| Title: Risk Management Policy | | | | |
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## CONTENTS


| SECTION | DESCRIPTION | PAGE |
|---|---|---|
| 1 | Introduction | 3 |
| 2 | Policy Statement (including Equality Impact Assessment) | 4 |
| 3 | Definitions | 5 – 7 |
| 4 | Organisational Structure | 7 - 8 |
| 4 | Role and responsibilities | 8 - 12 |
| 5 | Scope of Policy | 12 |
| 6 | Consultation | 12 |
| 7 | The Risk Management Process | 12 – 23 |
| 7.1 | • What is Risk Assessment | 12 – 13 |
| 7.2 | • Who Should Undertake Risk Assessment | 13 |
| 7.3 | • Risk Register – DATIX | 13 |
| 7.4 | • Risk Appetite | 13 – 14 |
| 7.5 | • Risk Identification | 14 – 15 |
| 7.6 | • The process for assessing risk | 16 |
| 7.7 | • Requirements of a Risk Assessment | 16 – 17 |
| 7.8 | • Risk Scoring | 18 |
| 7.9 | • Risk Treatment | 18 – 19 |
| 7.10 | • Local Accountability for Risk, Review and Escalation | 19 – 20 |
| 7.11 | • Testing Risk Responses | 20 |
| 7.12 | • Residual Risk | 20 |
| 7.13 | • Review | 20 |
| 7.14 | • Risk Escalation | 20 |
| 7.15 | • Levels of Risk Escalation | 20 -21 |
| 7.16 | • Risk De-escalation | 21 – 22 |
| 7.17 | • Risk Recording | 23 |
| 7.18 | • Learning | 23 |
| 7.19 | • Embedding Risk Management | 23 |
| 7.20 | • Risk Assurance | 23 |
| 8 | Evidence Base/ References | 24 – 25 |
| 9 | Monitoring Compliance | 25 – 26 |
| 10 | Training Requirements | 26 – 27 |
| 11 | Distribution | 26 - 27 |
| 12 | Communication | 27 |
| 13 | Author and Review Details | 27 |
| 14 | Appendices<br>Appendix 1 – SFH Committee Structure<br>Appendix 2 – Risk Appetite Matrix | 28 - 35<br>28<br>29 |

| | | |
|---|---|---|
| | Appendix 3 – Common Sources of information that are used by NHS organisations to populate their risk registers<br>Appendix 4 – Risk matrix<br>Appendix 5 – Risk Escalator | 30<br><br>31 -34<br>35 |


**Amendments**

| Issue | Issue Date | Section(s) involved | Amendment |
|---|---|---|---|
| 4.0 | 28-08mm-2014 | • All | • Full review and re-write |

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## 1. INTRODUCTION

This policy is issued and maintained by the Executive Director of Nursing & Quality (the sponsor) on behalf of the Trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

Risk Management is the process where the Trust proactively manages future uncertainty, facilitating the evaluation and control of risk. This document sets out Sherwood Forest Hospital NHS Foundation Trust's (hereafter referred to as "the Trust") policy to manage risks arising from all types of activities, (refer to 6.6.2).

This policy covers all areas of risk and opportunities within the Trust, including those associated with treating and caring for patients, employing staff, innovation, reputation, maintenance of premises and managing finances.

The document also sets out the Trust's procedure for risk assessment to comply with the general duties of the Health and Safety at Work Act and more specific duties in various Acts and Regulations, including the Management of Health and Safety at Work Regulations.

The Trust operates a single risk management policy which is the keystone of all other Trust policies, encompassing all aspects of risk management and applying to all activities (whether they are short or long term).

Effective risk management requires a culture where all staff are involved in reducing risks and improving quality and safety. Risk management is not solely the responsibility of the Trust's Risk Manager or any other single manager or group. It is however, a responsibility for all members of staff and must be part of objective setting in every business and management planning cycle and of every service development. It relies on all members of staff identifying and minimising risks within a progressive, honest, learning and open environment.

It is important that risk management is a systematic process, using existing expertise and structures along with clear direction, guidance and support from the Trust's senior management teams.

The outputs from the Trust's Risk Management Policy and supporting processes will inform the Trust's Board Assurance Framework and Annual Planning Processes. The policy recognises that there is a requirement for an annual Governance Statement, informed by an embedded system of assurance via the Board Assurance Framework (BAF) and joined by a clear public declaration on compliance with the Care Quality Commission's (CQC) registration standards, which require the Trust Board and nominated committees to consider the whole system of internal control.

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## 2. POLICY STATEMENT

The Trust Board of Directors (hereafter known as the 'Trust Board') is committed to ensuring the implementation of risk management and ensuring that risk management is embedded into the culture of the organisation to enable an environment which minimises risks and promotes the health, safety and well being of all those who enter or use the premises whether as staff, patients, contractors or visitors.

Risk management goes to the heart of what the Trust is doing - achieving the most favourable outcomes for patients, and reducing uncertainty. The aim of this policy is to ensure that the Trust has an effective system for identifying and managing risks with the aim of achieving its objectives, protecting patient's staff and members of the public, and protecting assets. The broad objectives of this policy are to:

a. Ensure compliance with all appropriate legislative and statutory requirements. This will enable all aspects of risk management to be approached in a structured manner, in line with the Care Quality Commission registration standards, Foundation Trust Compliance framework, and the NHS Litigation Authority (NHSLA) risk management frameworks.
b. Describe a co-ordinated approach for the management of risk.
c. Promoting safe working practices aimed at the reduction of risk, as far as is reasonably practicable.
d. Describe responsibilities and accountabilities for risk management at every level of the Trust
e. Manage risks to an acceptable level ensuring action plans for further controls are fully completed. Acceptable level is reached where risks are reduced in line with statutory requirements and/or so far as is reasonably practicable.
f. Integrate risk management with quality and performance management arrangements to become an integral part of the business planning and objective setting processes of clinical divisions and corporate directorates and the Trust as a whole.
g. Enable staff to be empowered to report risks and register concerns about unsafe practice.
h. Provide guidance on the risk management process and the benefits of how effective risk management will enable the Trust to contribute to a wider risk network within the health community.
i. Raise awareness of risk management through a programme of communication, education and training.
j. Promote continuous improvement through internal and external audit and assessment.

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**Equality Impact Assessment**
The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee (15-10-2014).

**Related Trust Policies / Procedures:**
The following Trust policies and procedures should be read in conjunction with this policy:

- Incident Reporting Policy & Serious Incident process
- Patient Complaints Handling Policy
- Claims handling policy
- Raising concerns, whistle blowing policy and procedure
- Supporting staff involved in Incidents, Complaints or Claims Policy
- Management of Capability Policy and Procedure

Other related policies and procedures will be appropriate dependent on the risk for example, Health and Safety Policies, Information Governance Policies etc

## 3. DEFINITIONS

| | |
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| **Assurance** | is a positive declaration intended to give confidence, a promise |
| **'The Trust':** | means the Sherwood Forest Hospitals NHS Foundation Trust. |
| **'Staff':** | means all employees of the trust including those managed by a third party organisation on behalf of the Trust. |
| **Risk:** | The chance that something will happen to have an impact on achievement of the Trust's aims and objectives or exposure to a chance of loss, injury or damage. It is usually measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or consequence on the organisation if the risk occurs). This can be opportunities / benefits (Upside risk) or threats to success (Downside Risk). |
| **Cause (Hazard):** | Something with the potential to cause harm. |
| **Consequence (harm / loss event):** | The harm or loss event caused by the hazard. |
| **Divisions, Specialties and Departments:** | form the management units through which services are provided / delivered in the Trust. |
| **Risk Control:** | is defined as the part of the risk management process that is concerned with the implementation of policies, processes, tools, and techniques that accept, eliminate, remove or transfer risk; or establish business continuity processes. Controls may be preventative, detective or post-event. [Graham & Kaye 2006] |
| **Risk management:** | The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. Effective Risk Management requires a culture, processes and structures able to manage potential opportunities and adverse effects. [Graham & Kaye 2006] |
| **Risk management process:** | The systematic application of management policies, |

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procedures and practices to the tasks of establishing the context, identifying, and analysing, evaluating, treating, monitoring and communicating risk.

**Risk Owner:** this is a person or group who has been given the authority to manage a particular risk and is accountable for doing so.

**Risk Profile:** this is a written description of a set of risks. A risk profile can include the risks that the entire Trust must manage or only those risks that an individual division, speciality, ward or department must address.

**Risk Assessment:** The systematic collection of information to determine the likelihood and severity of harm and identify where additional controls are needed to reduce the risk to an acceptable level.

**Risk Responses (4T's):**
Where risks have been identified, one or more options for responding to the risk must be taken;

- **Terminate** – *Avoid the risk by making the likelihood of its occurrence totally impossible (break the links at either point)*
- **Tolerate** - *Accept that the effects of the risk are (or have been following treatment) reduced to a reasonably practicable level*
- **Transfer** – *Involve a 3rd party to share some degree of risk via contract terms or insurance*
- **Treat** – *Take ACTION to reduce the overall risk score (weaken the link between cause and risk to* reduce LIKELIHOOD, weaken the link between risk and effect to reduce IMPACT)

**Testing Risk Responses (7A's)**
Risk Responses should meet the 7 A's test, they should be;

1) **Appropriate** – *in proportion to the level of risk posed*
2) **Affordable** – *time/money/effort balanced against the risk*
3) **Actionable** – *within a reasonable timeframe*
4) **Achievable** – *technically or legally possible*
5) **Assessed** –*will the risk-level post-action be reduced?*
6) **Allocated** – *controls and actions must be assigned to a lead*
7) **Agreed** – *all stakeholders must sign-up to the risk responses*

**Risk Treatment:** is defined as the selection and implementation of options for managing risks. [Graham & Kaye 2006]

**Risk Transfer:** is defined as the treatment or control of risk through sharing the burden of loss or benefit from a risk with another party. [Graham & Kaye 2006]

**Residual Risk:** remains after all appropriate actions have been taken to minimise the risk. In some cases the residual risk will be low and the Trust will accept the risk. Where the risk remains significant despite mitigation the potential consequences have to be

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| | appreciated by all those involved in the Trust, and communicated externally if necessary. |
| **Strategic Risks**: | Risks to the achievement of the Trust's strategic objectives. They are contained within the Trust's Board Assurance Framework (BAF). |
| **Operational Risks**: | Risks identified at divisional/ directorate or Clinical Business Unit (CBU)/department level. |
| **Risk Register (Datix):** | is a formal record that captures all known Trust Risks. For each risk, the Risk Register will capture the source of the risk, a description of the risk, the risk score (Consequence x Likelihood), the actions required to further mitigate the risk, a review date and an assessment of the affect of those further mitigating actions on the risk (Residual Risk).The Datix database is the Trust's database of corporate/ divisional / specialty/ service risks. |
| **Risk Appetite:** | The Trust understands and communicates the level of risk that it is willing to accept i.e. the amount of risk it is prepared to accept, tolerate or be exposed to at that time (or any defined time in the future). |
| **Board Assurance Framework (BAF):** | A document identifying the Trust's strategic objectives, the key risks to the achievement of these, the controls required to mitigate these risks, the assurance sources to prove that controls are effective, gaps in controls and assurances, and actions to remedy these. |
| **Acceptable / Tolerable Risk / Tolerance Line:** | describes a risk that is acceptable either because;<br>• the risk has been appropriately and robustly risk assessed and managed to the lowest possible level or,<br>• the probable benefits outweigh the probable harms (e.g. in innovative services). The Trust Board recognises that in these circumstances it is not always possible or desirable to eliminate all risk or,<br>• it scores 3 or less on the Trust agreed Risk Assessment Tool. |
| **Stakeholders:** | people or organisations who can affect or be affected by a decision or an activity. Stakeholders include those who perceive that a decision or an activity can affect them. Stakeholders can be external and internal |

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## 4. ROLE AND RESPONSIBILITIES

### 4.1 Organisational Structure

4.1.1 The Trust Board holds ultimate responsibility for ensuring that the Trust has effective risk management processes in place.

4.1.2 The Trust Board recognises its responsibility to ensure that risks that cannot be

addressed internally are communicated and appropriately considered with all relevant NHS partners, such as commissioners of services, members of the wider health care community, patient groups, enforcement & regulatory bodies and other appropriate stakeholders.

4.1.3 The Trust Board recognises its responsibility to determine and communicate its attitude to risk throughout the organisation, and to ensure that this attitude is applied in decision-making about prioritisation of policies, work streams, programmes, projects and operational delivery including associated funding.

4.1.4 The Trust Board will actively consider at its annual receipt of the risk register its risk appetite ('amount of risk it is prepared to accept, tolerate or be exposed to at that time' (or any defined time in the future)), and whether this requires changes to the weight given to any of the elements of the Trusts risk scoring matrix, (domains of consequence, severity of consequence or levels of likelihood), and/or to the thresholds for escalation in the Trust.

4.1.5 The Chief Executive has overall responsibility for risk management and discharges this through the designated accountability of other Executive Directors for different aspects of risk management.

4.1.6 Executive and Corporate Directors are collectively and individually responsible for the management of risk, and in particular for the areas included in their portfolios and as reflected in their individual job descriptions. These responsibilities will be discharged through Divisional Directors, Managers and Service Managers.

4.1.7 The discharge of these responsibilities is overseen and supported by a number of Trust committees that are ultimately accountable to the Trust Board (see section 3.3). Each committee is formally constituted, and has approved terms of reference.

**4.2.1 <u>Chief Executive</u>**

Is responsible for establishing and maintaining an effective risk management system within the Trust to meet all statutory requirements and adhere to guidance issued by Monitor and the Department of Health in respect of governance. The Chief Executive is the Accountable Officer responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's strategic goals and objectives.

The Chief Executive is supported in the role by the Executive and Corporate Directors below:

**4.2.2 <u>Executive Board Directors:</u>**

Executive/Directors have a number of responsibilities in relation to risk management. As members of the Trust Board, they have a corporate responsibility to ensure that the Risk Management Policy is fit for purpose, that it is implemented effectively and that the controls are in place to illustrate that all reasonable care has been taken to manage risk proactively.

Executive Directors will ensure their management teams maintain appropriate risk registers and establish processes for the overall scrutiny of divisional risk registers,

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accepting escalation of risks to executive director level where appropriate, and escalating to executive team level where risks cannot be adequately mitigated at executive director level.

4.2.3 **Non-Executive Directors** :

a. are responsible for providing scrutiny of the work of the Trust and holding Executive Directors to account
b. need to satisfy themselves that financial information is accurate and that financial controls and risk management systems are robust and defensible and that the Board is kept fully informed through timely and relevant information.
c. there are nominated Non-Executive Director chairpersons for each of the Board's Sub-Committees. There is Non-Executive Director membership on and chairmanship of the Trust's Audit and Assurance Committee, with responsibility for ensuring that effective systems are maintained for governance, risk management and internal control across all of the Trust's activities
d. Non-executive Directors ensure that underlying assurance processes are in place to demonstrate the achievement of the corporate objectives

4.2.4 **Specialist Advisors on Governance and Risk**

**a) Head of Governance**

a. Will ensure that structures and processes are in place to deliver the Risk Management Policy and to support the establishment of an effective, fully integrated risk management system at both corporate and divisional/departmental levels.
b. the Head of Governance has authority, on behalf of the Executive Director of Nursing and Quality to intervene in any part of the Trust, where controls to manage key risks are inadequate

**b) Risk Manager** :

The Risk Manager will provide risk management leadership across the Trust. They will be responsible for actively promoting a positive safety culture within the organisation and will provide advice and training to managers and staff. They will be accountable for the implementation of the Risk Management Policy and the establishment of a fully integrated risk management system. The Risk Manager will ensure that risk management is integrated into all functions of the Trust

**c) Health and Safety Manager:**

The Health and Safety Manager will provide competent advice, guidance and support to all levels of the organisation and promote the effective development, implementation and monitoring of health and safety management systems and arrangements in the work place.

**d) Information Governance Manager**

The Information Governance Manager will lead on data protection, confidentiality and Information Governance matters and associated risks within the organisation.

4.2.5 **Managers, Divisional Managers and Matrons** shall discharge their responsibilities for risk management by:

a. Ensuring adequate resources are made available to effectively manage risks

Final for approval

within their areas of responsibility.

b. Ensuring risks to the achievement of divisional / specialty objectives are identified, assessed and effectively managed to minimise those risks as far as practicable.
c. Ensuring risk management is incorporated into all clinical and non-clinical processes (including divisional business processes).
d. Ensuring that this policy and other information related to risk management processes is disseminated and upheld by all staff.
e. Identifying staff responsible for championing risk management and making their roles, responsibilities and accountabilities clear to them and to other staff.
f. Identifying the risk management training needs of divisional / specialty managers and ensuring their attendance at relevant training events.
g. Ensuring all staff have received corporate induction and specific local induction and are aware of their personal responsibility within the risk management process.
h. Ensuring new risks are approved by specialty / divisional Governance Forums prior to entry onto the risk register.
i. Ensuring that risks are reviewed by specialty / divisional Governance Forums.
j. Ensuring that evidence exists for all risk management activity to demonstrate that Trust standards and legal and statutory requirements are being met.

**4.2.6 Divisional Clinical Directors** shall discharge their responsibilities for clinical risk management by:

a. Actively managing clinical risk.
b. Implementing, supporting and co-ordinating risk management processes in line with this policy.

**4.2.7 Specialty Governance Leads & Quality and Safety Managers (or specialty equivalent)** shall discharge their responsibilities for risk management by:

a. Ensuring that risks to the achievement of department objectives and all significant hazards inherent within work processes are identified, assessed, effectively managed and risk assessments submitted to divisional / specialty governance forum for approval prior to entry onto the risk register.
b. Ensuring accurate risk registers are maintained and that risks and mitigating actions are implemented and regularly reviewed in line with this document.
c. Ensuring health and safety, incidents, complaints, claims and risk management processes are embedded within division / specialty / departments.
d. Ensuring there are sufficient competent people to perform risk assessments.
e. Ensuring that the results of risk assessments are brought to the attention of their staff group.
f. Seeking advice and guidance from the corporate risk manager on any aspects of risk management that are beyond their knowledge and skills.
g. Identifying the risk management training needs of staff, and monitoring and ensuring their attendance at relevant training events.
h. Being accountable for the clinical division or corporate directorate

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management of the Central Alerting System (CAS) broadcasts.

i. Ensuring that there are suitable arrangements in place for the review and control of serious and imminent danger, where this potential is identified during the risk assessment process.

**4.2.8 Divisional Clinical Governance Co-ordinators :**

a. Working closely with the Risk Manager, they will co-ordinate the risk management agenda in Divisions and provide real time information in support of risk mitigation
b. He/She will act as the link between operational management and the risk management system and will act as 'Risk – Champions' within their service area. Effectively checking, verifying and challenging risk assessments.
c. Will provide risk register reports to divisional governance forums.

**4.2.9** All staff must:-

a. Be aware of risk assessment findings and control measures appropriate to their work area.
b. Co-operate with and engage in the risk assessment process including using and complying with control measures implemented to ensure the health and safety of themselves and others.
c. Understand their accountability for individual risks and how their actions can enable continuous improvement of risk management.
d. Report systematically and promptly any perceived hazards, new risks or failures of existing control measures to their line manager.
e. Comply with any measures in place for dealing with a situation of serious and imminent danger.
f. Understand that risk management and risk awareness are a key part of the organisation's culture.

**4.2.10** The Trust employs other **specialist advisors** as listed below:

- Legal Services Manager
- Health and Safety Manager
- Fire Safety Adviser
- Security Officers
- Local Security Management Specialist
- Radiation Protection Officer
- Occupational Health Physicians and Nurses
- Infection Prevention and Control Team.
- Information Governance Lead
- Head of Estates and Facilities
- Independent Authorising engineers
- Moving and Handling Coordinator
- Medical Equipment and Devices Team
- Decontamination Lead
- Emergency Planning Officer

**4.3 Committee Structures and Reporting Arrangements**

4.3.1 The risk management policy shall integrate across all established committees within the Trust that have responsibility for risk in order to create a culture of risk

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reporting and feedback (refer to appendix 1). The following Committees/Sub-Committees and groups have responsibilities as outlined in their terms of reference for risk management:

- Trust Board
- Audit Committee (AC)
- The Quality Committee
- Trust Management Board (TMB)
- The Financial Planning, Investment and Commercial Development Committee
- Clinical Quality and Governance Committee (CQ&GC)
- Divisional Governance Meetings
- Specialty Governance Meetings

## 5. SCOPE OF POLICY

This policy applies to all areas and activities of the Trust and to all individuals working at the Trust including substantive and temporary staff, contractors, volunteers, students, trainees, locums and staff employed on honorary contracts

## 6. CONSULTATION

The following groups were consulted before being approved by the Trust Board:

a) Trust Management Board, 22/09/2014 and approved 27 October 2014

b) Clinical Quality and Governance Board Sub-Committee, 10/09/14 & approved 16/10/14

c) Quality Committee via e-mail consultation

d) Divisional Clinical Governance Meetings for Emergency Care and Medicine, Planned Care and Surgery, Diagnostics and Rehabilitation and Newark in August 2014

e) Individuals were consulted on and included the Health and Safety Manager, the Deputy Head of Internal Audit, the Interim Complaints Manager, the Legal Services Manager, the Interim Information Governance Manager, the Clinical Governance Lead, the Patient Safety Lead, the Clinical Policy and Guidelines Lead, the Datix Administrator, the Interim Risk Manager, the Director of Corporate Services/Company Secretary, the Head of Programme Management.

## 7. Risk Management Process

The following outlines the process adopted for the identification, assessment and management of risk within the Trust. As part of the Trust's Training Needs Analysis (TNA) risk management training will be provided to relevant staff and one aspect of this training will be an understanding of the identification, assessment and management process in greater detail with an accompanying user guide.

### 7.1 What is a risk assessment?

A risk assessment is nothing more than a careful examination of what, in the work practice and area, could cause harm to people or the organisation so that the individual or organisation can weigh up whether they have taken enough precautions or if they should do more. The product of risk assessment is a record of potential events and a summary of proposed responses that will reduce, control or tolerate the level of risk.

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If implemented well, risk assessments and risk registers will supplement, rather than become separate to, management conversations and meetings and should be reflective of the general ‘feel’ of an operational service at any particular point in time.

### 7.2 Who should undertake risk assessments?

Risk Assessment is part of every manager’s role, if there is uncertainty about being able to maintain safety, quality of care, performance targets/objectives, managers need to undertake a Risk Assessment.

Health and safety regulations require that employers (via line management) undertake a number of risk assessment activities, including the recording of the significant findings of risk assessments, communicating the outcome to staff and other affected parties.

### 7.3 Risk Register (Datix)

DATIX is the risk management software system used by the Trust to record risk assessments, incidents, accidents, claims, complaints, Patient and Public Involvement and issues raised via PALS.

DATIX is a management tool that enables the organisation to capture and review its data to demonstrate compliance and to identify trends and cross cutting themes for review and action. DATIX provides key data to support the trusts Risk Management Policies, processes and arrangements.

The DATIX system also contains the Trust’s **Risk Register.** The Risk Register is a live, continually evolving document. It describes for the Trust its risks and the actions required to mitigate them to an acceptable level (including accountabilities and timescales). The Risk Register provides a focus for the work of the Trust Board and its Committees by communicating risk information throughout the organisation, and providing the necessary assurances that risks are being effectively managed.

The register provides a mechanism for risks and risk treatments to be recorded and accessed by individuals, teams, and specialties / divisions to assist in informing clinical, non-clinical and business decisions.

Training will be delivered to nominated staff who are to input, review and manage risks on the Datix Risk Module and a step by step guide will be provided at the training session.

### 7.4 Risk Appetite

7.4.1 The Trust will aim for a zero appetite for undue risks to the health and/or safety of its staff and others.

7.4.2 The Trust will aim for a zero appetite for undue clinical risks, i.e. a level of risk that is greater than that accepted as consistent with safe clinical practice.

7.4.3 The Trust has a zero appetite for undue risks relating to failure to meet national targets and /or registration requirements from regulators, except where this would conflict with 7.4.1 and/or 7.4.2 above.

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7.4.4 The Trust may decide to accept risks in developing innovative pathways to improve patient care where this is in line with its clinical quality strategy. This level of risk will be no more than accepted as consistent with safe clinical practice.

7.4.5 The Trust may decide to accept financial risks and will use its financial capabilities to enable change in support of its ambitions.

7.4.6 The Trust may decide to take calculated reputational risks where it deems the outcomes will be beneficial to its stakeholders.

7.4.7 During the Trusts business planning processes the organisation will frequently give consideration to innovative, developmental opportunities which are inherently risky. The Risk Management Policy is not exclusively about the mitigation and control of risks but also the calculated encouragement to explore potentially more risky opportunities. (Good governance institute http://www.good-governance.org.uk/ See Risk appetite matrix, appendix 2).

### 7.5 Risk Identification

The Risk Management Cycle, which incorporates Risk Assessment, is illustrated below at Figure 1. The process begins with establishing the context of the risk, including identifying stakeholders then moves into the three stages of risk assessment – Identification, Analysis, and Evaluation. Once an assessment of risk is completed a suitable response to that risk must be sought. The final stage in the cycle is to monitor and review progress against the initial risk response and if necessary repeat the cycle to reduce risk further. Throughout all stages of the risk management cycle communication and consultation with the identified stakeholders is crucial to ensuring effective outcomes of the risk response.

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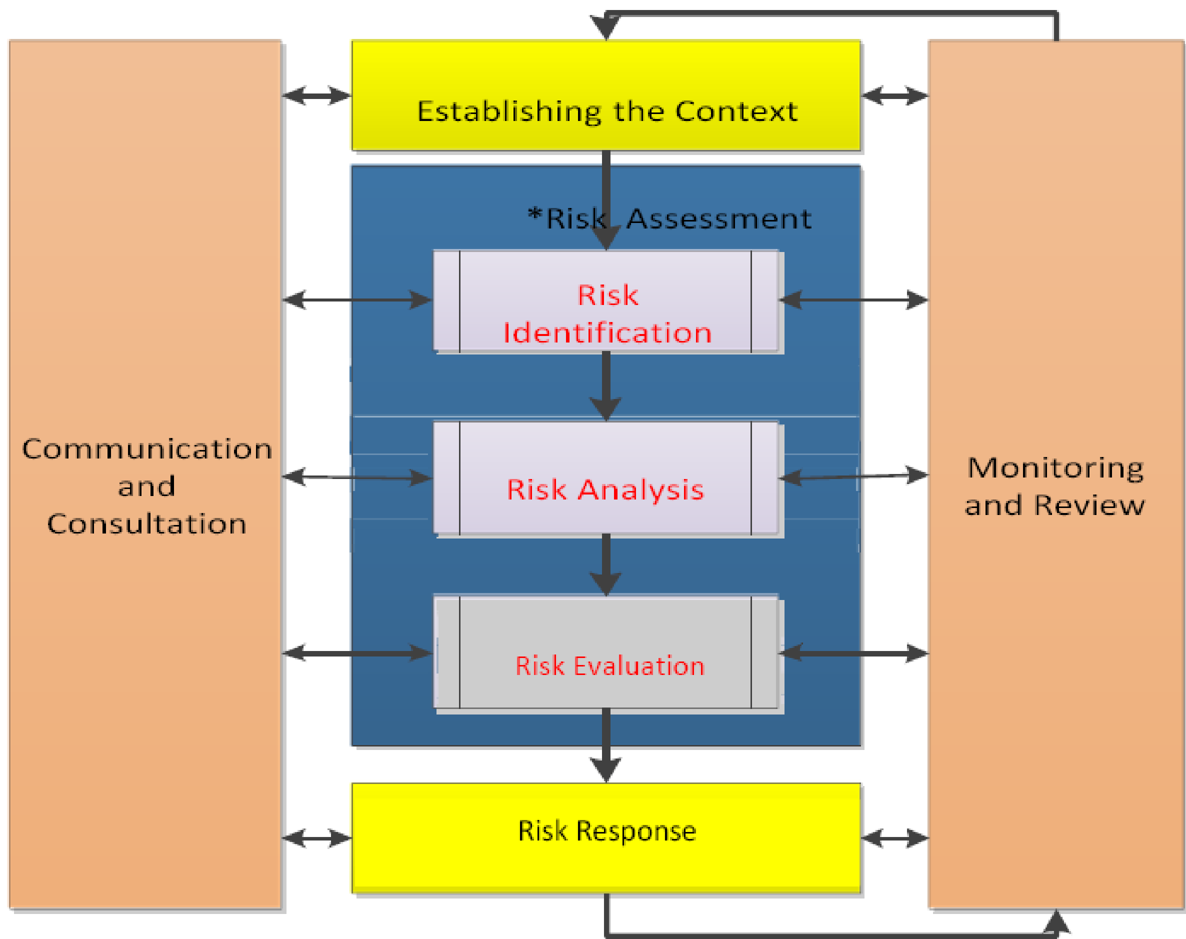


Figure 1. The Risk Management Cycle

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**Risk Assessment results in a risk score which is calculated using a risk matrix to reflect likelihood and severity (impact)*

7.5.1 The Trust is committed to reducing healthcare risks by undertaking risk management at every level of the organisation.

7.5.2 An important part of minimising risk involves reporting incidents. Any incident that 'has given or may result in actual or possible personal injury; to patient dissatisfaction; or to property loss or damage' must be reported following the Trust incident, complaint or claim procedures. A robust system of reporting allows the Trust to monitor incidents, complaints and claims; to review practice; and to identify trends and patterns. It also allows for the quick detection and resolution of any problems resulting from inadequate procedures, failure to adhere to safe systems of work, lack of training, or pressure of work.

7.5.3 Identification and assessment systems are vital to the success of the Trust's risk management process. Risks may be identified through a number of internal and external sources such as following a safety alert (e.g. from the Medicines and Healthcare Products Regulatory Agency (MHRA) and other reports issued by external bodies into areas of risk in the wider NHS. A risk may be realised if the Trust is not compliant with the steps outlined within the alert. (see appendix 3 for risk identification tools)

7.5.4 Risks identified from these sources must be assessed to predict their likelihood to affect the organisation and the consequences on the organisation should they occur.

**7.6 The Process for Assessing Risk:**

7.6.1 The risk assessment process provides a systematic examination of clinical and non-clinical processes and allows a Trust-wide risk profile to be developed subsequently enabling informed decisions to be taken about the management of the risks identified. The responsibility for ensuring suitable and sufficient risk assessments lies with managers with support as necessary from the specialists within the Trust who can advise on health and safety, clinical risk, business risks, etc. It is expected that all risks will be reduced to the level required by law and/or as far as is reasonably practicable.

7.6.2 Risk assessment and the maintenance of risk registers are essential components of the Trust's risk management programme and must not be solely an annual 'snapshot' but rather an embedded cyclic process to ensure that risks are regularly identified, assessed, managed, monitored and reviewed. Assessments should take account of all types of risk and the following list illustrates the risk domains that are of key importance to the Trust and must form the basis of the risk identification and assessment process:

- Injury – Physical / Psychological
- Patient Experience
- Environmental Impact
- Staffing and Competence
- Complaints / Claims
- Financial
- Objectives / Projects
- Business / Service interruption
- Inspection / Statutory Duty
- Adverse publicity / reputation
- Fire Safety / General scrutiny
- Information Governance / IT
- Medication

7.6.3 All aspects of a risk must be considered. Some risks may cross more than one domain and in those instances all relevant domains should be assigned a separate risk score. The domain with the highest risk score should be selected when inputting the risk on to the risk register. Risks should link to the Trust's or local objectives.

7.6.4 As part of a risk assessment each risk identified must be graded using the Trust's risk scoring matrix.

7.6.5 Following assessment the findings must be approved by the appropriate divisional / specialty governance forum prior to entry onto the risk register.

7.6.6 Each risk must be reviewed at a frequency based on the severity of the risk score

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(see Appendix 4). The manager responsible for managing the risk should perform the review along with others who were involved in the initial assessment in order to provide consistency in risk scoring. Following review or if conditions change the manager must ensure the risk register is updated to reflect any changes to the assessment.

7.6.7 Managers will set out a programme for risk assessments to be performed by identifying the various work processes and producing a prioritised list based on information from sources listed in sections Appendix 3.

**7.7 Requirements of a Risk Assessment**

7.7.1 **Hazard Identification (i.e. cause of risks)**

Hazard identification involves examining all causes of risk from the perspective of all stakeholders, both internal and external. Hazards (causes) can be systematically identified from a number of proactive and reactive processes/sources as described in section 7.5.3 and appendix 3.

When assessing risks, evidence must be examined from internal and external sources and processes within the organisation to identify what could reasonably be expected to cause harm. It is important to concentrate on significant risks that could result in harm to individuals or the organisation.

7.7.2 **Decide What or Who may be Harmed and How**

Health and Safety and organisational issues must always be considered e.g. are there risks to the safety and well-being of patients, staff and others? Consider people who might not be in the workplace all the time for example, cleaners, contractors, delivery persons, etc. especially if there is a chance that they could be injured by work activities. Consideration must also be given to risks affecting the reputation of the Trust, business objectives or continuity of service.

7.7.3 **Identify Current Controls in Place**

Consider how the risks/ hazards (causes) are already being controlled within the organisation.

7.7.4 **Evaluate the Risks Arising from the Hazards (Causes)**

When undertaking a risk assessment, the consequence or severity of the risk being assessed must be measured. In this context, consequence is defined as: the outcome or potential outcome of an event. Consequences must be scored using the risk consequence table in appendix 4.

Choose the most appropriate domain(s) (remember there may be more than one descriptor/domain for a risk) from the left hand column of the table. Work along the appropriate row until the most relevant definition of the risk consequence is found. The consequence score is the number at the top of the column.

Once a specific area of risk and its consequence score is agreed, the likelihood of the risk occurring can be identified by using the likelihood and risk scoring table included within appendix 4. Definitions of descriptors used to score the likelihood of a risk being realised are provided. The likelihood is assigned a number from ‘1’ to ‘5’: the higher the number the more likely it is the risk will occur. Frequency

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may not be useful in scoring certain risks associated with the success of time - limited or one-off projects and for these risks the likelihood score must be based on the probability of the risk occurring in a given time period. The likelihood score is a reflection of how likely it is that the risk will occur with the current controls in place.

### 7.8 Risk Scoring

7.8.1 Once a hazard (cause) is identified the severity of risk is measured using a matrix giving a numerical value to the consequence (impact) and the likelihood (probability) of the risk occurring to produce a single risk severity score. The Trust uses a 5 x 5 risk scoring matrix to assign a risk rating (i.e. a level of low to extreme) dependent upon the risk score (i.e. 1 – 25). The risk score is calculated by multiplying the consequence score by the likelihood score. The risk scoring matrix is included in appendix two.

7.8.2 When assessing a risk there are two risk severity scores that need to be recorded, these are:

- Current score – i.e. the level of the risk at time of assessment taking into account any current controls. The current score may alter following periodic review of the risk if further controls have since been put into place (i.e. actions to mitigate risk have been implemented) and this must be reflected in an altered score within the risk register entry.
- Target score – i.e. the level of the risk expected following the implementation of an action plan.

**NB**: If the current risk score equals or is lower than the target risk score the risk will have been treated and should be closed.

### 7.9 Risk Treatment

Risks may be:-

7.9.1 **Transferred:** Involve a 3rd party to share some degree of risk via contract terms or insurance. (The Trust is a member of the Liabilities to Third Parties Scheme (LTPS), Property Expenses Scheme (PES), and the NHSLA risk pooling schemes. This membership transfers some financial risk to these scheme providers).

7.9.2 **Treated**: In many cases further controls can be implemented to reduce the risks. Take ACTION to reduce the overall risk score (weaken the link between cause and risk to reduce LIKELIHOOD, weaken the link between risk and effect to reduce IMPACT). If so these should be recorded on the risk assessment document as future actions and should include timescales for completion and details of the individual accountable for implementing the actions.

7.9.3 **Tolerated**: Accept that the effects of the risk are (or have been following treatment) reduced to a reasonably practicable level

7.9.4 **Terminated:** In some cases risks cannot be tolerated, transferred or treated. In these cases the Trust may decide a particular risk should be avoided altogether and this may involve ceasing the activity that gives rise to the risk. Therefore, avoid the risk by making the likelihood of its occurrence totally impossible (break the links

Final for approval

at either point)

**7.10 Local Accountability for Risk, Risk Review & Escalation**

7.10.1 Risk assessments must be reviewed by the specialty / divisional Governance Forum at a frequency determined by the risk score. Regular review will ensure that when actions have been implemented they are reassigned as control measures with a subsequent revision of the risk score in the risk register entry.

7.10.2 Line managers are responsible for agreeing, implementing and monitoring appropriate risk control measures within their designated areas. Where the implementation of risk control measures is beyond the authority or resources available to the manager then this should be brought to the attention of the specialty / divisional governance forum.

7.10.3 Low Risks (Risk Score 1 – 6)
May be accepted without further treatment always consider whether further action is required to control any low risks with a consequence score of 4 or 5. Where it is decided to treat a low risk the risk shall be entered onto the risk register following approval by the appropriate specialty / divisional governance forum and reviewed on an annual basis until the target risk score is achieved.

7.10.4 Moderate Risks (Risk Score 8 -12)
Risk assessment details must be entered onto the risk register following approval by the appropriate specialty / divisional governance forum. An action plan to reduce the risk must be developed and uploaded to the risk register at the same time as the risk. The actions and timeframes must be populated on Datix and must be reviewed by the relevant manager and monitored by specialty / divisional governance forum on a quarterly basis to ensure implementation of actions within timescales until such time as the target risk score is achieved. In instances where the risk is accepted at a moderate level (i.e. no actions can be taken to reduce risk) then it must still be recorded on the risk register.

7.10.5 High Risks (Risk Score 15 – 20)
Risk assessment details must be entered onto the risk register following approval by the appropriate specialty / divisional governance forum. The actions and timeframes must be populated on Datix and reviewed by the relevant manager and monitored by specialty / divisional governance forum on a monthly basis to ensure implementation of actions within timescales until such time as the target risk score is achieved. In instances where the risk is accepted at its current level (i.e. no actions can be taken to reduce risk) then it must still be recorded on the risk register.

7.10.6 Extreme Risks (Risk Score 25)
Such risks must be brought to the immediate attention of the Divisional Clinical Director / Manager, or Corporate Director / Head of Service as appropriate who will subsequently contact the Risk Manager within the Governance Support Unit to provide independent advice in relation to the accuracy of scoring. Risks that are downgraded following this exercise shall follow the process outlined in section 7.10. Risk assessment details including action plan must be entered onto

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the risk register following approval by the appropriate specialty / divisional governance forum. The action plan must be reviewed / monitored by the divisional/specialty manager on a weekly basis. All extreme risks will be reported at the earliest opportunity to the TMB meeting by the relevant Director.

**Table 1** highlights the reporting and review process depending upon the risk score.

| | **Remedial Action to be taken** | **Risk Register Level and Monitoring Requirement** |
|---|---|---|
| Low Risks (Risk Score 1-6) | Speciality/Divisional Governance Forum confirms & challenges. Once agreed upload risk and action plan to Datix. | Tier 2 & 3 (Speciality /Trust Lead – Department Manager or ward Manager) Monitor at least annually. |
| Moderate Risks (Risk Score 8-12) | Speciality/Divisional Governance Forum confirms & challenges. Once agreed upload risk and action plan to Datix. | Tier 1 (Divisional Management Team / Central Head of Service) Monitor Quarterly. |
| High Risks (Risk Score 15-20) | Speciality/Divisional Governance Forum confirms & challenges. Once agreed upload risk and action plan to Datix. | Tier 1 (Divisional Management Team / Central Head of Service) Monitor Monthly. |
| Extreme Risks (Risk Score 25) | Inform the Divisional Clinical Director / Manager, or Corporate Director / Head of Service. Once score agreed upload risk and action plan to Datix. | Executive Director / Executive Team. Monitor Weekly. |

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## 7.11 Testing Risk Responses

Control measures and action plans in place to control a risk (the risk response) should be suitable and sufficient in their design; this simple set of rules helps risk assessors in designing risk responses and can also be used by governance groups as part of the assurance process for examining risk registers

7.11.1 Risk Responses should meet the 7 A's test.

- **Appropriate** – in proportion to the level of risk posed (legal compliance met)
- **Affordable** – time / money / effort balanced against the risk
- **Actionable** – within a reasonable timeframe
- **Achievable** – technically or legally possible
- **Assessed** – will the risk-level post-action be reduced
- **Allocated** – controls and actions must be assigned to a lead

- **Agreed** – all stakeholders must sign-up to the risk responses

7.12 **Residual Risk**

Once a risk has been properly analysed, described, current controls and assurances identified, a current risk score applied and any necessary action plans devised to respond to the risk (one or more 'T's) the next step in the process is to revisit the assessment of likelihood and severity once all actions have been implemented. i.e. residual risk is used to assess the potential effectiveness of our action plans. Again the risk matrix is used to allocate residual risk grades for each risk.

7.13 **Review**

All risks must be continually reviewed as more assurance information becomes available, action plans are implemented (and become current controls as time passes) and the people affected by the risk change.

7.14 **Risk escalation**

Risk escalation is a formalised process for identifying risks that cannot be effectively resolved with the resources available to the risk owner. Note that escalating a risk does not change the original risk owner, it calls upon the wider resource available to the management hierarchy to bring a risk under control.

If after undertaking your risk assessment you are unable to reduce the residual/target risk to below the line of tolerance (or the time it would take to achieve this would lead to continued and serious risk exposure) then the risk should be escalated to the next level up from its current position.

7.15 **Levels of Risk Management / Escalation available:**

- Executive Director / Executive Team
- Tier 1- Divisional Management Team/ Central Head of Service
- Tier 2 – Specialty Lead / Trust Lead
- Tier 3 – Local Department Manager / Ward Leader

The majority of risks are expected to remain at Tiers 2 and 3 but may require escalation if the risk owner is unable to bring about a reduction in risk score to below the line of tolerance.

When risks are escalated to a higher level from a lower level there are a number of steps your receiving manager should undertake;

i. Review the risk with the risk owner
ii. Allocate resource to reduce the risk (Add ACTIONS)
iii. Decide if the necessary actions outweigh the risk – move to tolerate a risk above the line of tolerance through the appropriate Governance forum
iv. Escalate again to the next level up

7.16 **Risk de-escalation**

It should stay at the escalated level until it has been resolved to below tolerance, it can then be de-escalated and moved to a tolerated risk.

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The table below summarises the risk escalation process described and evidences the Board to Ward Visibility of Risk Management.

| **Board to Ward Visibility of Risk Management<br>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<br><br>Delegate sub-committees with responsibility for managing and tracking actions<br><br>Feed all risks rated as 15 or more and/or have a consequence of 5 into the Corporate Risk Register<br><br>Address any risks flagged as Exec Team /Exec Director | Board & Sub-Committee's (AC / TMB) | Board – bi-monthly<br><br>Sub-committee in line with committee cycle | Board discussion<br>Escalation from sub-committees<br>Performance data<br>Compliance reporting (CQC, NHSLA, Audit, NICE Guidelines, Compliance etc)<br>Trust wide risk assessments<br>Patient and Staff Experience Surveys |
| Corporate Risk Register Exception Report | Receive and manage exceptions from the Corporate Risk Register (new risks, increased risks, actions outstanding, risks which remain Exec Team / Exec Director) | Board | Monthly | N/A |
| Corporate Risk Register | Identify, assess and manage all risks across the Trust rated as 15 or more and/or those with a consequence of 5<br><br>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 Exec Team / Exec Director)<br><br>Address and risks flagged as Exec Team / Exec Director and review Tier 1 | Trust Management Board<br><br>Clinical Quality and Governance Committee | Monthly | Board discussion<br>Escalation from sub-committees<br>Performance data<br>Compliance reporting (CQC, NHSLA, Audit, NICE Guidelines, Compliance etc)<br>Complaints, Litigations, Claims, Incidents and PALS reporting<br>Trust wide risk assessments<br>Patient and Staff Experience Surveys |
| Divisional Risk Registers | Identify, assess and manage all risks across the department (TIER 1, 2 & 3)<br><br>Accept risks and associated actions where these are rated less than 15<br><br>Escalate risks and recommend actions where these are rated 15 or more<br><br>Submit risk register to CQ&GC quarterly<br><br>Address and escalate any risks flagged as TIER 1 or above | Specialty Management Teams<br>Divisional Management Teams<br>Business Units<br>CQ&GC | Team discussions – monthly as part of governance forums<br><br>Submission of refreshed register quarterly to CQ&GC | Management, business and clinical team discussion<br>Performance data<br>Clinical Audit<br>Compliance etc.)<br>Complaints, Claims, Litigations, Claims, Incidents and PALS reporting<br>Trust wide risk assessments<br>Patient and Staff Experience Surveys |

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7.16.1 Where the risk rating for an open risk has either increased or reduced the risk must be presented to the specialty / divisional governance forum for approval. This process should provide either assurance that actions have been taken to control

the risk or identify where there are gaps in control and the proposed action plan including due date and responsible person.

**7.17 Risk Recording:**

**7.17.1 BAF**

NHS Chief Executive Officers are required to sign the Annual Governance Statement as part of the statutory accounts and annual report. The Trust Board must be able to demonstrate they have been properly informed about the totality of risks within the Trust, both clinical and non-clinical (including business risks). The Trust Board shall assure itself that strategic objectives have been systematically identified and the key strategic risks to achieving them are adequately managed. The BAF fulfils this purpose.

The BAF shall be received and monitored no less than twice per year at the Trust Board and at each Audit Committee.

Key strategic risks are defined as those potentially damaging to the achievement of the Trust's strategic objectives. The application of the Trust's Risk Management Policy shall assist in the rating of these risks.

Risks are identified, assessed and added to the risk register of the relevant service area. They are referred to and managed by the service area managers. Where the service area managers/Divisional Managers are unable to resolve and contain the risk at a tolerable level locally or the risk is rated 15 or above (or the risk has a consequence of 5), the risk is escalated to The Operational Governance Committee structure of Trust Management Board depending on the nature of the risk. The Trust Management Board will decide if risks are to be added to the Board Assurance Framework /Corporate Risk Register.

The Risk Manager and the Director of Corporate Services/Company Secretary reconcile the risks discussed at TMB and give consideration to which risks with a score >15 (and risks with a consequence of 5) need to be escalated to the Board via the Corporate Risk Register and the BAF.

The minutes of the Trust Board shall evidence that it identifies, records, assesses and analyses the Trust's strategic risks via the BAF and that it is involved in taking

Appendix 5 is a diagrammatic review of the risk escalation process.

**7.18 Learning**

7.18.1 Learning from incidents, complaints and claims and other such events is key to developing a culture within the Trust that welcomes investigation of such cases to provide opportunities to improve patient care, the services offered within the Trust, the working environment and the safety of staff, visitors and contractors.

7.18.2 A well established and active internal reporting culture provides the Trust with detail about actual and potential harm and associated risks for incidents, complaints and claims. Data from incidents, complaints, claims, and inquest activity, are managed, monitored and investigated in conjunction with divisions and specialties by the:-

Final for approval

- Patient Experience Team
- Litigation Team
- Health and Safety Team

7.18.3 Clinical incident data is uploaded to the National Reporting Learning System (NRLS) as part of the external reporting requirement.

7.18.4 The responsibility for investigating incidents will be undertaken by designated individuals within clinical divisions and corporate services with support from the Trust's Governance Support Unit according to the nature, severity and outcome of the incident.

7.18.5 Learning the lessons from internal incidents, complaints, claims and inquests is an important factor in the Trust's approach to managing risk. Following investigation, presentation of the final report and action plan will be monitored via the appropriate division or specialty and relevant Trust-wide groups.

**7.19 Embedding Risk Management**

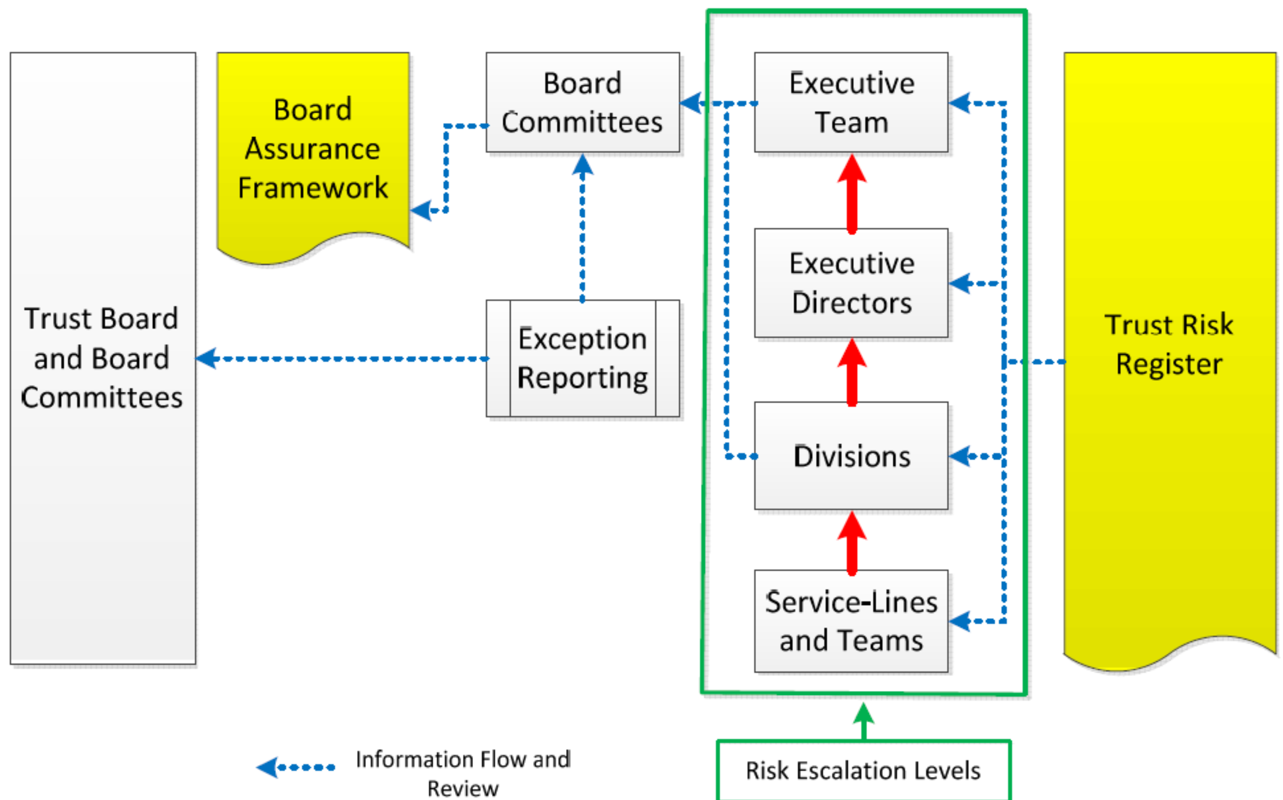
7.19.1 The effective implementation of this risk management policy will facilitate the delivery of a quality service and alongside staff training and support will provide an improved awareness of the measures needed to prevent, control and contain risks. To this end the Trust will:

a. Ensure appropriate levels of resources are available to develop and maintain effective risk management processes;
b. Ensure all staff have access to a copy of this policy;
c. Maintain a risk register that is subject to regular review;
d. Communicate to staff any actions to be taken in respect of risk issues;
e. Deliver risk management training and evaluate and monitor its effectiveness;
f. Ensure that training programmes raise and sustain awareness throughout the Trust about the importance of managing risk;
g. Monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

**7.20 Risk Assurance**

To ensure that the risk management process is, at all levels, governed with appropriate accountability and probity, risk registers will be maintained and presented for regular scrutiny at the appropriate forum as described in Section four. These groups retain responsibility for ensuring that risk responses are appropriate and timely.

Final for approval




7.20.1 The figure above shows the risk escalation flows between the Risk Register on the right (Where risks are being continually identified, managed, and escalated through the management hierarchy), and the assurance mechanisms to the left (where risks are being reported on for assurance purposes at Board Committees and Exception reporting from the Executive Performance Review process).

7.20.2 Risk escalation from one level to the next occurs when the residual risk cannot be brought under reasonable control.

## 8. EVIDENCE BASE

### 8.1 References


- CQC (2010) Essential standards of Quality and Safety
- DH (2013) NHS Outcomes Framework 2014 to 2015
- GrantThornton (2011) Clinical Audit: a brave new world?
- HEA (1997) Risk Assessment at Work : practical examples in the NHS
- Health Foundation (2013) The Measurement and Monitoring of Safety
- HM Treasury (2004) The Orange Book : Management of Risk - Principles and Concepts
- HM Treasury (2013) Audit and Risk Assurance Committee Handbook
- HSE (2013) HSG65 : Managing for Health and Safety
- ISO (2009) 31000: Risk management – Principles and guidelines
- ISO (2009) Guide 73, Risk management vocabulary
- ISO (2009) 31010, Risk management – Risk assessment techniques
- Monitor (2013) The NHS Foundation Trust Code of Governance
- NHSLA (2013) Maternity Clinical Risk Management Standards
- NHSLA (2013) NHSLA Risk Management Standards for NHS Trusts providing


Final for

- Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care
- NPSA (2008) A Risk Matrix for Risk Managers
- PWC (2014) Independent review of Sherwood Hospitals NH Foundation Trust's delivery of improvements to Board and Quality Governance – final report
- Australian/New Zealand standard AS/NZS 4360:2004.

## 9. MONITORING COMPLIANCE

9.1.1 An annual report on risk management in the Trust, based on all available relevant information, shall be produced in the first quarter following the end of the financial year. To ensure compliance with this policy the report, together with performance against the Key Performance Indicators (KPIs), shall be reviewed annually by the TMB and used to inform the development of action plans to remedy deficiencies and to inform future strategies. Existing audit / review mechanisms shall be used wherever possible to avoid duplication.

9.1.2 Regular self-assessment of compliance against the Care Quality Commission is a requirement of registration and the Trust must demonstrate that it meets the essential standards of quality and safety across all its services.

9.1.3 Systematic review of the risk management process is a key responsibility of the AC and the TMB.

9.1.4 Other internal and external audits shall take place as required by the Department of Health, Monitor, Audit Commission and other bodies.

### 9.2 Key Performance Indicators

9.2.1 Systems shall be in place to monitor and report performance against KPIs with findings reported to the AC, TMB and other Trust committees as required.

9.2.2 KPIs and audit requirements are described below

| KPI | Target | HOW will this KPI be monitored | REPORTING committee/ group | Frequency of Review | Lead |
|---|---|---|---|---|---|
| In date Risk Management Policy with risk management process described | Approved policy | Audit of minute – approved by Board of Directors | Trust Management Board | Annual | Risk Manager |
| Responsibility for risk is reflected in the terms of reference for Board Standing Committees | Approved Terms of Reference and included in standing | Annual Audit of Risk Management Policy | Trust Management Board | Annual | Company Secretary |

Final for approval

| | orders | | | | |
|---|---|---|---|---|---|
| Review of the Trust's Assurance Framework in full by the Board of Directors | Bi-annually | Board Minutes Satisfactory Audit Opinion | Trust Management Board | Annual | Company Secretary |
| Risk graded at 15 or above, or risks with a consequence of 5 using the Trust risk scoring matrix reported to the Trust Management Board for consideration for inclusion on the Corporate Risk Register | 100% | Trust Management Board minutes | Board of Directors | Annual | Risk Manager |
| Risk Register reviewed at TMB (operational governance) Committee's | On agenda monthly | Committee agenda's and minutes | Trust Management Board | Annual | Risk Manager |

9.2.3 When KPI's are not being met, the Risk Manager will produce an action plan which will be monitored via the Trust Management Board at least quarterly.

## 10. TRAINING REQUIREMENTS

**Risk Management Training**

10.1.1 The Trust is committed to the provision of training and education to ensure the workforce is informed, competent, prepared and possesses the necessary skills and knowledge to perform and respond appropriately to the demands of clinical care and service delivery.

10.1.2 Staff will be offered risk management training (including risk awareness training for senior managers) commensurate with their duties and responsibilities. On-going awareness raising regarding incident reporting and risk management awareness is included as part of the Trust's corporate induction for new starters and Mandatory Training Programme (see mandatory training policy).

10.1.3 Trust Board members will receive risk awareness training, commensurate with their roles and responsibilities.

10.1.4 The Trust employs advisers in specialist areas (3.2.10) to ensure that a link is provided for information, advice and training in these specialist areas.

10.1.5 A training needs analysis is required to help make the aspirations of this policy a reality.

Final for approval

## 11. DISTRIBUTION

Following formal approval, this policy will be published to and form part of the trust's suite of 'Governance Policies' accessible to all staff via the intranet within the Corporate Information intranet site.

Once published, information regarding its issue will be emailed by the Governance Support Unit to the following staff for information, dissemination and action as needed:

- Divisional Governance Groups
- Specialty Governance Groups
- (see below for all methods of communication)

## 12. COMMUNICATION

- All user e-mail to raise awareness of the revised policy via the communications bulletin
- This document will appear in the 'New and Updated' area of the Intranet
- Via the Medical Managers forum
- Via the Senior Nurse Forum

## 13. AUTHOR AND REVIEW DETAILS

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This document will be reviewed after 3 years, or sooner, should new evidence, legislation, guidance or best practice be issued.

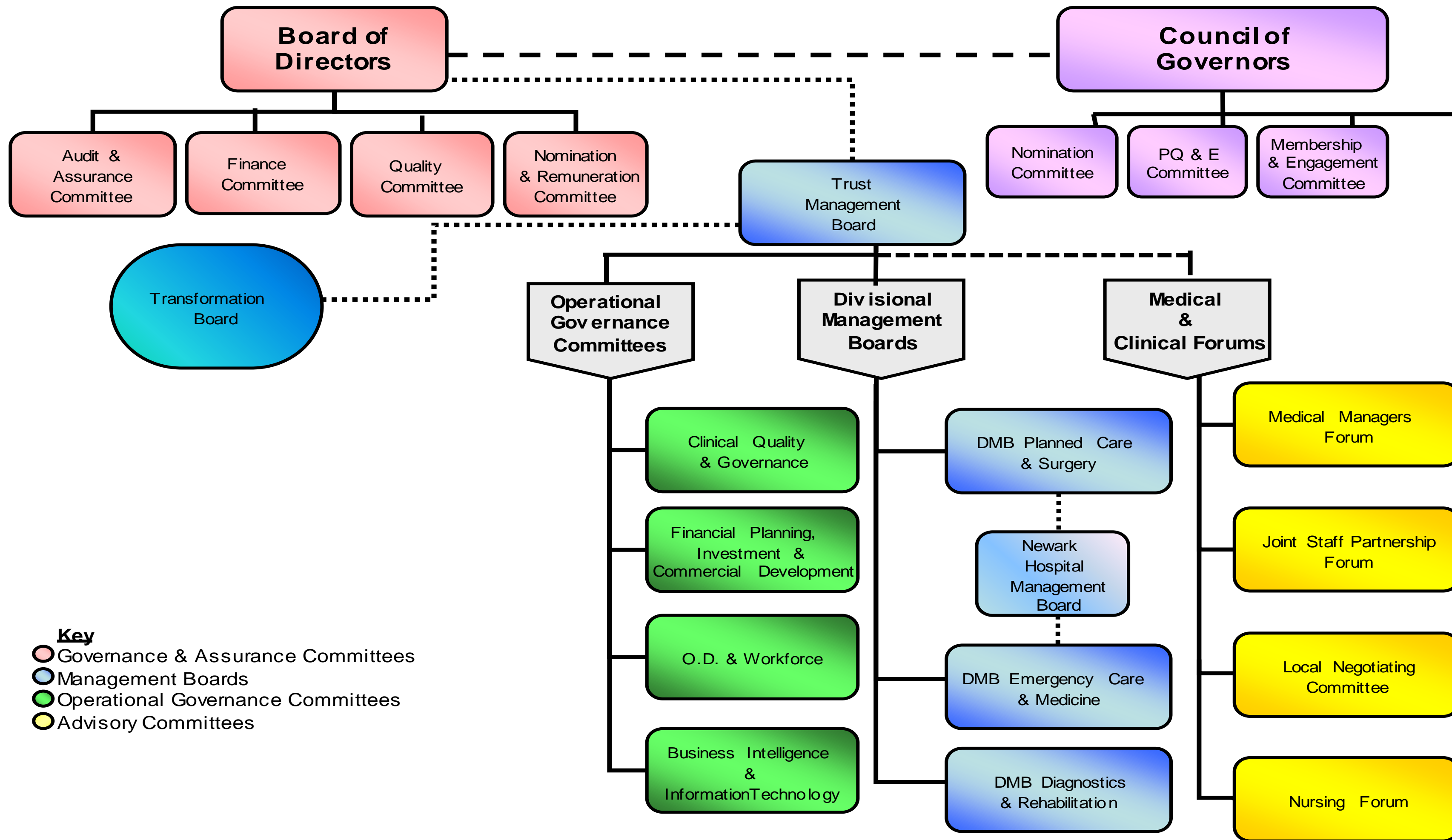
| **Issue/ Version:** | 4.0 |
|---|---|
| **Date Issued:** | 04.09.2014 |
| **Date to be reviewed by:** | August 2017 |
| **To be reviewed by:** | Risk Manager |
| **Executive Sponsor:** | Executive Director for Nursing & Quality |
| **Supersedes:** | |

## 14. APPENDICES

Final for approval

**Appendix 1**

# SFHFT Committee Structure



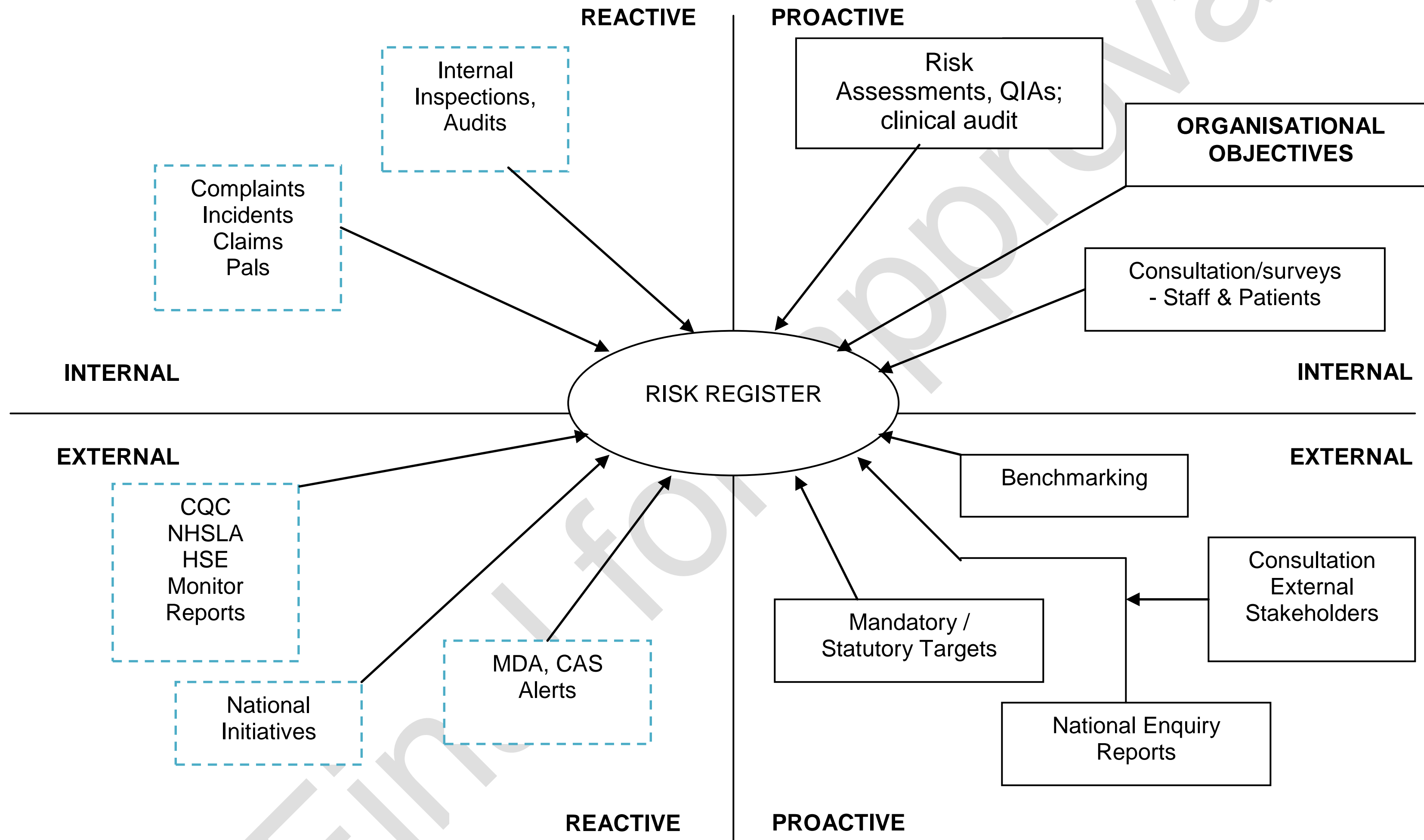
**Appendix 2**

# Risk Appetite for NHS Organisations
## A matrix to support better risk sensitivity in decision taking

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

| Risk levels ▶<br>Key elements ▼ | 0<br>**Avoid**<br>Avoidance of risk and uncertainty is a Key Organisational objective | 1<br>**Minimal (ALARP)**<br>(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential | 2<br>**Cautious**<br>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. | 3<br>**Open**<br>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | 4<br>**Seek**<br>Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). | 5<br>**Mature**<br>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 order to capitalise on opportunities. | 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 focussed 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 of organisation. | 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 outweighing the risks. |
| **APPETITE** | **NONE** | **LOW** | **MODERATE** | **HIGH** | **SIGNIFICANT** | |

**Appendix 3 –** The common sources of information that are used by NHS organisations to populate their risk registers




Formulating a Risk Register

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## APPENDIX 4 Risk matrix

## Categorisation Matrix

**1 Qualitative Measures of Consequences (Actual / Potential) –** select the descriptors which best fit the risk you have identified

| Domain / Descriptor | Insignificant 1 | Minor 2 | Moderate 3 | Major 4 | Catastrophic 5 |
|---|---|---|---|---|---|
| **Injury** (Physical / Psychological) | ▸ Adverse event requiring no/minimal intervention or treatment. **Impact prevented** – any patient safety incident that had he potential to cause harm but was prevented, resulting in no harm **Impact not prevented** – any patient safety incident that ran to completion but no harm occurred | ▸ Minor injury or illness – first aid treatment needed ▸ Health associated infection which may/did result in semi permanent harm ▸ Affects 1-2 people ▸ Any patient safety incident that required extra observation or minor treatment [W] and caused minimal harm to one or more persons | ▸ Moderate injury or illness requiring professional intervention ▸ No staff attending mandatory / key training ▸ RIDDOR / Agency reportable incident (7 plus days lost) ▸ Adverse event which impacts on a small number of patients ▸ Affects 3-15 people ▸ Any patient safety incident that resulted in a moderate increase in treatment [X] and which caused significant but not permanent harm to one or more persons | ▸ Major injury / long term incapacity / disability (e.g. loss of limb) ▸ >14 days off work ▸ Affects 16 – 50 people ▸ Any patient safety incident that appears to have resulted in permanent harm [Y] to one or more persons | ▸ Fatalities ▸ Multiple permanent injuries or irreversible health effects ▸ An event affecting >50 people ▸ Any patient safety incident that directly resulted in the death [Z] of one or more persons |
| **Patient Experience** | ▸ Reduced level of patient experience which is not due to delivery of clinical care | ▸ Unsatisfactory patient experience directly due to clinical care – readily resolvable ▸ Increase in length of hospital stay by 1-3 days | ▸ Unsatisfactory management of patient care – local resolution (with potential to go to independent review) ▸ Increased length of hospital stay by 4 – 15 days | ▸ Unsatisfactory management of patient care with long term effects ▸ increased length of hospital stay >15 days ▸ Misdiagnosis | ▸ Incident leading to death ▸ Totally unsatisfactory level or quality of treatment / service |
| **Environmental Impact** | ▸ Onsite release of substance averted | ▸ Onsite release of substance contained ▸ Minor damage to Trust property - easily remedied <£10K | ▸ On site release no detrimental effect ▸ Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K | ▸ Offsite release with no detrimental effect / on-site release with potential for detrimental effect ▸ Major damage to Trust property – external organisations required to remedy - associated costs >£50K | ▸ Onsite /offsite release with realised detrimental / catastrophic effects ▸ Loss of building / major piece of equipment vital to the Trusts business continuity |
| **Staffing & Competence** | ▸ Short term low staffing level (<1 day) – temporary disruption to patient care ▸ Minor competency related failure reduces service quality <1 day ▸ Low staff morale affecting one person | ▸ On-going low staffing level - minor reduction in quality of patient care ▸ Unresolved trend relating to competency reducing service quality ▸ 75% - 95% staff attendance at mandatory / key training ▸ Low staff morale (1% - 25% of staff) | ▸ Late delivery of key objective / service due to lack of staff ▸ 50% - 75% staff attendance at mandatory / key training ▸ Unsafe staffing level ▸ Error due to ineffective training / competency we removed ▸ Low staff morale (25% - 50% of staff) | ▸ Uncertain delivery of key objective / service due to lack of staff ▸ 25%-50% staff attendance at mandatory / key training ▸ Unsafe staffing level >5days ▸ Serious error due to ineffective training and / or competency ▸ Very low staff morale (50% – 75% of staff) | ▸ Non-delivery of key objective / service due to lack of staff ▸ Ongoing unsafe staffing levels ▸ Loss of several key staff ▸ Critical error due to lack of staff or insufficient training and / or competency ▸ Less than 25% attendance at mandatory / key training on an on-going basis ▸ Very low staff morale (>75%) |

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|---|---|---|---|---|---|
| **Complaints / Claims** | ▸ Informal / locally resolved complaint<br>▸ Potential for settlement / litigation <£500 | ▸ Overall treatment / service substandard<br>▸ Formal justified complaint (Stage 1)<br>▸ Minor implications for patient safety if unresolved<br>▸ Claim <£10K | ▸ Justified complaint (Stage 2) involving lack of appropriate care<br>▸ Claim(s) between £10K - £100K<br>▸ Major implications for patient safety if unresolved | ▸ Multiple justified complaints<br>▸ Independent review<br>▸ Claim(s) between £100K - £1M<br>▸ Non-compliance with national standards with significant risk to patients if unresolved | ▸ Multiple justified complaints<br>▸ Single major claim<br>▸ Inquest / ombudsman inquiry<br>▸ Claims >£1M |
| **Financial** | ▸ Small loss<br>▸ Theft or damage of personal property <£50 | ▸ Loss <£50K<br>▸ Loss of 0.1 - 0.25% of budget<br>▸ Theft or loss of personal property <£750 | ▸ Loss of £50K - £500K<br>▸ Loss of 0.25 – 0.5% of budget<br>▸ Theft or loss or personal property >£750 | ▸ Loss of £500K - £1M or loss of 0.5 – 1% of budget<br>▸ Purchasers failing to pay on time | ▸ Loss > £1M or loss >1% of budget<br>▸ Loss of contract / payment by results |
| **Objectives / Projects** | ▸ Interruption does not impact on delivery of patient care / ability to provide service<br>▸ Insignificant cost increase / schedule slippage | ▸ <5% over project budget / schedule slippage | ▸ 5 – 10% over project budget / schedule slippage | ▸ 10 – 25% over project budget / schedule slippage | ▸ >25% over project budget / schedule slippage |
| **Business / Service Interruption** | ▸ Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services | ▸ Short term disruption, of >8 hours, with minor impact | ▸ Loss / interruption of >1 day<br>▸ Disruption causes unacceptable impact on patient care<br>▸ Non-permanent loss of ability to provide service | ▸ Loss / interruption of > 1 week.<br>▸ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked<br>▸ Temporary service closure | ▸ Permanent loss of core service / facility<br>▸ Disruption to facility leading to significant 'knock-on' effect across local health economy<br>▸ Extended service closure |
| **Inspection / Statutory Duty** | ▸ Small number of recommendations which focus on minor quality improvement issues<br>▸ No or minimal impact or breach of guidance / statutory duty<br>▸ Minor non-compliance with standards | ▸ Minor recommendations which can be implemented by low level of management action<br>▸ Breach of Statutory legislation<br>▸ No audit trail to demonstrate that objectives are being met (NICE; HSE;NSF etc.) | ▸ Challenging recommendations which can be addressed with appropriate action plans<br>▸ Single breach of statutory duty<br>▸ Non-compliance with core standards <50% of objectives within standards met | ▸ Enforcement action<br>▸ Multiple breaches of statutory duty<br>▸ Improvement Notice<br>▸ Critical Report<br>▸ Low performance rating<br>▸ Major non compliance with core standards | ▸ Multiple breaches of statutory duty<br>▸ Prosecution<br>▸ Severely critical report<br>▸ Zero performance rating<br>▸ Complete systems change required<br>▸ No objectives / standards being met |
| **Adverse Publicity / Reputation** | ▸ Rumours<br>▸ Potential for public concern | ▸ Local Media – short term – minor effect on public attitudes / staff morale<br>▸ Elements of public expectation not being met | ▸ Local media – long term – moderate effect – impact on public perception of Trust & staff morale | ▸ National media <3 days – public confidence in organisation undermined – use of services affected | ▸ National / International adverse publicity >3 days.<br>▸ MP concerned (questions in the House)<br>▸ Total loss of public confidence |
| **Fire Safety / General Security** | ▸ Minor short term (<1day) shortfall in fire safety system.<br>▸ Security incident with no adverse outcome | ▸ Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area)<br>▸ Security incident managed locally<br>▸ Controlled drug discrepancy – accounted for | ▸ Fire code non-compliance / lack of single detector – patient area etc.<br>▸ Security incident leading to compromised staff / patient safety.<br>▸ Controlled drug discrepancy – not accounted for | ▸ Significant failure of critical component of fire safety system (patient area)<br>▸ Serious compromise of staff / patient safety | ▸ Failure of multiple critical components of fire safety system (high risk patient area)<br>▸ Infant / young person abduction |
| **Information Governance / IT** | ▸ Breach of confidentiality – no adverse outcome.<br>▸ Unplanned loss of IT facilities < half a day<br>▸ Health records / documentation incident – no adverse outcome | ▸ Minor breach of confidentiality – readily resolvable<br>▸ Unplanned loss of IT facilities < 1 day<br>▸ Health records incident / documentation incident – readily resolvable | ▸ Moderate breach of confidentiality – complaint initiated<br>▸ Health records documentation incident – patient care affected with short term consequence | ▸ Serious breach of confidentiality – more than one person<br>▸ Unplanned loss of IT facilities >1 day but less than one week<br>▸ Health records / documentation incident – patient care affected with major consequence | ▸ Serious breach of confidentiality – large numbers<br>▸ Unplanned loss of IT facilities >1 week<br>▸ Health records / documentation incident – catastrophic consequence |
| **Medication** | ▸ Incorrect medication dispensed but not taken | ▸ Wrong drug or dosage administered with no adverse effects | ▸ Wrong drug or dosage administered with potential adverse effects | ▸ Wrong drug or dosage administered with adverse effects | ▸ Wrong drug or dosage administered with adverse effects leading to death |

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[w] = minor treatment is defined as first aid, additional therapy, r additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission.

[x] = moderate increase in treatment is defined as a return to surgery, an un-planned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.

[Y] = permanent harm directly related to the incident and not the natural course of the patients illness or underlying condition is defined as permanent lessening of

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Bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ or brain damage.

[z] = the death must relate to the incident rather than to the natural course of that patients illness or underlying condition. 2

Consider how likely the outcomes (descriptors) are to happen

### Qualitative Measures of Likelihood

| **Level** | **Descriptor** | **Example** | % of risk |
|---|---|---|---|
| **1** | Rare | Difficult to believe that this will ever happen / happen again. | <10% |
| **2** | Unlikely | Do not expect it to happen / happen again, but it may | 10 – 40% |
| **3** | Possible | It is possible that it may occur / recur | 40 – 60% |
| **4** | Likely | Is likely to occur / recur, but is not a persistent issue. | 60 – 90% |
| **5** | Almost certain | Will almost certainly occur / recur, and could be a persistent issue | >90% |

3 Using the Risk Rating Matrix determine the Severity (Extreme / High / Moderate / Low)

### Risk Rating Matrix

| Consequence / Likelihood | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **1** | 1 | 2 | 3 | 4 | 5 |
| **2** | 2 | 4 | 6 | 8 | 10 |
| **3** | 3 | 6 | 9 | 12 | 15 |
| **4** | 4 | 8 | 12 | 16 | 20 |
| **5** | 5 | 10 | 15 | 20 | 25 |

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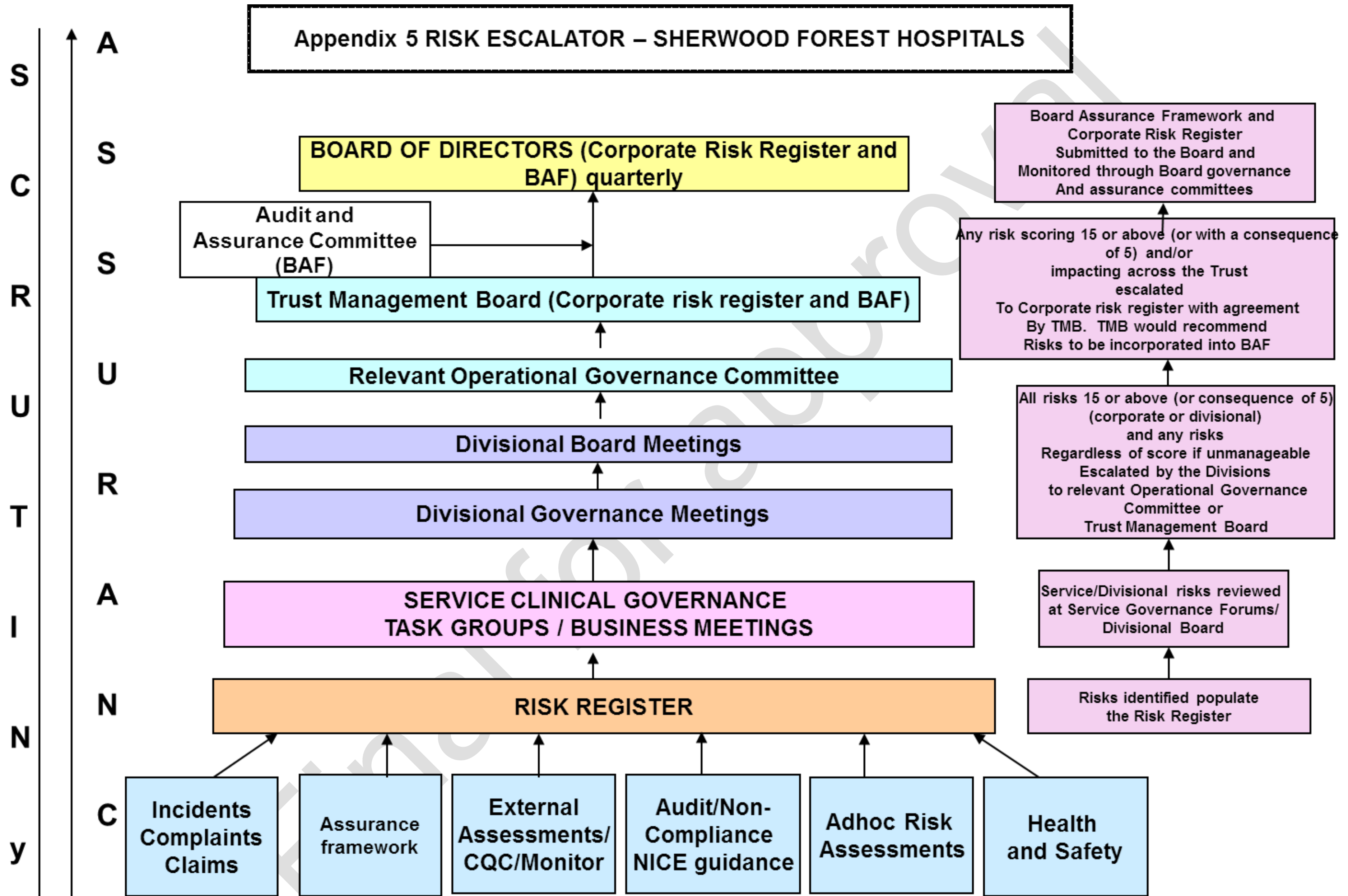


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