Agenda Item:

Board of Directors Meeting

Report

Subject: Risk Management Strategy
Date: Thursday 27th March 2014
Author: Shelley Watson - Interim Head of Risk
Lead Director: Kerry Rogers – Director of Corporate Affairs/Trust Secretary

Executive Summary

It is important that the Board of Directors provides leadership and a high level of commitment for establishing effective risk management systems across the Trust. The Chief Executive has overall accountability for the management of risk by the Trust and responsibility for specific risk management areas, has been delegated to the Trust Executive.

The current Risk Management Strategy had a review date of February 2013 and the Director of Corporate Services tasked the Interim Head of Risk with reviewing the strategy in October 2013. This work has been completed and the updated Risk Management Strategy incorporates the new accountability and responsibility structure for Sherwood Forest Foundation Trust. In addition to this the following new elements have been incorporated to ensure it remains fit for purpose and risk is managed effectively at SFHNFT.

- Risk Management Training (comprehensive programme commenced in Dec 2013)
- New and improved risk grading matrix to include a medication line and more definitive descriptions for staff
- Risk Register source of information
- Risk Escalation Process

These elements will ensure the Trust's staff receive the necessary mandatory training in risk management. This will raise awareness across SFHNFT's sites with regards to risk identification, grading and management of risk with the aid and use of risk registers. The risk escalation process will ensure that all staff understand how to escalate risk within the organisation.

Recommendation

The Board is invited to approve the draft Risk Management Strategy be circulated with Board's support for a process of consultation to the following key individuals:

- Executive Team (circulated Tuesday 18th March 2014)
- Clinical Directors
- Head of Governance
- Clinical Governance Lead
- Patient Safety Lead
- Heads of Nursing
- Divisional General Managers

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high	**Build successful relationships with**

quality care	**external organisations and regulators**
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	The Risk Management Strategy details the process for escalation of risk to the Corporate Risk Register and BAF.
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	All sources of risk included within the risk register spider diagram.
Links to NHS Constitution	
Financial Implications/Impact	Implications if the strategy is not embedded throughout the Trust.
Legal Implications/Impact	Implications if the strategy is not embedded and followed throughout the Trust.
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	
Monitoring and Review	Trust Management Board will monitor the effectiveness of the Risk Management Strategy.
Is a QIA required/been completed? If yes provide brief details	

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Risk Management Strategy & Policy

Version: 2

Designation of Policy Author(s)	Interim Head of Risk
Policy Development Contributor(s)	
Accountable Director(s)	Director of Corporate Affairs [Executive Director of Nursing from 1st April 2014]
Ratified By (Committee / Group)	Board of Directors
Date ratified	
Date issued/published on Intranet	
Review date	April 2016
Target audience	All staff including contracted staff and volunteers

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the DATIX Risk Management System.

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1 Executive Summary

1.1 Policy Scope

This document is in force across all areas of Sherwood Forest Hospitals NHS Foundation Trust and is to be adhered to by all staff including contracted staff and volunteers.

1.2 Policy Aim

Risk management is a fundamental component of safe effective and efficient management of the Trust. Although a risk free environment is impossible, much can be done to minimise risk by establishing coordinated strategies, policies and procedures that permeate all areas of Trust activities. This Risk Management Strategy is a document that explains to staff and the public how Sherwood Forest Hospitals NHS Foundation Trust intends to deliver its commitment to being an organisation that is committed to patient, staff and public safety and takes its risk management responsibilities seriously.

The Trust starts with the premise that 'Risk Management is everybody's responsibility'. Its practice must be embedded in the routine everyday management processes and structures of the organisation and encouraged through a responsible culture. The Risk Management Strategy promotes the philosophy of governance and requires all risk management to be systematic, robust and evident. This strategy requires that risk management processes are applied to business planning at all levels and that risk management issues should be communicated to key stakeholders where necessary. The underpinning principle of this strategy is that a responsible risk management culture is developed within the Trust that empowers all staff to make sound judgements and decisions concerning the management of risk, and risk taking.

The principles of this strategy are consistent with the Trust's key priorities – patient safety and clinical excellence. Implementation of the Risk Management Strategy will be co-ordinated through the committee and people structure identified in this strategy. This strategy will be reviewed on an annual basis and more frequently if new legislation or guidance mandates this to be necessary. This strategy is supported by a number of key Trust policies named in this strategy which clearly describes the processes that the Trust has put in place in order to robustly manage risk. The content of the strategy complies with current best practice, NHS Litigation Authority and Department of Health requirements.

1.3 Policy Description

The strategy covers clinical, organisational and financial risk, and identifies the key management structures and processes defining objectives and responsibilities within the Trust. This strategy confirms the Trust's commitment to developing a responsible culture. This will in turn, help maximise the identification, reporting and avoidance of risk, promoting the safest possible environment for patients and staff. Healthcare provision is by nature a high risk activity. The challenge for all staff is to reduce the potential for incidents occurring by being proactive in the management of risk through undertaking risk assessment, reporting incidents, maintaining 'Live

risk registers' responding positively to recommendations and requirements arising from external agency visits, inspections and accreditations. In addition the policy describes the process through which changes in response to active risk monitoring are implemented and how lessons are learned at both an organisational and local level.

2 Strategy / Policy Objectives

i. To provide a framework for the consistent and systematic identification, assessment and management of risk, throughout the organisation.

ii. To clearly define the roles and responsibilities of key staff, Divisional and Service managers, service level committees and sub-committees of the Trust Board with respect to risk management, including the escalation process.

iii. To implement risk management throughout all levels of the organisation including systems, processes and training

iv. To move towards better risk taking sensitivity in its decision making in line with the good governance risk appetite matrix.

v. To develop SFHNFT as the best place to receive care.

vi. To develop SFHNFT as a great place to work.

vii. To encourage innovation and excellence through transformation in order to deliver better quality and to reduce waste. (see the Trust's Quality Strategy)

3 Introduction

i. Risk Management is not an end in itself but is an essential component of the effective management of the organisation and the achievement of its strategic objectives. Risk is an inherent factor in all decisions and activities an organisation takes. In order to ensure that decisions made are risk informed and that risks associated with activities are reduced or eliminated where possible; it is essential to have an organisational culture in which effective risk management is integral. Risk management is about focusing upon experiences and learning lessons from Incidents, Claims and Complaints (see the Incident Reporting Policy, Concerns and Complaints Policy and Claims Handling Policy and Procedure), in order to improve upon clinical outcomes, improve the working environment, assess and, where possible, anticipate risk and thereby eliminate or reduce risk or harm, by enacting controls that are proportionate to the level of risk. This organisational Risk Management Strategy therefore outlines the following:

- The risk management arrangements and responsibilities within the Trust.
- The framework for internal controls assurance, the standards promoted mainly by (but not exclusively) the NHS Litigation Authority, the Care Quality Commission, and Monitor.
- Communication systems supporting risk management, clinical governance and Health and Safety.

- The development and implementation of systems designed to identify and assess risks leading to control measures to reduce or eliminate those risks (clinical, non-clinical, strategic, reputational and financial risk).
- Improved performance in risk management issues through communication, education and training.
- The creation of an environment, which secures support and commitment toward risk management.

ii. This is an overarching document embracing all aspects of Risk Management within Sherwood Forest Hospitals NHS Foundation Trust. The Trust has a number of Risk Management policy documents directly related to this strategy which must be read in conjunction with this strategy.

4 Definitions

4.1 RISK MANAGEMENT

i. A widely accepted definition of a risk is:

> "The probability or likelihood that harm, damage or loss may occur, coupled with the consequences of that harm".

ii. Whether applied to the processes, environment or people the identification and the management of risks will always be of greater value than an academic debate upon the definition and for the Trust's purposes risk management is described as a five stage process, namely:

1. The identification of all risks, which have potentially adverse, effects on the Trust's business and the safety of patients, staff and visitors, together with the quality of service.
2. The assessment and evaluation, elimination and reduction of the risks identified.
3. The creation of a system for the protection of assets and income combined with a cost effective service.
4. The creation of a management environment in which pro-active and positive action is taken to eliminate or reduce risks and ineffective or inappropriate working practices.
5. The creation of an environment in which staff are encouraged and supported to report errors, near misses and untoward incidents so that learning and improvement is the outcome.

iii. Risk management, therefore, applies to:

a) Material damage or loss
b) Loss of income
c) Personal injury
d) Professional negligence
e) Defective material, equipment or working practices

f) Hazardous substances
g) The environment and Health and Safety
h) Policy and Procedural compliance

4.2 CLINICAL GOVERNANCE

i. Clinical Governance is defined by the Government in "A First Class service: Quality in the New NHS" as:

"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish".

ii. Clinical Governance, therefore, is designed to ensure that patients receive the highest quality of NHS care possible and it covers the organisation's systems and processes for monitoring and improving services including:

- Organisational Development.
- Information Systems and Technology.
- User and External Views and Participation.
- Clinical Audit.
- Risk and Performance Management.
- Clinical Effectiveness, Research and Development.
- Incidents, Complaint and Litigation Management.
- Training and Development.
- Policy Frameworks (e.g. NHSLA/CNST policies etc.)

iii. Clinical Governance should, therefore, ensure:

- Continuous improvement of patient services and care.
- A patient-centred approach that includes treating patients courteously, involving them in decisions about their care and keeping them informed.
- A commitment to quality, which ensures that health professionals are up-to-date in their practices and properly supervised where necessary.
- The prevention of clinical errors wherever possible and the commitment to learn from mistakes and share that learning with others.
- Lessons are learned from incidents and near miss reporting

4.3 EXTERNAL AGENCY

i. The definition of an external agency review body is "an organisation that directly, or indirectly (through other bodies) regulates, audits, reviews or undertakes an inspection activity". This would include statutory and non-statutory bodies with a legitimate interest in the Trust and with whom the Trust is expected or requested to cooperate; examples of such organisations include:

- Care Quality Commission
- Mental Health Act Commission

- Commission for Social Care Inspections
- NHS Litigation Authority
- Audit Commission
- National Audit Office
- Health and Safety Executive
- NHS Protect
- Independent Inquiry commissioned by the Strategic Health Authority
- Monitor
- MHRA

4.4 ACCREDITATION

i. Accreditation – relates to audit and review activities of both internal and external bodies, which are required to inform Board Assurance that the services being delivered by the Trust are fit for purpose and achieving the desired outcomes as described in Trust strategy and policies. Accreditation provides independent assurance from a third party that the organisation has achieved a level of compliance with an agreed set of criteria/standards.

4.5 INSPECTION

i. Describes the role of statutory bodies with a remit specific to healthcare to assess and report on the performance of the organisation.

ii. For the purpose of this policy accreditations and inspections' refers to those visits where there are likely to be organisational and strategic implications. Informal visits and those to review operational aspects of a service or department need not be managed by the process described in this policy. Where there is any doubt advice should be sought from the Head of Governance

4.6 INTERNAL CONTROL

i. These describe the systems, procedures and behaviours by which the Trust controls its functions in order to achieve organisational objectives, safety and quality of services.

5 Duties / Responsibilities

Duties of key individuals responsible for risk management activities are outlined below.

5.1 The Chief Executive

i. The Chief Executive, as Chief Accounting Officer, has overall responsibility and accountability for risk management.

ii. The Chief Executive is responsible for signing the Annual Governance Statement. As chairman of the Trust Management Board and the reporting lines into TMB of the Clinical Governance and Quality Committee and other TMB Committees , the

Chief Executive is informed of organisational, clinical, financial, reputational and Health and Safety risk issues and therefore seeks assurance that risk is managed effectively in the organisation through an effective control environment.

5.2 Non Executive Directors

i. The role of Non-Executive Directors is to provide scrutiny of the work of the organisation and to hold Executive Directors to account for their performance. They must also ensure that quality and safety remain a strategic priority.

ii. Non-Executive Directors must be honest and open and develop constructive working relationships with Executive Directors.

iii. A nominated non-executive Director is the chairperson of each of Board's Committees and the Clinical Governance Committee. There is also non-executive membership on and chairmanship of the Trust's Audit and Assurance Committee, which has responsibility for ensuring that effective systems are maintained for governance, risk management and internal control across the whole of the organisation's activities. They also ensure that underlying assurance processes are in place to demonstrate the achievement of the corporate objectives.

iv. Non-Executive Directors must abide by the specific responsibilities set out in the Audit and Assurance Committee's and all Board committee terms of reference

5.3 Executive Director of Nursing

i. The Director of Nursing has executive responsibility for:

ii. All aspects of risk management and clinical governance. The post holder reports to the Chief Executive and The Board of Directors on all matters relating to Clinical Governance and Quality which includes risk management.

iii. Ensuring as joint chair of the TMB Committee for Clinical Governance and Quality, as an executive member of the Trust Management Board and being in attendance at the Board's Quality Committee that risks are appropriately escalated and that Terms of Reference and membership of these committees are appropriate and relevant and the workplans/agendas reflect the risks to quality and achievement of strategic aims/objectives...

iv. Ensuring Divisional Managers comply with their risk management responsibilities as set out in this strategy.

v. Leadership of the Governance Support Unit responsible for ensuring compliance with clinical governance and quality policies and procedures, managing risks to the achievement of objectives and quality metrics and adherence to clinical policies

vi. Ensure that the Duty of Candour is adhered to with regards to learning lessons from complaints and serious incidents.

5.4 The Medical Director

i. The Medical Director is responsible for:

ii. Ensuring as joint chair of the TMB Committee for Clinical Governance and Quality, as an executive member of the Trust Management Board and being in attendance at the Board's Quality Committee that risks are appropriately escalated and that Terms of Reference and membership of these committees are appropriate and relevant and the workplans/agendas reflect the risks to quality and achievement of strategic aims/objectives..

5.5 Chief Financial Officer

i. The Chief Financial Officer is responsible for:

ii. independence of Internal Auditors and appropriate IA plan to support systematic testing of control environment and appropriate reports to Audit and Assurance Committee

iii. Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies.

iv. Ensuring that detailed financial procedures and systems incorporating the principles of separation/segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions.

v. Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time and without prejudice to any other functions of Directors and employees to the Trust, the duties of the Chief Financial Officer include:

   a. The provision of financial advice to the Trust and its Directors and employees
   b. The design, implementation and supervision of systems of financial control
   c. Risk management as it relates to the policies, procedures and systems of financial control and management throughout the Trust.
   d. Ensure that financial risks are discussed and managed through the Finance Committee

5.6 Director of Human Resources

The Executive Director of Human Resources is responsible for:

i. The strategic direction of human resources for the Trust and for providing advice and guidance on all aspects of the Trust's workforce. This includes delivering related strategic objectives and monitoring risks that may threaten the achievement of these.

ii. The Director is also responsible for promoting and encouraging staff to report concerns in line with the Whistle blowing policy and monitoring the effectiveness of this policy.

iii. As chair of the O.D. and Workforce Committee ensures that O.D. and Workforce risks are identified, discussed and managed appropriately through the O.D. and Workforce Committee .

iv. Executive lead for Health and Safety ensuring that robust systems and processes are in place within the Trust.

v. Ensures that an effective appraisal process is in place within the Trust.

5.6 Director of Operations

The Director of Operations is responsible for:

i. Has delegated responsibility for risks associated with operational management.

5.7 Director of Corporate Affairs/Trust Secretary

ii. Responsible for the oversight and management of the Board Assurance Framework
iii. Ensuring alignment with the Corporate Risk Register
iv. Ensures that risks are identified and added to the BAF where appropriate
v. Responsible for the risk management training of Board members and following up those that do not attend.
vi. Keeping records of attendance for Board Risk Management training.
vii. Responsible for ensuring that risk is an integral part of the committee structure and incorporated into key agendas.

5.8 Divisional Managers / Clinical Directors

i. Divisional Managers and Clinical Directors are responsible for promoting effective risk management and ensuring there are effective and efficient operational systems in place within their service areas to implement effective risk management in compliance with this Risk Management Strategy by the development and implementation of local risk management treatment and interventions.

ii. Manage risk through a performance management framework. This includes ensuring staff receive appropriate training, promoting risk management, including incident and near miss reporting and feedback, and ensuring environmental, non-clinical and clinical risk assessments are conducted and necessary action plans developed and monitored for full implementation.

iii. Identify appropriate resources (including time, technology, access to other staff and inclusion in management/ staff meetings) to address risk management issues, including risk assessment action plans by linking them to service planning and by developing and reviewing the services risk registers.

iv. Implement and support appropriate policies and procedures to minimise risks within the Trust, ensuring policies and procedures are up to date and applied within their services.

v. Escalate risks where necessary to the Trust's corporate risk register. (need to make clear here that still divisional responsibility to manage their own risks even when escalated also to CRR

5.9 Head of Governance [Support Unit]

i. To act as the Chief Executive's key agent in overseeing clinical governance and risk assurance across the Trust. The Head of Governance has the authority, on behalf of the Executive Director of Nursing to intervene in any part of the Trust where controls to manage key risks are inadequate.

ii. To establish and maintain robust clinical governance systems within the organisation.

iii. Ensure the integration of risk management into all functions of the Trust.

iv. Provide expert advice, guidance and instruction on clinical governance matters to ensure that the organisation minimises risk, meets its statutory requirements and delivers high quality patient care.

v. Liaise closely with the Director of Corporate Services/Company Secretary and Executive Directors to ensure the Chief Executive receives appropriate assurance on all aspects of the business and in particular the Assurance Framework.

5.10 Risk Manager

i. The Risk Manager is responsible for maintaining and updating appropriate and compliant risk management policies and procedures including an effective capturing and reporting of Corporate Risks through the Corporate Risk Register.

ii. Supports escalation of risk for consideration of inclusion on the Board Assurance Framework in conjunction with the Head of Governance and the Director of Corporate Services/Company Secretary.

iii. Is responsible for ensuring the Trust has dynamic risk registers in place at a corporate and divisional level/ward level. Working with divisional teams to ensure they understand their accountability and responsibilities for managing risks in their areas.

iv. Is responsible for ensuring risk reports are formulated for the Trust Board Committee and TMB Structure and Divisional Governance meetings.

v. Is responsible for the oversight and management of the Datix Risk Management System risk register module.

vi. Line management of the Datix lead and Datix co-ordinator.

vii. Is responsible for producing and co-ordinating risk management training programmes.

viii. Communicating and collaborating with external stakeholders with regards to any risk management matters.

5.10 Divisional Clinical Governance Managers

i. Co-ordinate the risk management agenda in the Divisions and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Divisions.

5.11 Ward/Departmental Managers

i. Ward and Department Line Managers ensure that relevant staff training is provided and incidents are reported and actions taken when required. They provide feedback to staff, ensuring that Trust policies, procedures and guidelines are followed to minimise risk.

ii. It is the responsibility of the Human Resources Line Managers/Estates Managers to ensure that agency and contract workers receive relevant risk management information.(See Control of Contractors Policy)

iii. Do we need to be stronger regarding support for a strong reporting culture – fundamental cornerstone of effective risk management especially near miss reporting

5.12 All Trust Employees

i. Individuals are responsible for reporting any identified risks in order that they can be addressed and are accountable for ensuring their own competency and that their training needs are met in discussion with their line managers. Individuals must ensure they attend induction and statutory and mandatory training as required, including training on Risk Management. They must ensure that they practice within the standards of their professional bodies, national standards and trust policies procedures and guidelines.

ii. Again what about real emphasis on reporting incidents being aware of Whistleblowing policy, near misses etc

6 Risk Management Trust Principles

i. The Trust Board has legal and statutory obligations, which demand that the management of risk is addressed with a strategic and organised approach to ensure that risks are eliminated or reduced to an acceptable level. In this context the Trust Board defines "acceptable" as follows:

"Risks are where the combined assessment of likelihood and impact show that the cost of remedial action is disproportionate to the loss".

ii. The Trust is committed to the continued development of a risk management system to support the Trust five key aims in accordance with NHS guidance and best practice. This ensures that risk management is an integral part of the Trust's objectives, plans and management systems. We are committed to providing efficient and effective health care to our patients and a safe and healthy working environment, by using risk management to ensure high quality and safe patient care and to preserve the financial stability of the Trust. To this end the risk register will be utilised to prioritise the management of risk, operationally, tactically and strategically.

iii. Within the context of this commitment, the Trust will comply with all statutory and mandatory requirements and create the management arrangements and environment, which recognises the management of risk as a key organisational responsibility. This requires that all managers and clinicians accept the obligations and responsibilities outlined in the content of this strategy as one of their fundamental duties, incorporating risk assessment into their everyday planning and strategic duties, including business planning, cost reduction strategies and introduction of new services or changes to service delivery.

iv. In addition, every member of staff will be encouraged to recognise their personal obligations and responsibilities in identifying and minimising risks. This requires a robust and on-going process whereby risks are not only identified but also assessed with the objective of securing improvements to service delivery and practices. The reporting of incidents including serious incidents, near misses and errors and the risk assessment process, are essential to this purpose and will be actively monitored and encouraged.

v. The Board of Directors will be assisted by the work of the Board Committee Structure (Appendix 5) to continuously integrate the management of risk, safety and quality into the daily operation of the Trust and will draw on its sources of independent assurance from external agencies to be assured on the effectiveness of its internal processes.

7 Risk Management Process

7.1 Identification of Risks

i. Risks are primarily identified through the risk assessment process, however they can be identified through a number of other avenues such as following a safety alert (e.g. from the Medicines and Healthcare Products Regulatory Agency (MHRA)), internal incident reports and reports issued by external bodies into areas of risk in the wider NHS. A risk may be realised if the Trust was not compliant with the steps outlined within the alert. (see appendix xxx for risk identification tools)

ii. Corporate risks are identified through threats to such as the financial and operational/quality performance of the Trust and through failure to meet national targets. Corporate risks are also identified by the Divisions where the risk impacts more than one division, the division identifying the risk should decide if this needs to be incorporated into the corporate risk register, if the division cannot decided the risk should be escalated to the Trust Management Board for them to decide (see risk escalator Appendix 1). Any risk identified should be graded using the risk

rating/grading tool found in (Appendix 1) and added to the appropriate risk register if not resolved.

iii. Clinical Risk Management is a process where risks associated with patients' treatment or care are identified and analysed. Steps are then taken to reduce, control, or eliminate the risk. Local ownership of the assessment is essential in identifying potential or actual clinical risks for which measures can be put in place to remove or reduce the likelihood of occurrence.

7.2 Process for assessing all types risks

There are five key steps in the Risk Assessment Process:

Step 1

- Risk assessments should be undertaken by staff who have received training in the risk assessment process.
- Clinicians are responsible for clinical risk assessments when planning care and ensuring they are documented appropriately in case notes/pathways/care plans and/or nursing notes.

To identify the hazards.

- Observe the workplace overall and then systematically address individual areas, processes, including clinical procedures, drugs, chemicals or items of equipment.
- Look for what could reasonably be expected to cause harm. Ask people who work in the area for their opinion.
- For equipment and COSHH related hazards, refer to manufacturers' instructions or data sheets that can help to spot hazards and put risks into their true perspective.
- Review all incident / accident, complaint and claims and ill health records for themes as identified.
- horizon scanning, national inquiries etc to be alert to risks that have materialised elsewhere etc

Step 2

Decide who/what is likely to be harmed and how.

- Consider those people who may not be in the workplace all of the time e.g. employees (including agency / temporary staff), patients, visitors, contractors etc.

Step 3

- Evaluate the risks arising from the hazards and decide whether existing control measures are adequate or not.
- When you have identified the need for action, it is then necessary to consider introducing additional control measures.
- The use of the mnemonic ERIC helps to identify the strategy for control measures in order of importance:

E: Eliminate
Can the hazardous product or process be eliminated completely?

R: Reduce
Can the level of exposure to the hazard / potential for harm be lessened, or can a less hazardous alternative process/ product be used?
I: Isolate
Can personnel/patients be removed or protected from the potential harm?
C: Control
Can the risk of harm/ potential harm be controlled by?

- Methods of work/Procedures
- Training
- Information
- Instruction
- Supervision
- Provision of protective equipment

Step 4

- Record the risk assessment findings on the relevant record (e.g.DATIX Risk Register, Non-Clinical Risk assessment templates).
- Using the risk assessment matrix, establish the appropriate risk rating for the identified issue to provide an indication of significant risks that need urgent attention.
- Document control measures to be taken to eliminate/reduce the risk.
- Report findings to the relevant line manager.
- Risks rated as 15 or above should be recorded on and monitored/managed through the local risk register and escalated appropriately as per the escalation process. (Trust Management Board will consider risks to be added to the corporate risk register).

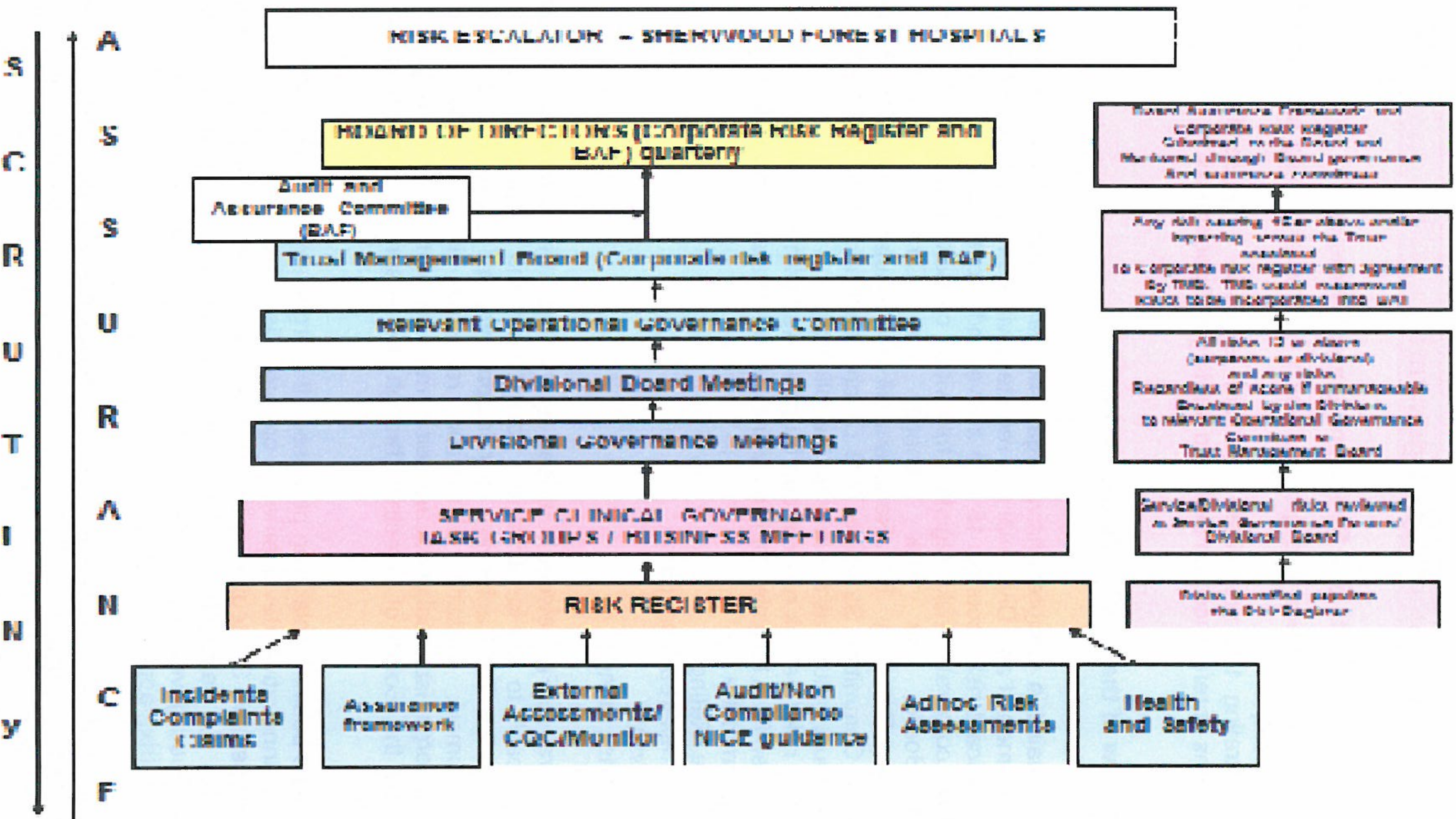
Step 5

- Review the assessment regularly including when new staff, new equipment or new methods of work are introduced.
- Maintain vigilance to ensure the risks remain controlled. If there are any significant changes, the relevant individual should carry out a further assessment to take account of the new circumstances.

7.3 Risk Management and Escalation

i. 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 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.

ii. 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 need to be escalated to the Board via the Corporate Risk Register and the BAF.



App 1

8 Organisational & Management Arrangements

8.1 Organisational Arrangements and Risk Management Structure

i. (Committees / sub-committees and groups, which have overarching responsibility for risk management)

ii. A diagram illustrating the committee structure is given in appendix 4. The Committee's terms of reference can be found starting at Appendix xx

8.2 Process for review of the Trust wide risk registers

i. The Trust will maintain comprehensive organisational, divisional and service risk registers. Departmental and Divisional risk registers will identify all risks within their areas and significant risks scoring 15 and above and organisation wide risks will feed into the corporate risk register following consideration by the Trust Management Board, the Risk Manager and Director of Corporate Services/Company Secretary. Risk Registers will be a regular agenda item through the Trust Board Committee Structure,TMB Committee's and Divisional Risk Fora. Risk Registers must include as a minimum the following:
   1. Source of risk (the risk register can be populated with risks from a variety of sources see Risk Register for Risk Management Strategy Appendix xx)
   2. Description of the risk
   3. Risk Score /Rating
   4. Summary risk treatment plan
   5. Date of review
   6. Residual risk rating

ii. The Board Assurance Framework is utilised by the Trust Board as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its principal strategic goals. The assurance framework document contains information regarding internal and external assurances that organisational goals are being met. The corporate risk register will be reviewed by the Board of Directors through the assurance framework on a quarterly basis.

iii. During the Trusts business planning processes the organisation will frequently give consideration to innovative, developmental opportunities which are inherently risky. The Risk Management Strategy 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 xx)

iv. Where risks are identified, mitigations and subsequent action plans are mapped against them. The risk register is used to develop the Board Assurance Framework which is scored using a 5x5 matrix of impact and likelihood (see Appendix x for the risk matrix). This adapted matrix is recommended by the National Patient Safety Agency. This is a 5x5 matrix, in which scores for impact or consequence of the risk

is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating. All risks scoring 15 and above will be reviewed monthly by the Trust Management Board and Board of Directors, where Divisions will be expected to escalate their high-level risks. Risks having a corporate impact will be escalated to the Trust Management Board for a decision for inclusion onto the corporate risk register which in turn will be considered for inclusion onto the Board Assurance Framework if there is a likely impact on the strategic risk profile.

v. The Trust Board has delegated responsibility of monitoring risks and assurances to the Trust Board Committee structure comprising the Audit and Assurance Committee, the Finance Committee and the Quality Committee. The Audit and Assurance Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

8.3 Annual Governance Statement

i. NHS Chief Executives as Accounting Officers are required to provide an Annual Governance Statement in their annual accounts. This statement describes the arrangements to identify and manage risks to the organisation's objectives and the effectiveness of the system of internal control covering four key risk areas:

- Clinical Governance
- Corporate Governance
- Financial Governance
- Information Governance

ii. The Trust's risk management system is designed to ensure that controls are effective and co-ordinated throughout the Trust by identifying and prioritising risks. In practice this requires the Trust not only to map out the risks and controls and the level of assurance required in each area, but also to identify where additional work is required to provide the assurances. The Trust's governance systems advise upon any changes in statutory or legislative requirements related to clinical or non-clinical risk respectively, and where appropriate produce policies and procedures to ensure compliance.

iii. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise the risks to the achievement of the Organisation's policies, aims and objectives.

- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

8.4 Process for the management of risk locally organisation wide risk management strategy

i. Each Division/Department will complete risk assessments, as per the Trust's Risk Management Strategy and associated Risk Assessment Policy. The locally identified risks, derived from completing the risk assessment template, will be utilised to formulate the Divisional/Departmental risk registers. Divisional Managers/Heads of Corporate Functions are responsible for ensuring that actions are put in place to mitigate identified risks. The Divisional Manager must escalate any risk with a score of 15 or has Trustwide implications to the appropriate operational governance committee for discussion and consideration to be included within the Trust's corporate risk register. All risks need to be considered and managed at a local level at Divisional Management Boards and other forums.

ii. Divisional Managers are required to attend relevant risk management committee meetings e.g. TMB (operational governance) Committees, Health and Safety Committee and any of the Trust Board Committee's as and when required.

iii. Department Managers must highlight all high/extreme risks to their line manager (i.e. Divisional Managers/ Heads of Corporate Functions).

iv. Divisional Managers and Corporate Heads of Department must escalate all identified extreme risks to their line manager i.e. Executive Director/Deputy/Assistant Director for consideration within the high-level risks for review by the Trust Management Board

8.5 Communication and Stakeholders

i. The Trust will work collaboratively with other local organisations and stakeholders in relation to risk management. This will include participating in local and regional forums related to risk management, working closely with the relevant NHS England, Health & Safety Executive and Care Quality Commission representatives and working with other local Trusts to identify risks, learn lessons and share good practice.

ii. Local Stakeholders/partners include:

Internal	**External**
Patients	NHS England
	NHS Litigation Authority
Employees	Care Quality Commission
Volunteers	Media
Employee Groups/Unions	Coroner
Contractors	Strategic Health Authority
Council of Governors	Trust Solicitors
Local NHS Trusts including CCGs	
Parents/Carers	Health and Safety Executive
	Environment Agency
	Department of Health

Local Higher Education Establishments
Voluntary Sector Organisations
Monitor
Local Safeguarding Children's Boards
Overview & Scrutiny/H&W Boards

9 Key References

i. NHSLA Risk Management Standards for Acute Trusts
ii. Clinical Negligence Scheme for Trusts – Maternity Clinical Risk Management Standards
iii. A Risk Matrix for Managers (NPSA), 2008.
iv. Civil Contingencies Act (CCA) 2013.
v. Health & Social Care Act (HSCA) 2012

10 Associated Documents

This list does not represent ALL policies related to risk management but are considered to reflect the list of key documents supporting the management of risk):

- The Incident Reporting Policy
- Concerns and Complaints Policy
- Claims Handling Policy and Procedure
- Fire Safety Policy
- Health and Safety Policy
- Infection Prevention and Control Policy
- Major Incident Plan
- Business Continuity Plan
- Management of Violence and Aggression
- Lone Workers Policy
- Manual Handling Policy
- Medical Devices and Equipment Management Policy
- Consent Policy
- Transfer and Discharge Policy
- Risk Assessment Policy
- Security Policy
- Lockdown Policy

11 Risk Management Training

i. The Trust must ensure that training is provided in order that the objectives of this strategy are met. Risk Management training commensurate with the duties of individuals should be made available to staff through the TNA process.

ii. The Board of Directors, (including Executive and Non-Executive Directors), must receive higher level risk management training on an annual basis. The annual training should update members on their collective/ individual roles and responsibilities in relation to the management of risk and promotion of quality improvement across the Trust. The Director of Corporate Services/Company Secretary will receive an Exception Report for non-compliance against Board level mandatory training. It is the Company Secretary's responsibility to follow up non-

attendance at mandatory training and enhanced risk management training for Board members to ensure full compliance is achieved.

iii. Individuals must not take on the role as Lead Investigator for a Root Cause Analysis (RCA) investigation unless they have undertaken Root Cause Analysis training. This training is delivered through the Governance Support Unit. The details of individuals who have been trained are recorded on the OLM system.

iv. 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 as part of the Statutory and Mandatory Training programme. (See Mandatory Training Policy).

v. Several specialist courses are also open to staff, details of which can be found in the Trust's Annual Training and Development Bulletin. Examples of these are:

- Conflict Resolution Training
- Root Cause Analysis (RCA)
- incident reporting
- Risk Management
- Risk assessment course
- Health and Safety courses

vi. A training needs analysis for risk management training has been developed and is available in the Mandatory training Policy via the intranet.

12 Policy Administration

12.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes (✓)		No (Tick)
External Stakeholders	None identified		
Trust Staff Consultation	This policy needs to be consulted upon with key internal stakeholders		End Date:

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
Circulate strategy and template to all Divisional Managers; Senior Managers (clinical and non-clinical) and Service Managers	Implementation of the policy is the responsibility of service managers.

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
7			
6			
5			
4			
3			
March 14	2	Shelley Watson – Interim Head of Risk	
October 12	1	Interim Company Secretary	Training, risk grading matrix, risk escalation process and new accountability and responsibility structure

12.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
In date Risk Management Strategy (RMS) in place with risk management structures described	Approved	Audit of Minute – approved by Board of Directors (BOD)	Trust Management Board	Annual	Risk Manager
Responsibility for risk is reflected in the terms of reference for Board Standing Committees	Included in Standing Orders	Annual Audit of RMS	Trust Management Board	Annual	Company Secretary
Review of the Trust's Assurance Framework in full by the Board of Directors	Quarterly	Board minutes Satisfactory Internal Audit Opinion	Trust Management Board	Annual	Company Secretary
Risk graded at 15 or above using the Trust risk scoring matrix reported to the Trust Management Board for consideration for inclusion on CRR	100%	TMB Minutes	Board of Directors	Annual	Head of Governance/Risk Manager
Risk Register reviewed at TMB (operational governance) Committee's	On agenda monthly	Committee agenda's and minutes	Trust Management Board	Annual	Head of Governance/Risk Manger

12.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Head of Governance/Risk Manager	Trust Management Board	Quarterly

13 Appendices

13.1 Risk Categorisation Matrix (APPENDIX 2)

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

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 (4-14 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) ▸ Failure to adhere to principles of the duty of candour /being open	▸ 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%)
Complaints / Claims	▸ Informal / locally resolved complaint ▸ Potential for settlement / litigation <£500	▸ Overall treatment / service substandard ▸ Formal justified complaint (Stage 1) ▸ Minor implications for patient safety if unresolved ▸ Claim <£10K	▸ Justified complaint (Stage 2) involving lack of appropriate care ▸ Claim(s) between £10K - £100K ▸ Major implications for patient safety if unresolved	▸ Multiple justified complaints ▸ Independent review ▸ Claim(s) between £100K - £1M ▸ Non-compliance with national standards with significant risk to patients if unresolved	▸ Multiple justified complaints ▸ Single major claim ▸ Inquest / ombudsman inquiry ▸ Claims >£1M
Financial	▸ Small loss ▸ Theft or damage of personal property <£50	▸ Loss <£50K ▸ Loss of 0.1 - 0.25% of budget ▸ Theft or loss of personal property <£750	▸ Loss of £50K - £500K ▸ Loss of 0.25 – 0.5% of budget ▸ Theft or loss or personal property >£750	▸ Loss of £500K - £1M or loss of 0.5 – 1% of budget ▸ Purchasers failing to pay on time	▸ Loss > £1M or loss >1% of budget ▸ Loss of contract / payment by results
Objectives / Projects	▸ Interruption does not impact on delivery of patient care / ability to provide service ▸ 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 ▸ Disruption causes unacceptable impact on patient care ▸ Non-permanent loss of ability to provide service	▸ Loss / interruption of > 1 week. ▸ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ▸ Temporary service closure	▸ Permanent loss of core service / facility ▸ Disruption to facility leading to significant 'knock-on' effect across local health economy ▸ Extended service closure
Inspection / Statutory Duty	▸ Small number of recommendations which focus on minor quality improvement issues ▸ No or minimal impact or breach of guidance / statutory duty ▸ Minor non-compliance with standards	▸ Minor recommendations which can be implemented by low level of management action ▸ Breach of Statutory legislation ▸ No audit trail to demonstrate that objectives are being met (NICE; HSE;NSF etc.)	▸ Challenging recommendations which can be addressed with appropriate action plans ▸ Single breach of statutory duty ▸ Non-compliance with core standards <50% of objectives within standards met	▸ Enforcement action ▸ Multiple breaches of statutory duty ▸ Improvement Notice ▸ Critical Report ▸ Low performance rating ▸ Major non compliance with core standards	▸ Multiple breaches of statutory duty ▸ Prosecution ▸ Severely critical report ▸ Zero performance rating ▸ Complete systems change required ▸ No objectives / standards being met
Adverse Publicity / Reputation	▸ Rumours ▸ Potential for public concern	▸ Local Media – short term – minor effect on public attitudes / staff morale ▸ 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. ▸ MP concerned (questions in the House) ▸ Total loss of public confidence
Fire Safety / General Security	▸ Minor short term (<1day) shortfall in fire safety system. ▸ Security incident with no adverse outcome	▸ Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) ▸ Security incident managed locally ▸ Controlled drug discrepancy – accounted for	▸ Fire code non-compliance / lack of single detector – patient area etc. ▸ Security incident leading to compromised staff / patient safety. ▸ Controlled drug discrepancy – not accounted for	▸ Significant failure of critical component of fire safety system (patient area) ▸ Serious compromise of staff / patient safety	▸ Failure of multiple critical components of fire safety system (high risk patient area) ▸ Infant / young person abduction
Information Governance / IT	▸ Breach of confidentiality – no adverse outcome. ▸ Unplanned loss of IT facilities < half a day ▸ Health records / documentation incident – no adverse outcome	▸ Minor breach of confidentiality – readily resolvable ▸ Unplanned loss of IT facilities < 1 day ▸ Health records incident / documentation incident – readily resolvable	▸ Moderate breach of confidentiality – complaint initiated ▸ Health records documentation incident – patient care affected with short term consequence	▸ Serious breach of confidentiality – more than one person ▸ Unplanned loss of IT facilities >1 day but less than one week ▸ Health records / documentation incident – patient care affected with major consequence	▸ Serious breach of confidentiality – large numbers ▸ Unplanned loss of IT facilities >1 ▸ 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

[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, cancelling 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
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

(HCSU/RMWG/2004 & NPSA 2008)

E = Extreme risk – immediate action required (stop the activity)

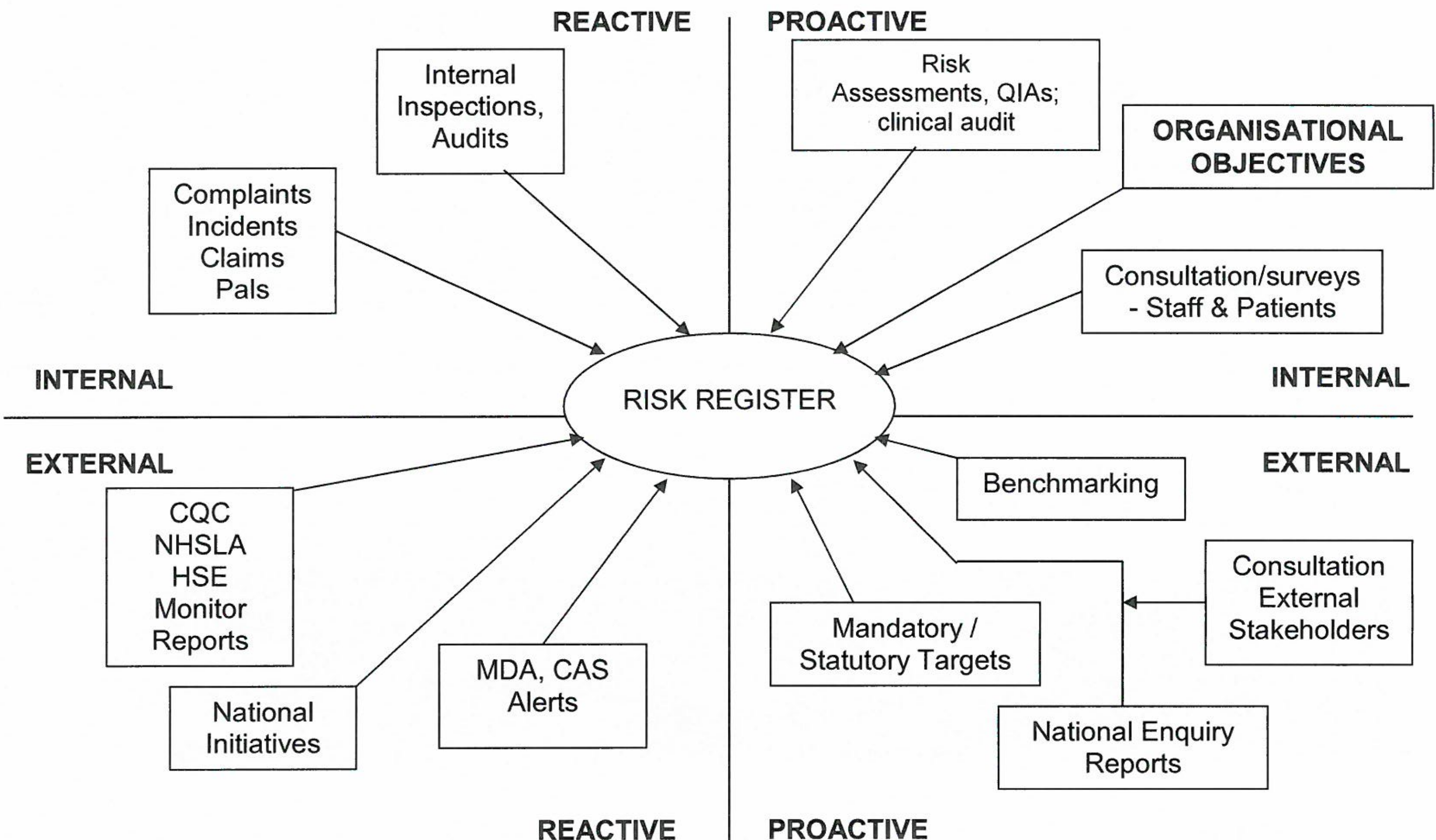
H = High Risk – Senior Management attention needed

M = Moderate Risk – management responsibility must be ascertained

L = Low Risk – manage by routine procedures

13.2 Risk Register for Risk Management Strategy APPENDIX 3

The common sources of information that are used by NHS organisations to populate their Risk Registers



Formulating a Risk Register

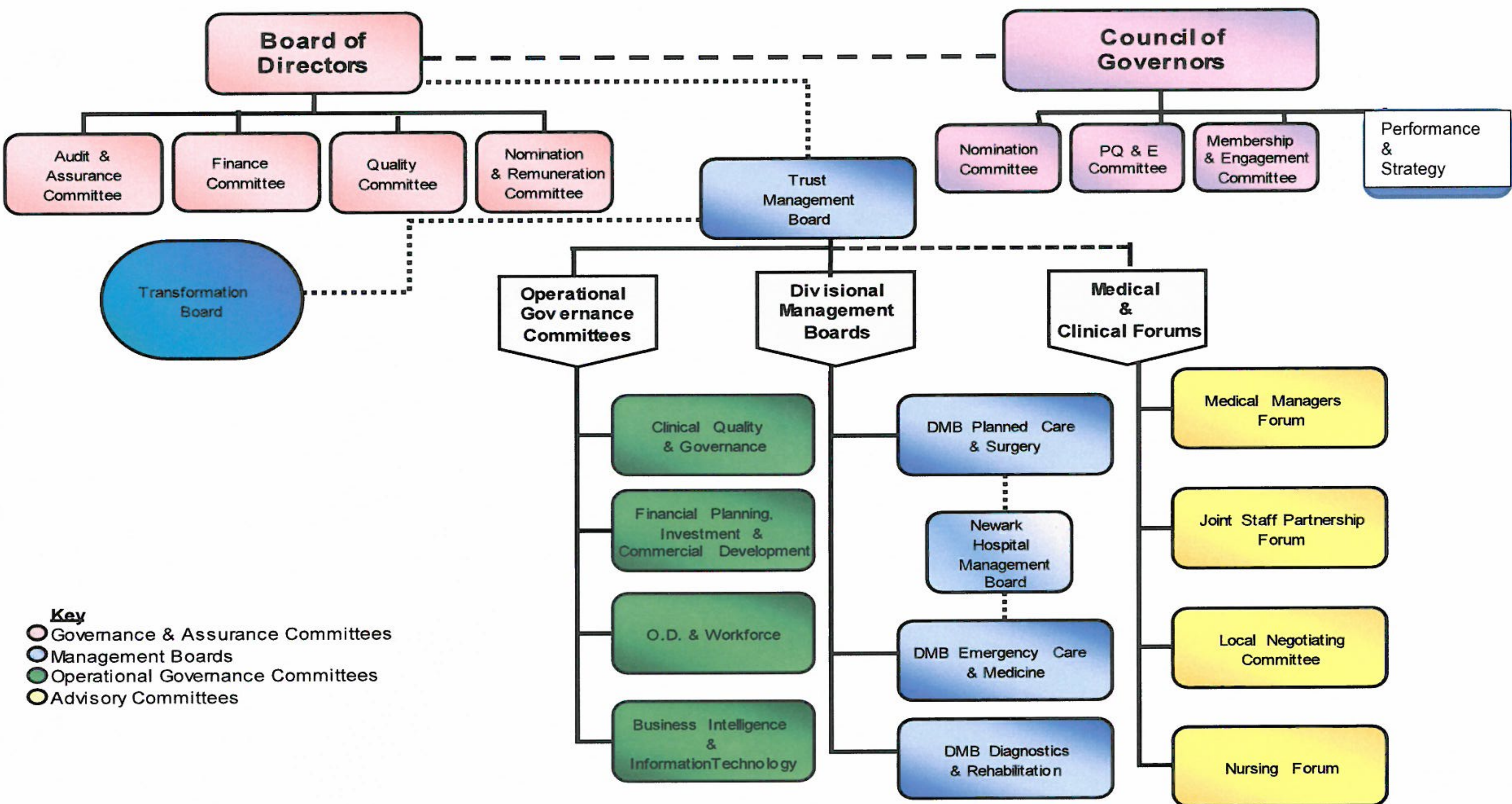
13.3 Risk Appetite (APPENDIX 4)

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 ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (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 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** 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 5



13.4 Initial Equality Impact Assessment Screening Tool