Tees, Esk and Wear Valleys
NHS Foundation Trust

Organisational Risk Management Policy

Ref: CORP-0066-v1

Status: Approved
Document type: Policy

Contents

1 Introduction

The Trust exists in an uncertain and challenging environment. It can only achieve its aims, providing high quality services and positive outcomes for patients, by managing, often competing, risks.

How risks are managed is, therefore, vital in making the Trust a safe, sustainable and successful organisation.

This document sets out a structured approach to identifying, assessing, evaluating and responding to risks.

It also seeks to inform business planning and all decision making by articulating the levels and types of risk which the Trust is prepared to accept in pursuance of its objectives (its "risk appetite").

(Note: This policy does not cover the assessment and management of clinical risks relating to individual service users. This is set out in the Harm Minimisation Policy).

2 Why we need this policy

2.1 Purpose

The purpose of this document is to describe and detail the arrangements for organisational risk management in the Trust.

The policy:

- Provides a consistent and standardised approach to the identification, management and mitigation of risk by which future problems can be prevented.
- Supports the Board, through the Board Assurance Framework (BAF), to focus on those risks which might compromise the achievement of the Trust's strategic objectives.
- Supports ongoing compliance with statutory and regulatory requirements, both clinical and non-clinical e.g. the fundamental standards, health and safety, governance and financial oversight, etc.
- Supports decision making on the future provision and development of services and enables the challenges of different delivery models (e.g. collaboration) to be systematically assessed and controlled.
- Encourages the sharing of good practice and learning lessons across the Trust.
- Forms a key component of the Annual Governance Statement, providing the pubic and stakeholders with assurances about the effectiveness of the organisation's approach to governance, risk and control.

2.2 Definition of Risk Management

Risk management is the continuous process by which risks are identified, assessed, evaluated, controlled or accepted.

It seeks to help the Trust reduce the incidence and impact of the risks it faces.

2.3 Objectives

The objectives of this policy are to:

- Support compliance with regulatory requirements and expectations e.g. the Provider Licence.
- Embed a consistent, systematic and standardarised approach to the management of risks across the Trust.
- Support understanding of, and competence in, the anticipation, assessment and management of risks amongst all staff.
- Provide clarity on the Trust's risk appetite to support effective decision-making.

3 Scope

3.1 Who this policy applies to

This policy applies to the whole Trust and to staff employed by it.

3.2 Roles and responsibilities

3.2.1 Organisational

Role	Responsibilities
Board of Directors	• Determines the Trust's approach to risk management including its risk appetite. • Approves organisational risk management policies and procedures. • Identifies strategic risks, principally through the Board Business Planning cycle, for inclusion in the Board Assurance Framework. • Oversees the Board Assurance Framework and provides direction on action to reduce the Trust's exposure to strategic risks. • Monitors (by exception) the management of operational risks contained in the Corporate Risk Register receiving assurance from the Executive Management Team (EMT). • Approves all risk control related statements (e.g. the Annual Governance Statement) taking assurance from the Audit Committee.

Audit Committee	• Provides assurance to the Board (through its oversight of governance, risk management and internal control) on the effectiveness and robustness of the Trust's risk management arrangements and controls environment. • Reviews the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board. •
All Board Committees, including the Audit Committee	Within their terms of reference: • Provide assurance to the Board on the effectiveness of controls. • Identify gaps/weaknesses in control and ensure these are addressed/escalated as required. • Identify and escalate new risks that could impact significantly on the Trust's ability to deliver its Strategic Direction, to the Board. •
Executive Management Team (EMT)	• Ensures the consistent application of risk management policies and processes within the Trust. • Provides assurance to the Board on the delivery of mitigations to reduce exposure to the strategic risks contained in the Board Assurance Framework. • Oversees operational risks contained in the corporate risk register and provides assurance (by exception) on the management of those risks to the Board. • Monitors (by exception) the management of operational risks within the Locality Risk Registers receiving assurance from the Locality Management and Governance Boards. • Agrees and oversees training in relation to risk management.
Specialty Development Groups (SDGs)	• Identify and communicate potential risks arising from national guidance, etc. • Provide advice on mitigating actions for cross-locality clinical risks.
Locality Management and Governance Boards (LMGB)	• Ensure the effective operation of risk management arrangements within their Localities and provide assurance on this to the EMT. • Provide assurance to the EMT on the delivery of mitigations to reduce exposure to risks contained in the Corporate Risk Register. • Oversee operational risks through their Locality risk registers and provide assurance (by exception) on the management of those risks to the EMT. • Monitor (by exception) the management of operational risks contained in the Clinical Directorate risk registers receiving assurance from their Quality Assurance Groups (QuAGs). • Bring material risks to the quality of services to the attention of the Quality Assurance Committee.
Corporate Directorate Management Teams (DMT)	• Ensure the effective operation of risk management arrangements within their Directorates and provide assurance on this to the EMT. • Provide assurance to the EMT on the delivery of mitigations to reduce exposure to risks contained in the Corporate Risk Register.

	• Oversee relevant risks through their Directorate risk registers and provide assurance (by exception) on the management of those risks to the EMT.
Quality Assurance Groups (QuAGs)	• Ensure the effective operation of risk management arrangements within their Directorates and provide assurance on this to the LMGB. • Provide assurance to the LMGB on the delivery of mitigations to reduce exposure to risks contained in the Locality Risk Register. • Oversee operational risks contained in their Directorate risk registers and provide assurance (by exception) on the management of those risks to their LMGB. • Identify and respond to potential risks arising from their consideration of performance information or escalated by wards/team.

*(**Notes**:*

(1) Directors have the ability to tailor their Locality's/Corporate Directorate's risk management arrangements to their governance structure subject to the responsibilities set out above being maintained.

(2) Oversee means:

- *Identifying new risks for inclusion in their risk register and ratifying their score/level*
- *Monitoring the implementation of agreed mitigating actions requiring corrective measures as necessary*
- *Approving material changes to existing risk profiles*
- *Escalating risks where appropriate*
- *Approving the closure or de-escalation of risks.)*

3.2.2 Individual

Role	Responsibilities
Chief Executive	• As the Accounting Officer, overall responsibility for risk management in the Trust. • Owner of the BAF (on behalf of the Board) and the Corporate Risk Register (on behalf of the EMT).
Non-Executive Directors	Satisfy themselves that management controls and systems of risk management and governance are sound and are used effectively.
Trust Secretary	• Provision of support for the Chief Executive e.g.: o The drafting of corporate risk management policies, procedures, etc o Maintenance of the BAF o Preparation of reports to the Board on the BAF/Corporate Risk Register.

	• Provision of independent advice on governance and compliance matters (including risk management) to the Board.
Director of Quality Governance	• Development and maintenance of the risk management system. • Compilation and maintenance of the Corporate Risk Register. • Reporting to the EMT on the corporate risk register. • Identification and commissioning of training and development on risk management. • Provision of best practice advice on risk management within the Trust's quality governance arrangements.
Directors	• Provision of assurance to the EMT on the operation of risk management arrangements within their Locality/Corporate Directorate. • Owner of their Locality/Corporate Directorate Risk Registers (on behalf of their LMGB/DMT). • Ensuring that staff have access to and receive appropriate training on risk management (as agreed by the EMT). • Reporting on the delivery of operational risks to the Quality Assurance Committee (Directors of Operations only). • Risk Managers (on appointment by the Chief Executive) for BAF level risks (Executive and Corporate Directors only). • Risk managers for risks contained in the Corporate Risk Register (on appointment by the Chief Executive). • Ensuring the delivery of mitigating actions assigned to them within required timescales.
Heads of Service	• Provision of assurance to their LMGB/DMT on the operation of risk management arrangements within their Clinical Directorate/Corporate Department. • Owner of their Clinical Directorate risk register (on behalf of their QuAG) or Corporate Department risk register (if appropriate). • Ensuring that staff have access to and receive appropriate training on risk management (as agreed by the EMT). • Risk Managers (on appointment by the Director of Operations/Corporate Director) for risks contained in the LMGB/DMT Risk Register. • Ensuring the delivery of mitigating actions assigned to them within required timescales.
Ward/Team Managers	• Owner of their ward/team risk log. • Identification of emerging/potential risks for escalation to their QuAG. • Delivery of mitigating actions assigned to them by their Head of Service.
All staff	Awareness of risk in performing their day to day duties, and reporting situations which they consider present risk to their line manager.
Risk Owner	• Day to day management of the risk on behalf of a governance group (e.g. LMGB, DMT, QuAG, etc).

	• Reporting to the governance group on the status of risks contained in its risk register and the provision of assurance on:
	  ○ The operation of controls
	  ○ Progress on mitigating actions
	• Responsibility for ensuring maintenance of records on the DATIX system.
	• Appointment of risk managers (if appropriate).

Risk Manager	Day-to-day management of individual risks assigned to them including: • Being able to report on their status • Ensuring appropriate controls are enacted • Ensuring that mitigating actions, if appropriate, are completed within agreed resources/timescales. (The risk owner/risk manager can be the same person)

4 Policy

4.1 Definition of Risk

Risk is an uncertain event or set of events which, should it/they occur, will have an effect on the achievement of objectives.

Risks, therefore, have three elements:

- A definite cause.
- An uncertain outcome.
- An impact/effect on objectives.

It is important to differentiate “risks” from “issues”:

Issue	Risk
Is happening	Not happening now but there is a genuine possibility that it might happen
Action taken to resolve it	Action taken to eliminate the possibility of it occurring or reduce the impact if it does

In simple terms, once a risk occurs it becomes an issue.

4.2 Risk Appetite

Risk appetite is the amount and type of **risk** that an organisation is willing to accept in order to meet its objectives (Strategic Goals).

The Trust recognises that:

- It is impossible to deliver services and achieve positive outcomes for patients and other stakeholders without risk; however, these risks must be managed in a controlled way.
- Methods of controlling risks must be balanced in order to support innovation, learning and the imaginative use of resources when it is to achieve substantial benefit.
- The Trust may accept some high risks because of the cost of controlling them.

In general the Trust:

- Has a low appetite for risks that impact on safety and security, both individually and organisationally. It will, therefore, seek to avoid or substantially control all risks that have the potential to:
    - cause significant harm to patients, staff, visitors, contractors and other stakeholders;
    - have severe financial consequences which could jeopardise the Trust's viability;
    - threaten the Trust's compliance with law and regulation.
- Has a moderate risk appetite for risks that impact on operational delivery or reputational issues. It will, therefore, balance the impact of risks with the potential opportunities; accepting those which provide a satisfactory level of reward (or value for money).
- Has the greatest appetite to pursue quality improvement and innovation and prepared to take opportunities where positive results can be anticipated.

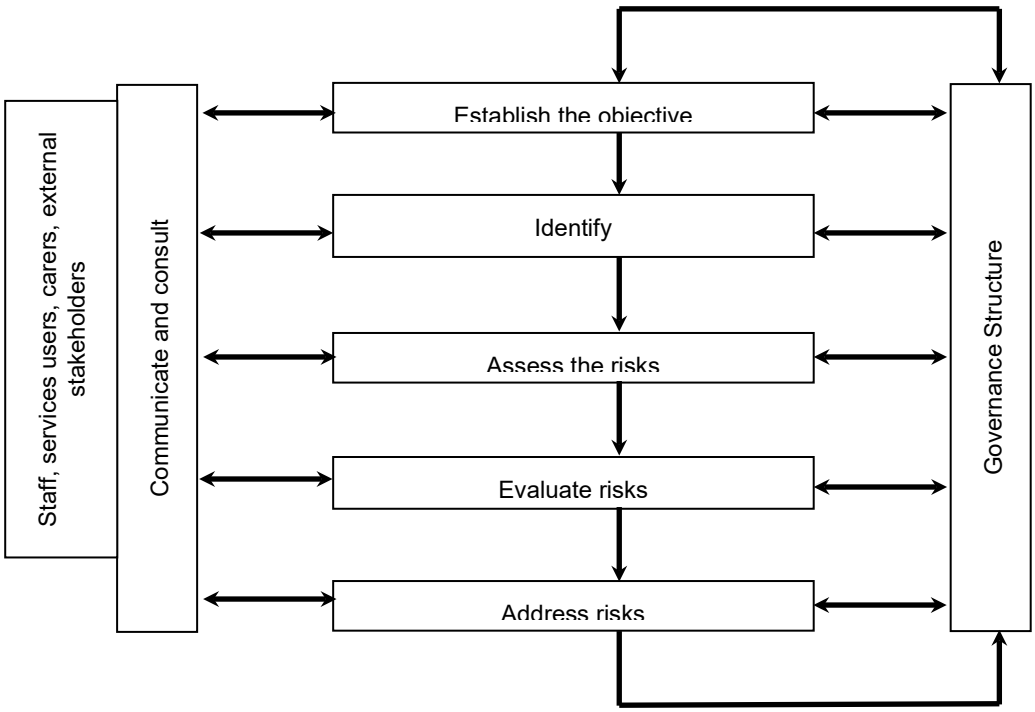
The risk appetite is operationalised through:

- The Risk Management Framework
- The Business Planning Framework
- The Trust's Scheme of Delegation
- Programme and project management arrangements

4.3 Risk Management Framework

The Trust's framework for risk management has five stages: **Establishing** the objective, **Identifying** the risk, **Assessing** the risk, **Evaluating** the acceptability of the risk and finally **Addressing** the risk.

Framework for Risk Management



The principles of the risk management model will be employed to assess all risks in the organisation.

Detailed guidance on the components of the Framework is provided in Appendix 1.

4.4 The Board Assurance Framework

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's Strategic Risks are being managed effectively across the organisation.

It has two main purposes:

- It is a strategic risk register providing a tool to capture and assess actual, specific risks to the achievement of the Trust's objectives and, most importantly, to plan and track the delivery of actions to reduce the likelihood or impact of those risks.
- It provides focus on the health of critical controls to help the Board know whether they are actually working in practice.

The BAF sets out:

- The Trust's principal business objectives.
- The principal risks to their achievement.
- The controls in place to manage the risks.
- The means by which the Board plans to receive assurance as to the adequacy and effectiveness of those controls (for example, internal audits, performance metrics or third party assessments).
- Details of any identified gaps in control.
- Details of any identified gaps in sources of assurance i.e. where there is limited or reasonable assurance available in respect of particular controls
- Remedial actions agreed to close off/strengthen gaps in controls and assurances.
- Planned actions to reduce the likelihood or impact of the identified risks.

The Board has reserved, to itself, oversight for each corporate objective and management of the associated risks and assurances; however, in doing so it relies significantly on assurances (as detailed in the BAF) from its Committees, the Executive Management Team and third parties e.g. the Internal Auditors.

The BAF is maintained by the Trust Secretary on behalf of the Chief Executive.

4.5 Risk Grading and Risk Ownership

All risks will be evaluated to understand the current controls in place to manage them, the potential impact if the risk was to materialise and the likelihood of this occurring.

This is undertaken using a defined process (detailed in Appendix 1 to this policy) through which a risk score (number) and risk grade (narrative/colour) are calculated.

A risk score has three aspects:

- The inherent (original) risk score – this is the level of risk before the application of controls. The calculation of the inherent risk can assist in determining which controls are key.
- The present risk score – this the level of risk at the time of reporting taking into account the controls in place and the progress of actions to mitigate the risk.
- The target (residual) risk score – this is the level of risk once all reasonable actions have been taken to mitigate the risk.

(Note: The present and target risk scores might be the same where it is appropriate to tolerate the risk).

The risk grade determines the approach to oversight, monitoring and escalation/de-escalation of a risk.

The tables below define the risk ownership together with monitoring arrangements and risk tolerance based on the risk grade:

Risk Grade	Authority to accept*	Overseen by:	Monitored by/Assurance to:	Risk Manager appointed by:
Strategic	*Board*	*Board*	-	*Chief Executive*
Very High	EMT	EMT	Board	Chief Executive
High	LMGB/DMT	LMGB/DMT	EMT	Director
Moderate	QuAG	QuAG	LMGB/DMT	Head of Service
Low	Ward/Team Manager	Ward/Team Manager	QuAG	Ward/Team Manager

(Notes:

- "Accept" includes approval of the risk description, risk score/grade and treatment
- *When accepting the risk consideration should be given to the Trust's risk appetite. The risk should be escalated if it is considered that it breaches the general principles set out in section 4.2*
- *Unless stated, delegation arrangements (e.g. to accept risks) in Corporate Directorates shall be at the discretion of the Corporate Director)*

4.6 Risk Registers

The Trust has risk registers at the following levels within its governance structure:

Risk Register	Risk Levels:	Oversight:	Maintained by:
Board Assurance Framework	*Strategic Risks*	*Board of Directors*	*Trust Secretary*
Corporate Risk Register	Very high	EMT	Director of Quality Governance
Locality/Corporate Directorate Risk Register	High	LMGB/DMT	Director of Operations/Executive/ Corporate Director
Clinical Directorate/Corporate Department Risk Register	Medium/Low	QuAG	Head of Service
Team/Ward Risk Logs	Low	-	Ward/Team Manager

(Note: The provision of risk registers in Corporate Departments shall be at the discretion of the Corporate Director. Where these are not maintained the relevant risks shall be included in the DMT risk register)

4.7 Risk Recording

The Trust uses an electronic risk management system, a module of the DATIX system, to maintain the BAF and all risk registers.

The DATIX risk management module is accessible through the Trust's intranet ("Intouch). With the exception of the BAF all staff have access to the risks recorded on the system.

All fields in the system should be completed (including "nil" entries) for all risks.

The system is owned and maintained by the Director of Quality Governance.

Ward/Team Risk Logs are held as hard copies and record the following information only:

- A description of the risk.
- The date is was identified.
- The immediate action taken to address or mitigate the risk.
- The date the risk was discussed by the QuAG or other locality governance group (this must be within 31 days of the risk being identified).
- The outcome of the QuAG or locality group discussion.

4.8 Reporting

4.8.1 The Board

The Board shall consider:

(a) The BAF, in its entirety, twice per year (including to report the outcome of the fundamental review following the approval of the Business Plan).

(b) In the intervening months, reports providing:

- A summary of the positions of risks contained in the BAF.
- The profiles for risks contained in the BAF where approval of significant changes is required or those with mitigating actions due/behind plan.
- A schedule (by exception) of mitigating actions behind plan for those risks contained in the Corporate Risk Register.
- Any new strategic risks identified by the Board's Committees or EMT for potential inclusion in the BAF.

4.8.2 Quality Assurance Committee

The Committee shall determine the format for the reporting of risk as part of the LMGB reports.

4.8.3 EMT

The EMT shall receive and consider quarterly reports on:

(a) The corporate risk register.

(b) The Locality Risk Registers (by exception) including mitigating actions behind plan.

4.8.4 LMGBs/DMTs/QuAGs

At each meeting the LMGB/DMT/QuAG (or equivalent) shall receive and consider:

(a) Its own risk register.

(b) For the LMGBs and DMTs (where appropriate) the QuAG or similar level risk registers (by exception) including:

- Any new risks escalated.
- Mitigating actions behind plan.

(c) For the QuAGs, any risks identified by wards and teams through their monthly reports.

(Note: Report templates are available at: intouch/standard work)

4.9 Amending Risk Registers

Changes to a risk register must be approved by the relevant governance group (e.g the Board, LMGB, QuAG, etc).

A formal note must be made of all significant changes in the minutes of the meeting.

Nothing in the above requirements shall prevent a risk owner from escalating a risk in an emergency but the matter should be formally reported to the next meeting of the relevant governance group.

4.10 Risk Escalation & Step Down

The escalation of risks within the governance structure shall be undertaken in accordance with the Assurance and Escalation Framework based on the risk score.

Appropriate assurance groups for escalation/step-down are as follows:

Risk Register	Group for Escalation	Group for Step Down
Corporate	*Board (if there are strategic implications)*	LMGB/DMT
LMGB/DMT	EMT	QuAG (or equivalent)
QuAG	LMGB	Relevant Governance Group/Ward or Team Manager
Ward Team Risk Log	QuAG	-

Risks shall be escalated/stepped down by the risk owner (on the decision/recommendation of the relevant governance group) based on the assessed risk grading (see section 4.5 above).

Risks may also be escalated where it is considered, taking into account the Trust's risk appetite, that the approval of a higher level governance group is required (e.g. an LMGB might wish to seek the views of the EMT prior to accepting a high graded clinical risk).

(Note: see also the Assurance and Escalation Framework on the requirement, and process, to escalate significant issues/concerns directly to the Chief Executive or another Director)

4.11 Risk Transfers

Where a risk is identified in one area, but the appropriate risk owner sits in another Trust area the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The risk owner at that escalation level should then decide whether to discuss the management of the risk with the proposed receiving area or whether to escalate it further.

For example, *a risk identified by a Team manager within MHSOP but which was felt should be transferred to E&FM would be discussed at QuAG. The Head of Service would then decide whether to raise the risk directly with the E&FM Directorate or whether to escalate the issue to Director of Operations level.*

Where a risk is identified in one area, but the appropriate risk owner sits outside of the Trust, the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The senior risk owner at that escalation level should then decide whether to discuss management of the risk with the proposed external risk owner or whether to escalate it further.

4.12 Risk Closure

A governance group (e.g. EMT/LMGB/QuAG) may determine that a risk should be closed (rather than stepped down in accordance with section 4.10) including in the following circumstances:

- The risk has been terminated or transferred (see Appendix 1)
- Mitigating actions have been completed, resulting in the target risk score being achieved, and there is assurance (evidence) that the actions have been successful.
- Changes have occurred that mean the underlying condition creating the risk has disappeared.

The closure of a risk, including the reasons for doing so, shall be recorded in the minutes of the relevant governance group.

5 Definitions

Term	Definition
Annual Governance Statement	An annual statement signed by the Accountable Officer on behalf of the Board that forms part of the Annual Report. The AGS provides public assurances about the effectiveness of the organisation's approach to governance, risk and control.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved.
Board Assurance Framework (BAF)	The document which brings together, in one place, all of the relevant information on the risks to the Trust's strategic

	objectives
Control	A process, policy or procedure which is being used to manage the risk i.e. to prevent, detect and correct an undesired event.
Consequence (impact)	The effect of a risk if it happened.
Gap in assurance	An area where there is insufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Inherent risk	The assessed level of raw or untreated risk i.e. the amount of risk before the application of controls
Likelihood	The probability that the risk will happen
Mitigation/mitigating action	An action to manage or contain a risk to an acceptable level or to reduce the threat of the risk occurring e.g. new or strengthened controls, improved assurance arrangements, etc.
Positive assurance	Actual evidence that a risk is being reasonably managed and objectives are being achieved e.g. an auditor's report
Risk	Risk is an uncertain event or set of events which, should it/they occur, will have an effect on the achievement of objectives. There must be a genuine possibility that the risk will occur.
Risk appetite	The amount and type of risk that an organisation is willing to accept in order to meet its strategic objectives.
Risk assessment	The systematic approach and processes used to understand and document the threat posed by a risk
Risk grade	An expression of the seriousness of the risk based on the risk score
Risk management	The process by which risk is understood, analysed, addressed and monitored to make sure organisations achieve their objectives.
Risk register	A tool for documenting risks and the actions being taken to mitigate them
Risk score	A numerical value on the quantum of a risk based on its consequence and likelihood.

6 Related documents

The integrated Governance Framework
The Quality Governance Arrangements document
The Assurance and Escalation Framework

The Business Plan
The Corporate Planning Framework
The Performance Management Framework
The Programme Management Framework
The Project Management Framework
As risk controls - all other strategies, frameworks, policies and procedures

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- 1:2:1 coaching will be provided to all Directors and Heads of Service.
- The Board will review and approve the draft BAF (March 2018) taking into account changes to the Trust Business Plan.
- The EMT will consider and approve the draft Corporate Risk Register (February 2018).
- Each LMGB/DMT/QuAG will review their risk registers to reflect this policy and changes arising though the development of their Service Plans (March 2018).

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Board Members	Briefing	One to two hours	Three yearly cycle
Directors/Head of Service	1:2:1 coaching Group Briefing	One hour Half day	On appointment Three yearly cycle
Members of QuAGs	Group Briefing	Half day	Three yearly cycle
Staff identified by Directors/Heads of Service	Coaching (Datix risk management module)	One to two hours	On appointment and thereafter by request

8 How the implementation of this policy will be monitored

An audit of the implementation of the policy will be undertaken by the Nursing and Governance Directorate on behalf of the EMT by the end of April 2018.

The focus of the audit shall be to provide assurance that:

- Risk registers are in place for both EMT and all LMGBs, DMTs and QuAGs.

- Risk logs are in place for all wards/teams.
- The risk registers are held in the approved format.
- Risks are being properly assessed and graded.
- There is evidence of risk escalation/step down etc.
- Reporting of risks is taking place in accordance with this policy.

The EMT will provide a report to the Audit Committee on the outcome of the audit.

Assurance will also be provided by the annual review of the Trust's risk management arrangements in accordance with the Internal Audit Strategy.

The outcomes of the reviews by the EMT and the Internal Auditors will inform the Annual Governance Statement for consideration by the Audit Committee and Board in May 2018.

On an ongoing basis assurance will be provided on the operation of the policy though exception reporting, including progress on mitigating actions, in accordance with section 4.8.

9 Document control

Date of approval:	30 January 2018	
Next review date:	30 September 2021	
This document replaces:	The Risk Management Policy (included in the Integrated Governance Framework)	
Lead:	Name	Title
	Phil Bellas	Trust Secretary
Members of working party:	Name	Title
	The Audit Committee Jennifer Illingworth	- Director of Quality Governance
This document has been agreed and accepted by: (Director)	Name	Title
	Colin Martin	Chief Executive
This document was approved by:	Name of committee/group	Date
	Executive Management Team	10 January 2018
This document was ratified by:	Name of committee/group	Date
	Board of Directors	30 January 2018
An equality analysis was completed on this document on:	22 January 2018	

Change record

Version	Date	Amendment details	Status
1	30 Jan 2018	New policy	Published
1	October 2020	Review date extended	Published
1	06 July 2021	Review date extended to 30 Sept 2021	Published

Appendix 1 - Risk Management Framework - Guidance

1 Purpose

1.1 This document provides detailed guidance on the Trust's risk management framework as set out in paragraph 4.3 of the Organisational Risk Management Policy.

1.2 It covers the following matters:

- Establishing the objective
- Identifying risks
- Describing risks
- Accessing risks
- Addressing risks
- Mitigating risks

1.3 A "one page" overview of the risk management model is set out in Annex 1.

2 Establishing the objective

2.1 The Trust's objectives (its Strategic Goals and Priorities) are set out in the Business Plan and supporting Service Plans.

3 Identifying Risks

3.1 **Annual Review:**

The principal risks to the achievement of the Trust's Strategic Goals will be considered, annually, as part of the refresh of the Business Plan. These discussions will form the basis for the review of the Board Assurance Framework.

The LMGBs/DMTs will undertake a review of the risks to the delivery of their service plans, other key operational risks and risks arising from third parties. In doing so the LMGB/DMT will take into account any directions from the EMT and, if appropriate, the views of the SDGs.

The EMT will consider the outcome of the assessment undertaken by the LMGBs/DMTs to refresh the Corporate Risk Register.

3.2 In-year Reviews:

The identification of risk is not limited to an annual review but is also dynamic. During the year risks will also be identified by the Board, EMT, LMGBs, DMTs, etc through both internal and external sources as set out below:

The standard processes set out in the Trust's Quality Governance Arrangements document, including the work of the Specialty Development Groups, daily lean management and relevant policies (e.g.: the External Agency Visits Protocol) support this approach.

The standard report template has also been designed to ensure visibility of risks.

The governance group identifying the risk will undertake an assessment (see (5) below) to determine its inclusion in the appropriate risk register.

4 Describing Risks

The descriptions of all risks should include:

- *A statement on the hazard (what could go wrong)*
- *A statement on the cause*

Care should be taken in framing the description as it will impact on how the risk is assessed and addressed.

5. Assessing Risks

The assessment of risk will tell us how significant the risk is, how well we control the risk and areas where improved control is required. This will enable us to ensure appropriate oversight of the risk within the Trust's governance arrangements.

It is critical that all available information is gathered at the risk identification stage in order to assess the impact and inform the approach to managing the risk.

The Trust uses the following approach to ensure risks are assessed consistently:

- The risk will be rated in terms of consequence and likelihood.
- The ratings are used to determine the Risk Score.
- The risk grade is identified from the Risk Score.

The following assessments of the risk should be undertaken:

- The position if no controls were in place to manage the risk (the "inherent" risk score).
- The position at the time of assessment taking into account the controls in place and their effectiveness (the "present" score).
- An assessment of the position if all reasonable controls were in place and operating effectively (the "target" risk score).

The assessments will be undertaken by the Risk Manager and reported to the next meeting of the Board, LMGB, DMT or QuAG, etc, as appropriate.

However, where a risk is assessed as having a present risk grade of "very high" (risk score 27+) or "high" (risk score 18-25) the Chief Executive or the relevant Director, respectively, should also be notified under the Assurance and Escalation Framework.

5.1 Rating Consequence and Likelihood

Ratings for a risk's consequence and likelihood are as follows:

Categories for Consequence	Rating	Categories of Likelihood	Rating
Negligible	1	Rare	1
Minor	3	Unlikely	2
Moderate	5	Possible	3
Major	7	Likely	4

Catastrophic	9	Almost Certain	5

Descriptions of the above ratings are provided in Annex 2.

Risks can be multi-faceted, therefore, the domain providing the highest rating should be used.

5.2 Risk Scores

Risk scores are calculated by multiplying the consequence rating by the likelihood rating:

Likelihood Rating							
	Almost Certain	5	5	15	25	35	45
	Likely	4	4	12	20	28	36
	Possible	3	3	9	15	21	27
	Unlikely	2	2	6	10	14	18
	Rare	1	1	3	5	7	9
			1	3	5	7	9
			Negligible	Minor	Moderate	Major	Catastrophic
			Consequence rating				

5.3 Risk Grades

The Trust has identified four risk levels based on the following risk scores:

Risk Grades	Risk scores	
	From	To
Very High	27	45
High	18	25
Medium	7	15
Low	1	6

Example

An LMGB considers that there is a risk to the future provision of services due to projected staff turnover rates.

The LMGB recognises that the risk could impact on safety, quality, regulatory compliance, human resources and on the Trust's reputation.

Firstly, the LMGB examines the inherent risk. Using the criteria set out in Annex 2 it considers:

- *A score of 7 under the "human resources" domain best describes the potential consequences of the risk .*
- *The likelihood of the risk occurring, if there were no controls, should be scored 4 (likely).*

This provides an inherent risk score of 28 (7x4) - a "very high" risk.

Next the LMGB considers the present level of risk.

It recognises that some controls are in place (e.g. the retire and return policy) or are being implemented (e.g. the recruitment and retention action plan; discussions with staff approaching retirement; actions in response to staff friends and family test results, etc); however, it is aware that some of these actions are ongoing and others are not fully embedded.

Taking into account the criteria in Annex 2 it considers that the consequence score should remain at 7 but the likelihood should be 3 (possible). As this risk is, therefore, "high" it is agreed that it should be accepted for inclusion on the LMGB risk register.

Looking at the target (residual) risk score, the LMGB takes into account the position if all reasonable mitigating actions are fully implemented and embedded in the Locality. Once again the consequence score (7) is unchanged but the likelihood is reduced to 2 (unlikely) providing a target risk score of 14 (medium risk).

6 Addressing the risk

The objective in addressing a risk it to ensure that it does not develop into a problem where its potential impact is realised. It is important at this stage to consider the arrangements (controls) that already exist to manage the risk and whether these are sufficient and are operating effectively (assurance). Having properly identified, then assessed the risk and reviewed current control measures one of the following general approaches (the four Ts') can be selected:

- ***Transfer the risk*** - this might be undertaken through contracting out, service level agreements etc and conventional insurance. These arrangements might transfer some of the risk, but may also give rise to some new ones to manage, e.g. the management of contracts.

- ***Tolerate the risk*** – our ability to take effective action against some risks may be limited, or the cost of taking action may be disproportionate to the benefit gained. If the risk is tolerated a 'watching brief' is required by the risk manager and contingency plans should be developed to address any impact.

  Risks are also tolerated when all of the mitigating actions have been implemented and are shown to be working and there are no further actions that would reduce the risk score.

- ***Treat (control) the risk*** – the majority of risks will be in this category. This will require the implementation of remedial action, setting up of systems, infrastructure, assigning management responsibility, processes, equipment, staffing, training and development, etc. The introduction of new technology or processes of care or service may eliminate the identified risk; however, they could also lead to new risks.

  Advice should be taken, where appropriate on the development of mitigating actions e.g. from a Specialty Development Group or experts in corporate services.

  Care should be taken to frame the mitigating actions so they are outcome focussed. For example a consequence or likelihood score should not be changed as the result of the development or completion of an action plan but on there being assurance that the actions have had their intended effect.

- ***Terminate the risk*** – this is a variation on the 'treat' approach and involves taking quick decisive action to eliminate the risk altogether. This could include restricting or suspending a service until adequate controls are put in place.

To assist in determining the appropriate approach, the risk manager will calculate the target risk score (the risk score if all appropriate and proportionate controls were in place and working effectively).

- If the difference between the present and target risks scores is insignificant it might be appropriate to tolerate the risk depending on its nature.

- If there is a significant difference between the present risk score and the target risk score it might be appropriate to treat, transfer or terminate the risk.

7 Mitigation Plans

Mitigation plans should be developed:

- To close off any gaps in control or assurance.
- To reduce the threat (likelihood and consequence) of the risk.

All mitigations must:

- Include a description of the planned action, a due date and identify an individual responsible for delivering the action.
- Be outcome focussed and directly related to the threat.
- Be approved (together with any resource implications) by the appropriate governance group for the risk (EMT/LMGB/DMT, QuAG, etc)

Monitoring of the delivery of mitigating actions will be undertaken through usual reporting arrangements (see section 4.8 of the main policy).

A mitigating action should not be closed unless the risk manager has assurance that it has been completed.

The completion of a mitigating action should trigger a review of the risk score; however, care should be taken to ensure that, before making any changes, the action has had its intended outcome.

Risk 'One Pager' **Annex 1**

Principles: *Transparent, Co-ordinated, Knowledge and Learning and Effective*

Identify the Risks	Assess the Risks	Address the Risks	Report, Monitor and Review on the Risks
• Objective driven: Relate risks to the impact they will have on Trust/service objectives, standards, patient care or mandatory requirements. • Hazards, threats and risk: something that may have an impact on the achievement of objectives, the organisation, staff or patients. • Hazard/risk types: Clinical, service objectives/standards, project, reputation, strategic partner, strategic, staff, patient safety, compliance/targets, integrated working, property • Gathering intelligence: Through horizon scanning (forward-looking research identifying tomorrows risks and getting better prepared, patient information, incident information, near-miss reporting, incidents and events in the NHS	• Impact/consequences: Quality/objectives and targets, injury and ill health, finance and resources, reputation/publicity, litigation • Risk rating: the classification of each risk based on multiplying the potential impact/consequences by the likelihood of it occurring. • Uncertainty: some risks will have uncertain impact/consequence and likelihood. Seek help with these and remember our key principles and desire to be transparent.	The four 'Ts'' • Transfer: Passing the risk on to someone outside the Trust. • Tolerate: Watch the risk to ensure that its likelihood or impact doesn't change and that existing controls are effective. • Treat: (controls): Plan and implement a series of actions to bring the risk down to an acceptable level, e.g. care plan, procedures, policy, standards, training, education, revised working arrangements. • Terminate: Take quick decisive action to remove the risk, e.g. case review, crisis meeting. • Existing Control Measures: The measures already in place to manage the risk. Make sure these are effective and monitor. • Contingency: An action or arrangement that can be put into place to minimise the impact of a risk when is has gone wrong or is about to.	• Risk Register: Information about the risks at strategic level and service level. Has to be prepared and monitored regularly. The register indicates the risk, existing control measure, risk owner, impact and likelihood, action to be taken, and contingencies. • **K**ey risks to the delivery of the Trusts Strategic Direction (the BAF) are kept under regular review by the Board of Directors • Reporting: Informing key stakeholders internal and external about the risk we have identified, our arrangements that exist to manage these and any action to improve control.

Know your Role and Responsibility

Annex 2

Risk Ratings

Descriptions of Consequence Ratings:

Assessments should be made against all relevant domains. The score for the domain with the highest consequence should be used to calculate the risk score.

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence ratings (severity levels) and examples of descriptors				
	1	3	5	7	9
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ regulatory	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence ratings (severity levels) and examples of descriptors				
	1	3	5	7	9
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
	environment				
Personal Data Security	-	Potentially serious breach but risk assessed as low e.g. files were encrypted	Serious breach and risk assessed as high (e.g unencrypted data). Non-clinical data	Serious breach and risk assessed as high (e.g unencrypted data) Clinical Data	Serious breach with likelihood that the ICO will take formal action against the Trust.

Descriptions of Likelihood Ratings:

Likelihood ratings can be determined using either the potential frequency or probability of the risk occurring.

Likelihood rating	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Chance of the risk happening	<5%	5% - 20%	20% - 50%	50-80%	.>80%

Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Corporate					
Name of responsible person and job title	Phil Bellas, Trust Secretary					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Not applicable					
Policy (document/service) name	Organisational Risk Management Policy					
Is the area being assessed a…	Policy/Strategy	X	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area covered	The entire Trust					
Aims and objectives	• To support compliance with regulatory requirements and expectations e.g. the Provider Licence. • To embed a consistent, systematic and standardarised approach to the management of risks across the Trust. • To support understanding of, and competence in, the anticipation, assessment and management of risks amongst all staff. • To provide clarity on the Trust's risk appetite to support effective decision-making.					

Start date of Equality Analysis Screening	September 2017
End date of Equality Analysis Screening	January 2018

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay 0191 3336267

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Everyone - in that is provides a framework for assessing and responding to organisational risk.					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	/No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s **No** – Please describe any positive impacts/s The policy provides a framework for assessing and responding to potential risks including those which might impact on the protected characteristics.				
3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	
Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)		
4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership				
Yes – Please describe the engagement and involvement that has taken place				
No – Engagement with groups etc is not considered to be required due to the nature of the policy. However, it might be required in assessing the impact of, or mitigating actions to address, individual risks.				

5. As part of this equality analysis have any training needs/service needs been identified?					
Yes	Please describe the identified training needs/service needs below The policy identifies three elements of required training: - On risk management - On the completion of the relevant documentation i.e. the risks profiles - On the operation of the DATIX system				
A training need has been identified for;					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Phil Bellas				16/1/18	
Your reporting (line) manager: Colin Martin				**16/1/18**	
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046					