

- To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.
- To review the Trust strategic risk register at each meeting or as the Board determines.
- To monitor the Board Assurance Framework, and ensure its presentation to the Trust Board at intervals that the Board determines.
- To assess the overall effectiveness of risk management and the system of internal control.
- To challenge on the effectiveness of controls, or approach to specific risks.

8.2.3 The Finance and Performance Committee

The Finance and Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.

8.2.4 The Quality Sub-Committee

The Quality Sub-Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research & development issues; and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Trust Board as appropriate.

8.2.5 Senior Management Team

The Senior Management Team in its role as the Executive decision making committee of the Trust maintains oversight of the operational risk and is responsible for the operational management and monitoring of risk, through the Corporate Risk Register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring their delivery.

8.2.6 Risk Scrutiny Committee

The Risk Scrutiny Committee is responsible for ensuring there is an appropriate and robust risk management system in place and working throughout the organisation.

It is responsible for moderating new risks and escalated risks to the Corporate Risk Register and Board Assurance Framework and recommending and advising the Senior Management Team on the escalation and de-escalation of risks.

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Those risks associated with an initial score of 12 or more will be escalated to the Risk Scrutiny Committee and will be reported to the relevant board committee.

8.2.7 CAG and Corporate Directorate Risk Management Arrangements

CAGs and corporate areas will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.

The CAG forums have the responsibility, through the Clinical Directors, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. The CAGs will develop, populate and review their risks, drawing on risk processes within the services, to ensure that Service, Directorate and CAG Risk Registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular CAG and its services. Directorate meetings similarly will review the risk registers and contribute to the development of the Directorate and CAG Risk Registers and ensure risk registers are in place and operating within the defined tolerances and escalation processes.

Directorate and CAG management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

9.0   Training

9.1   The training of staff is an integral part of the Trust's approach to risk management.

Training requirements to fulfil this strategy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Learning and Development Policy in conjunction with the widest possible range of subject matter experts in the organisation (including the Head of Risk and Assurance) on an annual basis to ensure that:

- All new staff attend an Induction programme which includes risk management training

- All Board members, non-voting Executive CAG Managers and Clinical Managers will receive annual risk management training in the format of a risk management awareness seminar, co-ordinated by the Head of Risk and Assurance

- The Trust will provide appropriate training and guidance to enable staff to take responsibility for managing risk within their own working environment. Learning opportunities will be published annually, identifying the availability of training and development opportunities for staff (including mandatory training).

Specific training will be provided in respect of high-level awareness of risk management for the Board. Risk Awareness Sessions are included as part of the Board's Development Programme.

The specific training required by staff group is outlined in Appendix 3 along with a description of how the training is managed.

10.0 An Open and Fair Culture

10.1 All members of staff have important roles to play in identifying, assessing and managing risk. To support staff in this role the Trust promotes a fair, open and consistent environment and does not seek to apportion blame. In turn, this encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report any situation where things have, or could have gone wrong. However, appropriate action in accordance with Trust Policies will be taken when an employee has acted illegally, maliciously or recklessly.

10.2 Concerns regarding unsafe practice may be reported by staff through a confidential route under the "*raising concerns at work policy*"

11.0 Stakeholders

11.1 There is a range of organisations and individuals which required information on adverse events or significant risks facing the Trust – for example, service users, governors and members, commissioners, regulators, local government and central government. The main local stakeholders are all represented in the Foundation Trust Governors, part of whose role is to ensure that the Trust operates in a way that is consistent with its statement of purpose.

12.0 Review

12.1 Compliance with the standards set out in the Risk Management Strategy will be assessed routinely by the Audit Committee and by the Trust Board. CAG Managers and local management teams will also be responsible for reviewing compliance with this strategy within their management groups and via formal line management arrangements.

12.2 The robustness of the framework detailed in the Strategy will be contained within a risk management annual report and subject to scrutiny by internal audit. It will also be endorsed by a self-certification to Monitor that is signed off annually by the Trust Board.

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

13.0 Related Policies

Information Governance Policy
Claims Handling Policy
Emergency & Major Incident Policy
SLaM Mandatory Training Policy
AWOL – Missing & Absent Policy
Being Open & Duty of Candour Policy
Clinical Risk Assessment & Harm Policy
Health & Safety Risk Assessment Policy

14.0 References

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- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Matrix for Risk Managers, National Patient Safety Agency (2008)

- Risk Assessment Framework, Monitor, August 2013
- The NHS Foundation Trust Code of Governance, Monitor, March 2010
- Monitors Enforcement Guidance. March 2013
- Integrated Governance Handbook: 2006
- The NHS Audit Committee Handbook, Department of Health (2011)
- Board Assurance Frameworks: A simple rules guide for the NHS 2009
- The Health NHS Board Principles for Good Governance, National Leadership Council, 2010
- Taking it on Trust, Audit Commission 2009

15.0   Equality Impact Assessment

The trust is committed to promoting equality of opportunity for all its employees and the population it serves. The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.

16.0   Review and Version Control

This Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. This strategy will be reviewed every three years or sooner if circumstances dictate. Any changes will be reviewed by the Quality and Audit Committees and any recommendations are submitted to the Board of Directors for formal ratification.

Version control:

Version	Date	Author	Status	Comment
1.0	18/09/2007	Damien Gibson	Final	Initial version
2.0	22/01/2008	Jenny Goody	Final	Updated to comply with current practice and NHSLA requirements
2.1	01/09/2008	Jenny Goody	Interim	Updated to reflect changed name / ToR of CGRMC and updated ToRs of CRC, RMC & AC
3.0	25/11/2008	Jenny Goody	Final	Annual review, further detail added; no significant changes
4.0	15/02/2010	Jenny Goody	Draft	Annual review, references to non-risk aspects removed, updated to reflect current practices
4.1	01/09/2010	Jenny Goody	Draft	Updated to clarify the relationship between the Trust's objectives, the AF, the CRL and local RARs
5.0	26/07/2011	Jenny Goody	Final	Full policy review
6.0	30/10/2013	Jenny Goody	Final	Annual review, minor updates
7.0	22/10/2013	Jenny Goody	Final	Updated to reflect AF reporting process, to address QGF gaps and IA recommendations
7.1	25/02/2014	Jenny Goody	Draft	Updated to reflect the Trust's response to KPMG's recommendations relating to its governance structure and risk escalation process
7.2	29/07/2014	Jenny Goody	Final	Updated to reflect current practices
8.0	25/07/2016	Jill Hall	Final	Full policy review and update to reflect current practices

Process for managing risk

1.1 Process overview

1.1.1 The NHS adopted Risk Management Standard developed by Standards in Australia and Standards New Zealand in 2002. This was superseded by Risk Management Standard ISO 31000:2009. This standard underpins the Monitor principles as discussed previously. This section outlines the overall risk management process in the standard and examines the risk rating and ranking process, looks at risk treatment, explains what a risk register is and outlines how risk assessment, monitoring and review is undertaken within the Trust

1.1.2 The following sections will lead you through the process for identifying and managing risks.

2.0 Stage 1: Clarifying objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process.

To understand whether something constitutes a risk it must first be understood what the objectives/outcomes are that you want to achieve.

Strategic or Corporate Objectives - Identify and clarify which Trust Strategic or Corporate Objective is relevant to the Division, directorate, service or area. Look at the Trust Business Plan and the latest local business plan. If this step is missed or omitted then the risk register will be neither relevant nor effective.

Local Objectives As well as the above, think what the local team or area objectives are. By identifying the objectives it can be identified whether there is a risk to manage.

2.1 Stage 2: Defining and recording risks

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended on for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible gather those staff together those who are able to assist with the identification of risk for the area. Guidance on how to do this is available in the Risk Management Handbook.

2.2 Stage 3: Defining and recording risks

Once the risk has been identified then:

- **Describe it** so that others understand what the risk is. Think about the *cause, effect and impact*

- **Assign an owner** to the risk

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:
o:

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

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

- **Rate the likelihood** of the risk materialising

- **Rate the consequence** of the risk happening

All these things should be recorded on a risk register following risk assessment. The following sections describe in detail how to complete the risk register, including a blank risk register with a single risk line on it, annotated to show what the different sections are to be used for. Detailed descriptions follow.

2.3 Stage 4: Completing a Risk Register

Traditionally completing a risk register can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings in the register that need to be completed are:

Risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the Action Owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many Action Owners. The Risk Owner must know, or be informed, that they are the owner, and accept this.

Source of how or where the risk was identified. This could include:

- Business planning
- Clinical Audit
- Complaints/PALS
- External Audit
- External Review
- Incident

- Internal Audit
- Legislation
- NICE guidance
- Regulatory standard
- Risk Assessment
- Risk Register (existing)

Risk description this section, as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following sub-headings will help to clearly describe risks:

Cause → Effect → Impact

Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an Owner and target completion date.

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

Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted
- **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity
- **Take the opportunity** – actively taking the advantage, regarding the uncertainty as an opportunity to benefit

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways that they need to be informed about.

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

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

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

Considering the proximity, or how soon a risk may occur, can help to compare risks for decision-making.

Previous Risk Rating and **Current Risk Rating** – these columns are mirror images of each other. Each time the register is reviewed or updated the risk register should move the current rating into the previous column and recalculate the current rating. This is so the history and progress of a risk can be reviewed.

Trend - shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by a directional arrow.

Review Date should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

Risk Target is the amount of risk that is accepted or tolerated, or the level that has been decided to manage the risk down to. When deciding the risk target, consider the following:

- What risk rating should a risk be managed down to in an ideal world?
- What level can the risk actually and practicably be managed down to?
- Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
- Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?
- What are the defined tolerance and escalation thresholds for the level of risk?

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

RED represents a very high tolerance of the risk, i.e. willing to tolerate a risk rated with either a very high likelihood or consequence (or both)

AMBER represents a reasonably high tolerance to the threat occurring i.e. more open to the threat occurring, often if there are operational or resourcing constraints

GREEN averse to the risk if the risk materialises this cannot be tolerated

The term 'risk appetite' or 'risk appetite target' may also be used. When the risk has been managed to the target level then this may indicate the risk has been managed down to a level defined within the Trust's risk appetite definitions.

3.0   Stage 5: Escalation and De-escalation

Risk Escalator – SLaM NHS Foundation Trust

Board of Directors
Board Assurance Framework
Corporate Risk Register

Board Assurance Framework and Corporate Risk Register submitted to Board n and monitored through Board governance and assurance committees

Audit Committee
Board Assurance Framework

Assurance Committees
Board Assurance Framework
Corporate Risk Register
Review at each meeting

Senior Management Team
Board Assurance Framework
Corporate Risk Register
Monthly

Risks scoring 15 or above impacting across the Trust escalated to corporate risk register with agreement by SMT and recommend risks to be incorporated into the BAF

Risk Scrutiny Committee
Corporate Risk Register and Directorate / CAG Risk Registers

All risks 15 or above (corporate or CAG) and any risks regardless of score if unmanageable escalated by the CAGs to RAG

CAG/Corporate Areas (Operational SMT)
Review Delivery risk registers
Agree escalation of Programme and Clinical Directorate risks

CAG Business Meetings (Performance Review Meetings)
CAG Risk Registers

Service / CAG risks reviewed at CAG Governance Forums / CAG Boards

Risk Registers

Risks identified populate the Risk Register

Ward to Board escalation

Board to ward feedback and de-escalation (where appropriate)

| Internal / External Audit | Complaints /PALS/ incidents | Risk Assessment | Business Planning | Clinical *Audit* | Legislation | Litigation | External Review |

3.1 Risk will be escalated or de-escalated within the defined tolerances and authority to act for each level.

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

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

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

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

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

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

4.0 Risk Profile

A summary of risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing Risk Register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be shown. If exposure to risk is above this, and therefore the tolerance set at that level, managers can see that they must take prompt action such as upward referral of relevant risks. The Trust Board and Senior Management Team define risk tolerances.

Risk Management Strategy

Appendices

Appendix 1: Board Governance Structure

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┌─────────────────────────┐        ┌─────────────────────────┐
│ Senior Management Team   │╌╌╌╌╌╌╌╌│      Trust Board         │
└─────────────────────────┘        └─────────────────────────┘
     ┊                                          │
     ┊          ┌──────────┬──────────┬─────────┼─────────┬──────────┐
     ┊          │          │          │         │         │          │
     ┊   ┌────────────┐ ┌────────────┐ ┌──────────────┐ ┌──────────────┐ ┌────────────┐
     ┊   │   Audit    │ │ Quality Sub-│ │  Finance &   │ │ Remunerations│ │ Charitable │
     ┊   │ Committee  │ │ Committee   │ │ Performance  │ │  Committee   │ │   Funds    │
     ┊   │            │ │             │ │ Sub-Committee│ │              │ │            │
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     ┊          ┌──────────────┐
     ┊╌╌╌╌╌╌╌╌╌╌│Risk Scrutiny │
                │  Committee   │
                └──────────────┘
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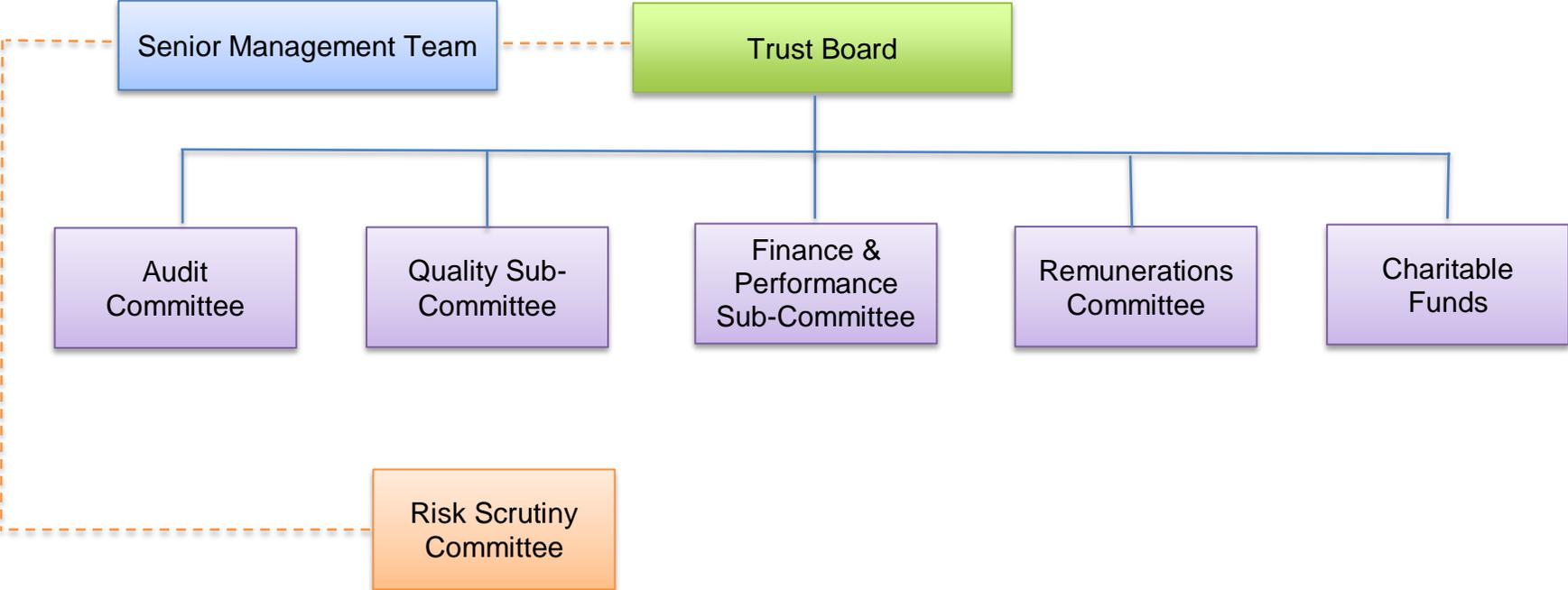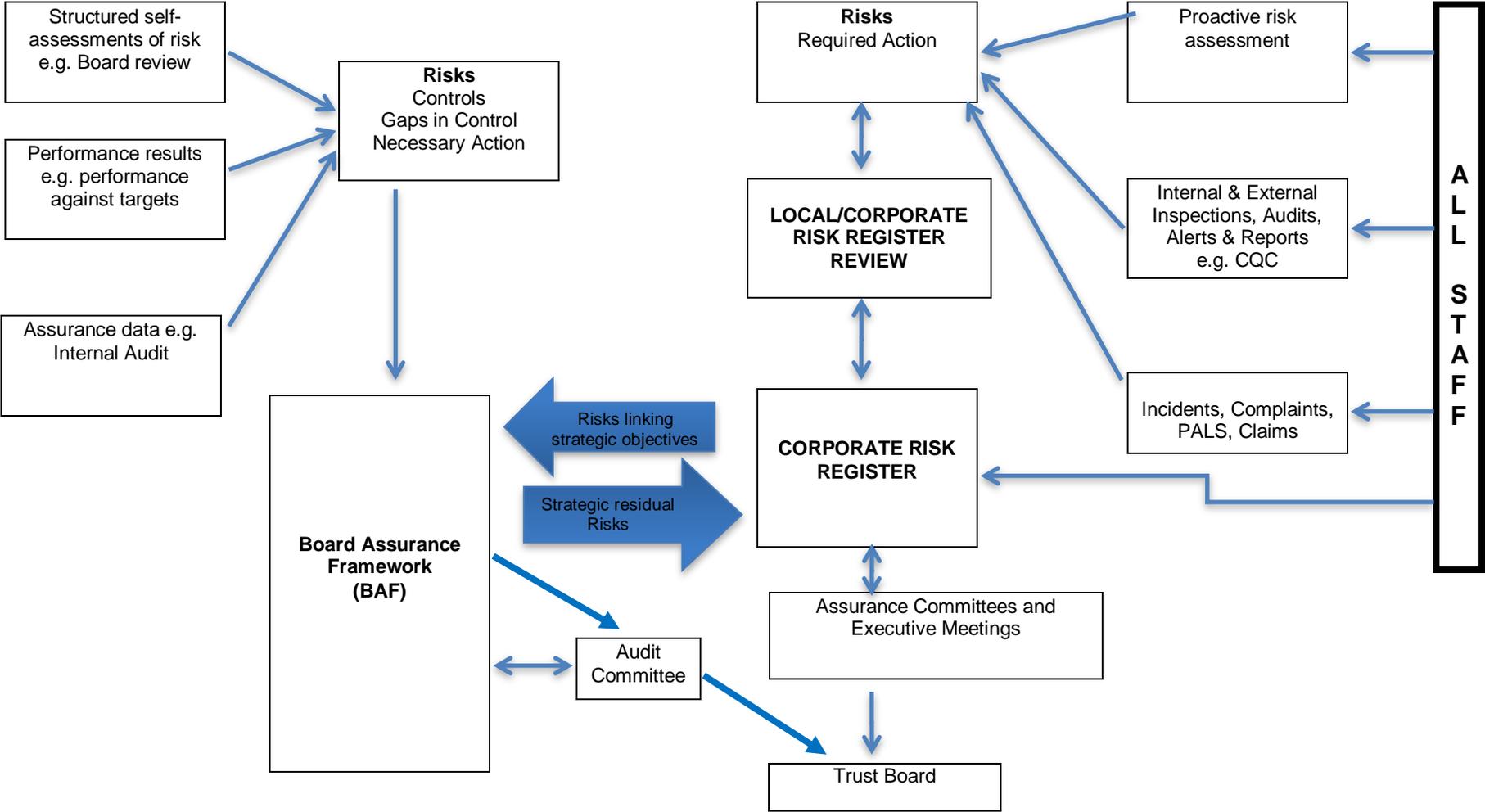
Appendix 2: Assurance Map

Assurance Map - Board to Ward/Floor Visibility of Risk Management Process Outline

Report	Purpose	Reviewed by	Frequency	Sourcing Risk from:
Board Assurance Framework	Identify, assess and manage all risks to the Trust's strategic objectives Delegate sub-committees with responsibility for managing and tracking actions Feed all risks rated as 15 or more and/or have a consequence of 5 into the Corporate Risk Register Address any risks flagged as RED	Board & Board Committees	Board - Bi-monthly Sub Committees - In line with committee cycle	Board discussion, Monitor, Quality Assurance Framework, Leadership Walkarounds Escalation from sub-committees Performance data (IPR) Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Trust wide risk assessments/Clinical Audits Patient & Staff Experience Surveys
Risk profile summary	Receive and manage exceptions from the Corporate Risk Register (new risks, increased risks, actions outstanding, risks which remain RED)	Board	Quarterly	Corporate Risk Register and BAF
Corporate Risk Register	Identify, assess and manage all risks across the Trust Accept risks and associated actions where these are rated 15 or more Report and manage exceptions (new risks, increased risks, actions outstanding, risks which remain RED) Address any risks flagged as RED	ED's Risk Scrutiny Committee	Bi-monthly	Committee discussion, Serious Incident Review Group Escalation from sub-committees and Divisional Boards Performance data Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Reporting (Complaints, Litigation, Incidents & PALs) Risk Assessments Patient & Staff Experience Surveys
Other Risk Registers - IM&T. H&S, HR	Identify, assess and manage all risks across the responsibility Accept risks and associated actions where these are rated less than 15 Escalate risks and recommended actions where these are rated 15 or more Submit Register to Trust Secretary quarterly Address any risks flagged as RED	Corporate teams, Divisional Directors and ED's	Team discussion - Monthly Submission of refreshed register - Quarterly	Management, operational and clinical team discussion Performance data Clinical Audit Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc) Reporting (Complaints, Litigation, Incidents & PALs) Risk Assessments Patient & Staff Experience Surveys

Appendix 3: Flow diagram: risk identification, risk registers (RR) & information flows between the corporate risk register and BAF

Structured self-assessments of risk e.g. Board review

Performance results e.g. performance against targets

Assurance data e.g. Internal Audit

Risks
Controls
Gaps in Control
Necessary Action

Board Assurance Framework (BAF)

Risks linking strategic objectives

Strategic residual Risks

Risks
Required Action

Proactive risk assessment

LOCAL/CORPORATE RISK REGISTER REVIEW

Internal & External Inspections, Audits, Alerts & Reports e.g. CQC

CORPORATE RISK REGISTER

Incidents, Complaints, PALS, Claims

Assurance Committees and Executive Meetings

Audit Committee

Trust Board

ALL STAFF

Appendix 4: Risk Evaluation Tool

This risk evaluation tool is to be used for the evaluation of risks across the Trust. The range of risk categories covered will include clinical risk, health and safety risk, service risk, project risks and strategic business risk. The tool will help you to decide the level of **residual** risk that you have identified.

Step 1
Consider the possible consequence of the identified risk if it happens.
Think broadly across the domains of:

- *Injury (physical/psychological) to patients, staff, visitors & contractors*
- *Adverse publicity*
- *Patient experience*
- *Quality*
- *Finance*
- *Human Resources, staffing and competence*
- *Business Objectives/projects*
- *Business/service interruption*
- Statutory duty/inspection
- Environment

Step 2
Choose a description of how serious the consequence might be from the following, taking into consideration any controls that are in place. The descriptions in table 1 on the following page should be used to obtain a consequence score, it should be noted these are illustrative only and other descriptions can be used.

Consequence scoring

1	Negligible (no harm)
2	Minor (low)
3	Moderate
4	Significant (severe)
5	Critical (death)

Many issues need to be factored into the assessment of consequence. Some of these are:

- Does the organisation have a clear definition of what constitutes a minor injury?
- What measures are being used to determine psychological impact on individuals?

- What is defined as an adverse event and how many individuals may be affected?

Step 3

Consider how likely it is that a risk with a consequence of this seriousness will actually happen. Table 2 on the following page should be used to obtain a likelihood score.

Choose a description from the following:

1	Rare	*Extremely unlikely to happen*
2	Unlikely	*Unlikely to happen*
3	Possible	*Reasonable chance of happening*
4	Probable	*Likely to happen*
5	Almost certain	*More likely to happen than not*

Step 4

Once the risk consequence and likelihood have been determined use the matrix at Table 3 on the following page to identify the degree of risk. The matrix shows both numerical scoring and colour bandings.

Appendix 5: Risk Matrix and guidance

What is the likelihood of the consequence occurring?

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

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Risk scoring = consequence x likelihood (C x L)

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

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

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

Consequence scores

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

	Consequence score (severity levels) and examples of descriptors

	1	2	3	4	5
Domains	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on 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 Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices	Multiple breeches in statutory duty Prosecution Complete systems change required

				Low performance rating Critical report	Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1– 0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
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 stay in hospital by 4-15 days RIDDOR/agency reportable event 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 5-15 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
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine	Wrong drug or dosage administered, with no adverse effects Physical attack such as pushing, shoving or	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure	Unexpected death Suicide of a patient known to the service in the past 12 months Homicide committed by a mental health patient

	transport for patient	pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health councelling (no time off work required)	Grade 2/3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information/communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain	ulcer Long-term HCAI Retained instruments/material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall resulting in injury such as dislocation/fracture/ blow to the head Loss of a limb Post-traumatic stress disorder Failure to follow up and administer vaccine to baby born to mother with hepatitis B	Large scale cervical screening errors Removal of wrong body part leading to death or permanent incapacity Incident leading to long-term mental health problem Rape/serious sexual assault

RiskAppetite for NHSOrganisations
A matrix to support better risk sensitivity in decision taking

Good Governance Institute

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels	0 Avoid	1 Minimal (ALARP) (as little as reasonably possible)	2 Cautious	3 Open	4 Seek	5 Mature
Key elements	Avoidance of risk and uncertainty is a Key Organisational objective	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits
APPETITE	NON	LO	MODERATE	HI	SIGNI	

Appendix 7: Definitions

Hazard	Anything that has the potential to cause injury, loss, damage or harm
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected
Risk	"What can go wrong and how likely is it to go wrong"
Risk Assessment*	The process by which hazards are identified and the risk rated using tools implemented by the Trust for use by all employees. Assessments can either be general or specific, but will be undertaken by competent persons who have received appropriate degree of information, instruction and training
Risk Management	Risk management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk. This includes the application of Health and Safety Regulations in every day working activity
Risk Matrix	The tool that is used to "score" each risk and determine its place on the Trust Risk Register, levels of authority are determined through the matrix and this will provide a priority list for managers to use within their respective area of control
Risk Register	Is a log of all risks (operational and strategic) that threaten the organisations success in achieving its objectives
Strategic Risk Register	The highest-ranking risks assessed at 15 and above from the Directorate level will be used to populate and inform the Trust's Strategic Risk Register
Control	The control of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures
Assurance	Evidence that control measures are working effectively to manage risk. This can be internal (e.g. workplace review, scrutiny by a Committee or the Board) or external (e.g. audit by an outside body such as the Health and Safety Executive or Care Quality Commission). Assurance can be positive (providing evidence that controls are achieving the desired outcome) or negative (providing no such comfort and perhaps indicating the need for further action).
Residual risk	Are those which remain after considering the controls in place to reduce the risk and the implementation of any additional controls that may have been identified as necessary

* Non-patient risk assessment

Appendix 8: How to do a risk assessment

Purpose
The purpose of this document is to assist the trust staff in conducting a risk assessment. The guidance is intended to encourage greater consistency in the way risk assessment is applied across the trust and promote vigilance in identifying risk and the ways in which it can be reduced.

Introduction
The Management of Health and Safety at Work Regulations 1999, Regulation 3 place a legal duty on all employees to assess all significant risks in the work place. This includes all clinical tasks, activities, situations and risks. The Regulations also state that risk assessments should be suitable and sufficient, taking account of the work tasks, activities and situations undertaken and the environment in which these take place.

The assessment should identify the hazards associated with the task, activity or situation and establish control measures to minimise the risk. This in turn, based upon the risk levels, allow you to prioritise actions.

There is also a legal duty to monitor and review the risk assessments to ensure they remain suitable, (appropriate to the task, activity or situation), effective and sufficient (continue to meet the needs of the task, activity or situation).

The important thing that needs to be considered is, **does the hazard pose a significant risk?** If so, have you implemented control measures to reduce the risk to an acceptable level?

If there is a lack of or 'gap in control' to reduce the risk, then further actions and precautions, 'controls' may be required.

It is not usually possible to eliminate all risks by the trust has a duty to protect patients, staff and visitors as far as 'reasonably practicable'. This means you must avoid unnecessary risk.
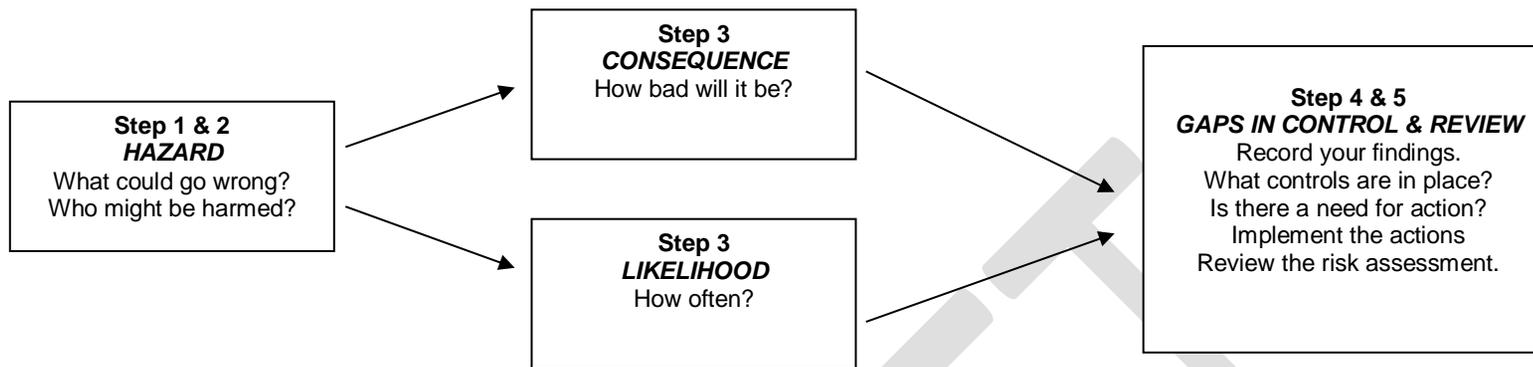
Definitions:
Hazard:	Anything that has the probability or may cause harm (what could go wrong)
Likelihood:	The chance of harm occurring as a result of exposure to a hazard
Consequence:	The level of harm that may occur as a result of exposure to or contact with a hazard
Risk:	Risk is the chance high or low that an event/hazard will occur or may prevent the trust from achieving its objectives

What is a risk assessment?
A risk assessment is simply a careful examination of the hazards associated with work tasks, activities, or situations in the trust that could have the potential to cause harm to patients, staff and visitors. It allows you to consider and evaluate if there are 'suitable' (appropriate to the task, activity or work situation) and 'sufficient' (meet the needs of the task, activity or work situation) controls in place to reduce the level of risk to the lowest possible level. In other words have you taken enough precautions (controls) or should you do more to prevent potential harm from the hazard?

Using a methodology of the Health and Safety Executives *5 Steps to Risk Assessment* and the NPSA *Guide to Healthcare Risk Assessment* shown in the diagram, a risk assessment seeks to answer the following key questions:

```
  ┌─────────────────────────┐         ┌─────────────────────────┐
  │        Step 3           │         │       Step 4 & 5        │
  │      CONSEQUENCE        │         │  GAPS IN CONTROL &      │
  │    How bad will it be?  │         │       REVIEW            │
  └─────────────────────────┘         │  Record your findings.  │
                                      │ What controls are in    │
  ┌─────────────────────────┐         │      place?             │
  │        Step 1 & 2       │         │ Is there a need for     │
  │         HAZARD          │         │      action?            │
  │   What could go wrong?  │         │ Implement the actions   │
  │   Who might be harmed?  │         │ Review the risk         │
  └─────────────────────────┘         │      assessment.        │
                                      └─────────────────────────┘
  ┌─────────────────────────┐
  │        Step 3           │
  │       LIKELIHOOD        │
  │      How often?         │
  └─────────────────────────┘
```

How to carry out a risk assessment

The steps below will enable you to complete the risk assessment form. A template form can be found at appendix F.

Step 1	Identify the Hazards (what could go wrong)
	- Walk around your workplace and look at what could reasonably be expected to cause harm. Ignore the trivial and concentrate on significant hazards, things that could result in serious harm or affect numerous people e.g. Medicines not stored or locked away/trailing electrical lead causing a trip hazard. - Ask those involved with the task, activities or situation for their opinion. They may have noticed things, which are not immediately obvious to those not involved with the task on a regular basis - Look at and provide a description of the hazards associated with a task/activity/situation, include any hazards associated with any equipment, substances or processes used in the task/activity/situation - Remember to prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong - Take in to account things that have gone wrong in the past and near miss incidents - Check manufacturer instructions for equipment or data sheets for chemicals as they can also help you spot hazards and put risks in their true perspective - Check if individual's health has been affected e.g. sickness absence due to skin problems caused by using a particular chemical/complaints of feeling unwell when working in a certain environment
Step 2	Who might be harmed and how?
	- Identify those individuals or groups of people who may be at risk of harm if exposed to the hazard - Remember the most vulnerable patients are more likely to suffer harm - When considering people who, potentially could be harmed don't forget to consider new workers or trainees, young workers, new and expectant mothers and people with disabilities - Cleaners, visitors, contractors or maintenance workers who may not be familiar or in the work place all the time

Step 3	**Evaluate the risks** (how bad – consequence and how probable (often) – Likelihood) and decide on the actions required
	• Having spotted the hazards, detail the existing control measures already in place to prevent harm occurring
	• Are these controls adequate?
	• Intelligence data such as incident reports many indicate that a control you have in place is not effective
	• Are controls reducing risk or harm to its lowest level?
	• Is there a 'Gap in Control' and therefore a need for additional action and controls to reduce the risk? Look at the hierarchy of risk control
Step 4	**Record your findings and proposed actions then implement them**
	• Complete the risk assessment form and action plan
	• The actions required should be detailed in the action plan section of the risk assessment form, summarising how the controls are to be achieved. A responsible person is then allocated the responsibility of ensuring the actions are completed within a targeted date
	• Using the Trust risk matrix, quantify the level of risk by choosing the level of consequence and likelihood of the harm occurring based on all the information you have gathered
	• Evaluate the risks and decide whether the existing control measures are adequate or if more could be done
	• Consider how likely it is that each hazard could cause harm. This will determine whether or not you need to do more to reduce the risk. Even after all precautions have been taken, some risk usually remains. What you have to decide is, whether the remaining level of risk is acceptable, if not then further action is required
	• When writing the results of the risk assessment keep it simple, for example 'tripping over rubbish: bins provided, staff instructed, weekly housekeeping checks instigated'
	• It is important that you can show that:
	A thorough check was make to identify all the hazards and treat all the significant risks;
	The controls are reasonable and the remaining risk is acceptable
	The solutions are realistic, sustainable and effective
	NB it may be reasonable to accept some degree of preventable risk, if the benefits to be gained outweigh the risk
Step 5	**Review your risk assessment and update if necessary**
	• Risk assessments and action planning should be reviewed and monitored regularly
	• Risk levels that are medium or high should be placed on the risk register. So that the action plans can be monitored regularly. Decide if you have a 'local risk' or 'Corporate risk'
	• Once an action on the plan has been completed and the new or additional control implemented the risks should be re-evaluated and the results recorded
	• Remember, research and new developments increase the pace of change, and those changes can alter existing and/or introduce new hazards
	• Review your risk assessment regularly and at least on an annual basis:
	Regularly and at least on an annual basis
	When learning from incidents which may indicate a control is not working or needs to be changed
	When you are planning a change to a task, activity or situation
	When there has been a significant change to a service or way of working

Risk assessment doesn't need to be overcomplicated and identifying hazards is common sense. However risk assessment should only be carried out by a competent person, that is, someone who is familiar with the task, activity or situation, the environment is which the activity takes place and who has sufficient knowledge and understanding that they can identify those hazards present. Additionally the competent person should recognise their limitations and be prepared to seek advice as necessary.

Risk Evaluation Tool
In order to separate those risks that are unacceptable from those that are acceptable the risks should be evaluated.

Control Measures
Once the risk assessment has been completed and the risk level indicates further actions and controls are necessary to ensure that the risk is reduced to as low as is reasonably practicable then consider the following:
   a)   Can the hazard be removed altogether?
   b)   If not, how can I control it?

When controlling risk, try applying the principles below:

Use **ERIC PD**

ELIMINATE   get rid of the hazard; replace it with something less hazardous
REDUCE   the level of risk by reducing the nature of the hazard e.g. use similar quantities, lower voltage etc
ISOLATE   the hazard from people, for example by putting up barriers or guarding
CONTROL   exposure to the hazard by controlling who has access or limiting exposure time
PPE   issue Personal Protective Equipment
Discipline and Culture

Improving risk management need not cost a lot of money, however failure to carry out suitable and sufficient risk assessments and not controlling significant risk in the workplace can cost the Trust in more ways than one.

If a task, activity or situation remains the same then a generic risk assessment can be produced. However, the assessment must be reviewed when the environment changes affecting the task, activity or situation and/or the process changes.

Risk Assessment Action Plan
The actions required should be detailed on the action plan section of the risk assessment form, summarising how the additional controls required to close the gap are to be achieved. A key individual is then allocated the responsibility of ensuring the actions are completed. A target date must be set and activity against the action monitored.

Unless the risk level is specified as 'acceptable' where only actions necessary are to monitor and review the assessment and established controls for effectiveness, all of risk levels will require further actions applied to reduce them to the lowest acceptable level. Once completed, the action is implemented and closed.

Monitor and Review

All risk assessments must be reviewed not less than annually and/or if:

- There is a significant change in equipment or process
- There is a change to the task activity or situation process or environment
- After an incident or accident
- There is a change to the people who are affected by the task, activity or situation
- There is a change in legislation
- There is a change to or introduction of new equipment
- The routine, process, system or procedure is no longer valid

If you have any questions regarding the completion of the risk assessment please contact the Head of Risk and Assurance.
Training on the risk assessment process is available from the Risk Team

References:
HSE Guide Five Steps to Risk Assessment IND163 (rev3), revised 06/1
NPSA Healthcare Risk Assessment Made Easy, March 2007

Appendix 9: Identifying Risks

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

Appendix 10: Trust training for the management of risk

Staff groups	Training need	Frequency	Format
Executive and Non-Executive Directors of the Board	Board Risk Awareness training	Annual	Workshop session as part of Board Development Programme
Trust senior managers	General Risk Awareness Training	Every 3 years	PowerPoint presentation/workshop
	Risk assessment training	Every 3 years	PowerPoint presentation/workshop
	Risk register training	Every 3 years	
	Management of risk for senior managers	Every 3 years	PowerPoint presentation/workshop
All new staff	Risk awareness training and an understanding of the role of risk management in the organisation	Once only Completed as part of induction	PowerPoint presentation/workshop
Existing staff	Ad hoc bespoke training	As required	Variable according to need PowerPoint/workshop
	Risk assessment training	Ad hoc / as required	
Staff involved in risk management	Individually addressed according to individual needs	Dependent on individual needs	As required

The Board development session will be booked and attendance noted by the Trust Secretary. Any non-attendance will be followed up by circulation of presentation and briefing materials and a 1:1 session provided by the Head of Risk and Assurance or nominated deputy.

All other mandatory training will be booked and managed in accordance with the Trust training needs analysis as outlined in the Learning and Development Policy.