

Reporting to:	Trust Board, September 2015
Title	Risk Management Strategy
Sponsoring Director	Director of Corporate Governance
Author(s)	Head of Assurance
Previously considered by	Operational Risk Group, Risk Committee (Aug 15)
Executive Summary	<p>In line with best practice, the Risk Management Strategy is reviewed annually. The Trust's risk management processes are reviewed annually by Internal Audit as part of their review of the Board Assurance Framework. The last review, carried out in July 2015 gave an opinion of substantial assurance on the processes in place in the Trust.</p> <p>The main changes to the strategy are:</p> <ul style="list-style-type: none"> • Updated definition of risk (2.1) and more detail on risk appetite (2.2 with detailed risk appetite statements at appendix A). • Updated strategy aims and objectives (3) • Addition to risk owners (3.3.3) about considering assurance when identifying controls • Revision to risk controls (7.3.3) • Revision to risk accountability (8.1) and risk tolerance (8.2), local management of risk (8.3) and risk profiles (8.4) to take account of changes in process relating to executive sign off and escalation of risks. <p>Appendix A is a flowchart of the risk management process. Appendix B outlines the updated risk appetite statement Appendix C is the latest version of the risk action plan.</p> <p>The complete document can be found in the information pack.</p>
Strategic Priorities	
1. Quality and Safety	<input checked="" type="checkbox"/> Reduce harm, deliver best clinical outcomes and improve patient experience. <input checked="" type="checkbox"/> Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards <input checked="" type="checkbox"/> Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme <input type="checkbox"/> To undertake a review of all current services at specialty level to inform future service and business decisions <input checked="" type="checkbox"/> Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	<input checked="" type="checkbox"/> Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	<input type="checkbox"/> Support service transformation and increased productivity through technology and continuous improvement strategies
4. Community and Partnership	<input type="checkbox"/> Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population <input type="checkbox"/> Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5. Financial Strength: Sustainable Future	<input checked="" type="checkbox"/> Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	<input checked="" type="checkbox"/> If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience <input checked="" type="checkbox"/> If we do not implement our falls prevention strategy then patients may suffer serious injury <input checked="" type="checkbox"/> If the local health and social care economy does not reduce the Fit To Transfer (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm

	<input checked="" type="checkbox"/> Risk to sustainability of clinical services due to potential shortages of key clinical staff <input checked="" type="checkbox"/> If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards <input checked="" type="checkbox"/> If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input checked="" type="checkbox"/> If we do not have a clear clinical service vision then we may not deliver the best services to patients <input checked="" type="checkbox"/> If we are unable to resolve our (historic) shortfall in liquidity and the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well led
<input type="checkbox"/> Receive <input type="checkbox"/> Review <input type="checkbox"/> Note <input checked="" type="checkbox"/> Approve	Recommendation To approve the Risk Management Strategy.

Risk Management Strategy

1 Overview

The Trust has well developed and embedded risk management processes which are reviewed annually by Internal Audit as part of their review of the Board Assurance Framework. The last review, carried out in July 2015 gave an opinion of substantial assurance on the processes in place in the Trust.

In line with best practice, the Risk Management Strategy is reviewed annually and is supported by a risk management action plan. The action plan has been updated to take account of the findings of the risk management survey of senior managers (the 'Risk Management Healthcheck'). The existing risk appetite statement has been refined by the Risk Committee to include risk appetite levels for each corporate objective.

The strategy outlines the key aims and objectives, managers roles and responsibilities, the risk management organisational structure, and the risk management process. A risk management handbook supplements the strategy and provides more detailed guidance for staff.

2 Background

The Trust takes an integrated approach to risk management, irrespective of whether risks are clinical, non-clinical, financial, operational, business, or strategic with the aim of minimising its exposure to risk in line with the current risk appetite of the organisation. Risk management is embedded within the Trust's overall performance management framework, and linked to business planning. As Accountable Officers, the Board of Directors has legal and statutory obligations which demand that risk is managed in a strategic and methodical manner. In view of these statutory duties, it is important that staff are empowered to manage risk at a local level wherever possible and that clear arrangements are in place to escalate risk issues when it is appropriate.

3 Risk Management Process

On-going risk assessment should form part of the management and decision-making process of all areas of the organisation. In addition, all areas should take account of their business objectives for the coming year and ensure that they assess the risks to achieving these. The approach should be both pro-active and reactive. To assess risks, the Trust uses the National Patient Safety Agency (NPSA) classification 5 x 5 matrix.

Risks are assessed by the Care Groups and Centres and Corporate Areas and the results of the assessments should be discussed at local governance meetings. As part of the risk assessment it is essential to describe the controls in place to mitigate or manage the risk and secure the delivery of an objective. The risk owner should also consider what level of assurance is required to understand whether the stated controls are effective and how these assurances will be obtained and evaluated.

Once a risk has been identified, it is important to consider the additional control measures which can be put in place to reduce the risk. A balance must be found between the potential impact if the risk comes to fruition and the costs of additional controls. The Trust is required to manage its risks in such a way that people are not harmed and losses are minimised to the lowest acceptable level. Action plans are required for all high and medium risks (scoring 8 or above). These action plans will be monitored through Care Group and Centre governance systems. For high risks, progress against action plans will be monitored by the Operational Risk Group.

4 Risk registers

Registers of risks are held on the web-based risk register system (Insight4grc). This allows risk and action owners to update the status of assigned risks and actions. The system holds a structured set of risk registers for each area and corporate department, as well as strategic and trust-wide risks.

5 Risk escalation process

The level at which risks will be managed / escalated is shown below:

Risk Colour (score)	Remedial Action	Action	Decision to accept risk	Risk Sign off	Level of Monitoring
Very low (0-3)	Individual	watching brief	Ward / Service Manager	Service Head	Ward / Service
Low (4 – 6)	Ward/ Service Manager	retain and manage risk	Service Head	Service Head	Service Line
Medium (8 – 12)	Service Head	attempt to manage avoid or transfer risk	Centre Management Team	Assistant COO* / Centre Manager	Centre / Care Group Governance meeting
High (15–16)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Risk Committee (strategic risks - BAF)	Assistant COO or Care Group Director*, (operational areas) or relevant Director	Centre, Care Group, Operational Risk Group. Risk Committee & Trust Board
Very High (20-25)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Risk Committee (strategic risks - BAF)	COO or relevant Director	Centre, Care Group, Operational Risk Group. Risk Committee & Trust Board

5.1 Risk tolerance

Risk tolerance is *'the specific maximum risk that an organization is willing to take regarding each relevant risk'*.

- Green / light amber risks are within tolerance and do not require any *additional* actions or controls
- Dark Amber risks require additional controls
- Red risks require urgent action

A flowchart outlining the process is appendix A.

6 Risk appetite statement

Risk Appetite is *'the total exposed amount that an organisation wishes to undertake on the basis of risk-return trade-offs for one or more desired and expected outcomes'* i.e. risk appetite relates to the level of risk the Trust will take in pursuit of its objectives. This statement should be used to guide the organisation in delivery of the corporate objectives. Risk appetite is a series of boundaries, appropriately authorised by the board, which guide staff on the limits of risk that they can take.

Over the last few months, the Risk Committee have developed a series of risk appetite statements linked to the corporate objectives The Good Governance Institute produced a risk appetite matrix which was used to determine the Trust's attitude to risks in relation to the key elements of this matrix. These risk appetites were then mapped to the strategic objectives to develop guidance for managers

The risk appetite statements are at appendix B.

7 Risk management Healthcheck

The Risk Management Healthcheck was carried out in 2011, 2012, 2014 and 2015. The Healthcheck consists of 24 pairs of opposing statements which relate to the respondent's views on risk management. The questionnaire is widely distribution to managers (including clinical directors). The average score of 80 has not changed significantly from last year's average of 82 but is a significant improvement from the first score of 36.2 in 2011.

The results of the Healthcheck have been used to inform the risk management strategy and risk management action plan.

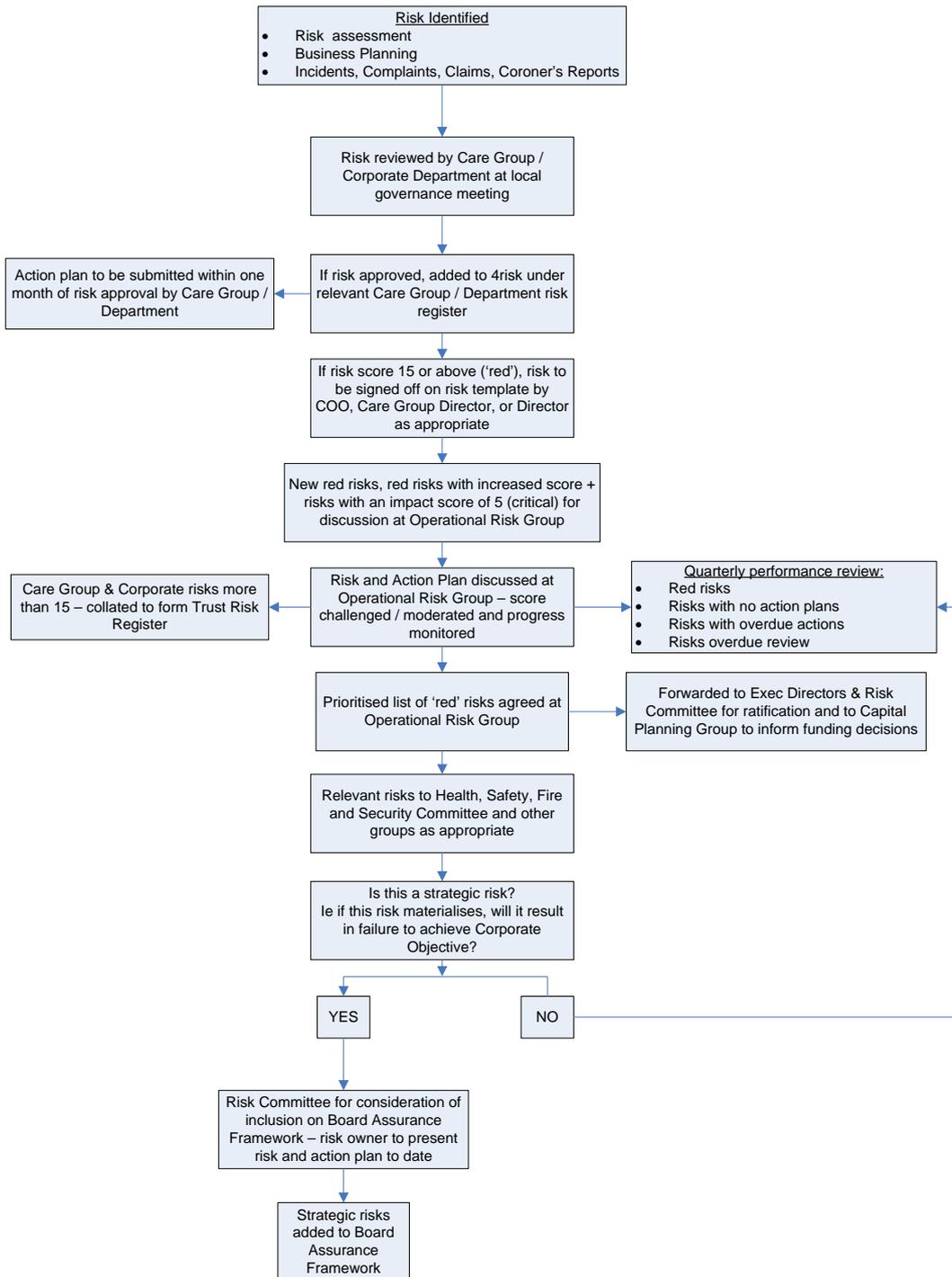
8 Risk management action plan

The Risk Management Action plan forms part of the Risk Management Strategy. The latest update is attached at appendix C.

The following actions have been added to the plan:

- Update Risk Management Handbook with guidance on using risk appetite
- Publish 'Risk Management Strategy' on a page for staff
- Develop guidance on assurance linked to new Insight4GRC upgrade (risk register)

Risk Management Process



Appendix B Risk Appetite Statement by objective

Risk appetite is 'the total exposed amount that an organisation wishes to undertake on the basis of risk-return trade-offs for one or more desired and expected outcomes' **ie risk appetite relates to the level of risk the Trust will take in pursuit of its objectives**

Objective	Risk appetite statement	Risk appetite (level)
1 Reduce harm, deliver best clinical outcomes and improve patient experience.	The Trust will support innovation with demonstration of commensurate improvements in outcomes	Moderate (3)
2 Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards.	The Trust is keen to consider all delivery options and select those with the highest probability of productive outcomes even when there are elevated levels of associated risk	Open (4)
3 Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
4 Undertake a review of all current services at specialty level to inform future service and business decisions.	The Trust is keen to consider all delivery options and will encourage new thinking and ideas that could lead to enhanced profitability	Open (4)
5 Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
6 Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work.	The Trust will encourage new thinking and ideas that could lead to enhanced staff engagement.	Open (4)
7 Support service transformation and increased productivity through technology and continuous improvement strategies.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
8 Develop the principle of 'agency' in our community to support prevention agenda and improve the health and well-being of the population.	The Trust is prepared to take decisions that are likely to bring scrutiny but where the potential benefits outweigh the risks. Value and health benefits will be considered, not just cost and resources allocated to capitalise on opportunities.	Open (4)
9 Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies.	The Trust has limited tolerance for risk taking, limited to those events where there is only a small chance of any significant repercussion for the Trust should there be a failure.	Cautious (2)
10 Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme	The Trust is 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.	Moderate (3)

Appendix C Risk Management Action Plan

Ref	Recommendation	Priority (low, medium, high)	Exec Director	Action Owner	Implementation Date	Update on position	Prev period RAG	Rec'nded RAG
1.1	Risk appetite levels to be developed and communicated to management teams	Medium	Director of Corporate Governance	Head of Assurance	Jun-15	<ul style="list-style-type: none"> Risk Management Healthcheck score: "I understand what risk I am allowed to take" has improved from 1.5 in 2011 to 3.6 in 2015 (on -3 to 6 point scale) Target risk scores are included on risk registers which describes the amount of risk the areas are willing to accept after effective mitigation. Formal Risk Appetite statement agreed at Feb Risk Committee and included in updated risk management strategy (Aug 15) All new red risk scores are approved at appropriate level in line with Risk Management Strategy 	AG	G
1.1.1 NEW	Update Risk Management Handbook with guidance on using risk appetite	Medium	Director of Corporate Governance	Head of Assurance	Sep-15	Risk management Strategy updated and undergoing consultation. This contains more guidance on risk appetite and an appendix outlining risk appetite by corporate objective		AG
3.1	Deliver tailored programme for centre managers on risk management strategy and risk registers	High	Director of Corporate Governance	Head of Assurance	Sep-15	Care Groups and departments are assisted with their on-going risks through regular meetings with Assurance team to update their registers. Arrangements are made to meet with areas where they fail to maintain their register on an scheduled basis. Rolling training sessions with new managers within Centres as required. On-going process due to turnover of staff.	AG	G
4.1	Closer relationships with Local Health Economy – CEO/Chair meetings, Director meetings	High	CEO	n/a	Sep-15	<ul style="list-style-type: none"> Facilitated 'Relationship Meetings' with CCGs undertaken to identify key issues and possible solutions. CCGs invited to attend SaTH Board to present their 5yr plan. SaTH Exec Directors available to attend CCG Boards to discuss issues as they arise. Closer working through FutureFit workstreams Discussions to take place about shared risks eg FTT 	A	A
4.2	Working with Health Economy to develop schemes we can all support each other in achieving to promote a cultural shift from sickness to health where we begin to focus much more proactively on admission avoidance, care closer to home	High	CEO	n/a	Nov-15	<ul style="list-style-type: none"> Chairman discussion with health economy re: Healthiest half million FutureFit modelling involves LHE clinicians/key stakeholders and focuses on care closer to home. Agreement on preferred model expected late 2015. However, the Health Gateway Review undertaken Feb-15 rated delivery confidence as AMBER. New Strategic Priority agreed which supports this recommendation 	A	A

5.1 6.1	Better understanding of risk management at ward/department level (measured by RM Healthcheck)	High	Director of Corporate Governance	Head of Assurance	Jun-15	Annual Risk Management Healthcheck by Centres shows improvement across all measures since 2011. Further 'Healthcheck' sent out late April 2015. Compared with 2014, 4 measures had deteriorated, 2 had improved, and 18 had stayed the same. Main area of deterioration related to understanding of risk management strategy - see action below	AG	AG
5.1.1 NEW	Publish 'Risk Management Strategy' on a page for staff	Medium	Director of Corporate Governance	Head of Assurance	Oct-15	Risk Management Strategy updated and undergoing consultation. Risk Management Strategy 'on a page' in draft		A
5.1.2 NEW	Develop guidance on assurance linked to new Insight4GRC upgrade (risk register)	Medium	Director of Corporate Governance	Head of Assurance	Oct-15	Insight4GRC upgrade includes facility to include '3 levels' of assurance against each control. This will be rolled out starting with the highest scoring risks.		R
7.1	Sustained performance standards	High	Chief Operating Officer	Asst COOs	Sep-15	Performance at end of July 15 <ul style="list-style-type: none"> A&E - 90.74% against 95% target Incomplete RTT - 91.25% against 92% target CQC IMR June-15 - Trust risk score=Band 3	AG	AR
7.2	Developing and implementing an Information Management & Technology Strategy	Medium	Finance Director	Head of IT	Sep-15	<ul style="list-style-type: none"> Infrastructure in place. Clear project management arrangements in place to prioritise competing demands. To link investment strategy to strong clinical sustainability argument to drive efficiencies to attract any external modernisation funding (for Pathology, Radiology, Pharmacy, EPR, GP comms) Successful allocation/drawdown from technology fund to facilitate developments New Strategic Priority agreed 	AR	A
7.3	Delivering estates strategy	Medium	Finance Director	Assoc Director of Estates	Mar-16	<ul style="list-style-type: none"> Infrastructure in place. Appointed Head of Estates who takes up post in Oct 15. Appointed Interim Head of Capital Nov-14 8 Facet Survey commissioned to inform future work plan and underpin strategy A number of risks identified including asbestos, fire and water safety and progress being made Approval given to appointing Health and Safety Advisor to work with Estates 	AR	A
7.4	Delivering planned financial outcomes	Medium	Finance Director	Deputy Finance Director	Mar-16	The in-year financial forecast for 14/15 outturn deteriorated from £8.2m deficit to £12.2 deficit. Permanent PDC secured in 14/15 to improve liquidity position. Underlying deficit remains with forecast for 15/16 currently £18.2m deficit	R	R

RISK MANAGEMENT STRATEGY

RM01

To be read in conjunction with: Risk Management Handbook

Version:	V13
Originally issued	February 1994
Approved by:	Risk Committee
Approval date:	
Ratified by:	Trust Board
Date ratified:	
Name of originator/author:	Head of Assurance
Lead Director	Director of Corporate Governance
Date issued:	September 2015
Review date:	September 2015
Target:	Overarching Strategy for specific Trust Risk Management Policies

Document Control Sheet

Author/Contact:	Clare Jowett, Head of Assurance clare.jowett@sath.nhs.uk
Document ID	RM01
Version	13
Version History – V13	Trust Board –
Status	Final
Date Equality Impact Assessment	9.11.07 This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group
Issue Date	
Review Date	June 2016
Distribution	Please refer to the SATH intranet for the latest version of this policy. Any printed copies may not necessarily be the most up to date
Key words	RM01 risk, risk management, risk register, risk matrix, assurance, risk assessment, risk appetite

Version history

Version	Date	Author	Status	Comment
V1	Feb 94	JB	Original	
V2	Jan 01	TL	Final	
V3	Oct 02	TL	Final	
V4	Apr 03	TL	Final	
V5	Sept 05	TL	Final	
V6	Dec 06	CJ	Final	
V7	Jan 08	CJ	Final	
V8	Feb 09	CJ	Final	
V9	Feb 10	CJ	Final	
V10	Oct 11	CJ	Final	
V12.2	Aug 14	CJ	Final	
V13	July 15	CJ	Draft	Updated definition of risk (2.1) and more detail on risk appetite (2.2 and appendix A). Updated strategy aims and objectives (3) Addition to risk controls (7.3.3) about considering assurance Revision to risk accountability (8.1) and risk tolerance (8.2), local management of risk (8.3) and risk profiles (8.4) All appendices updated with current versions

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1 Statement of Intent

The Shrewsbury and Telford Hospital NHS Trust is committed to changing healthcare for the better by being values driven which will have clear and tangible benefits for our patients and our staff.

The Trust Board recognises that effective risk management is central to achieving this aim whilst allowing the Trust to make the most of opportunities, (*'Make it happen'*) whilst minimising the risks taken and should be part of the Trust's culture and strategic direction. This strategy helps to embed the Trust values by recognising our role as individuals, and as an organisation, is to provide the safest possible care, using the best evidence of what provides the greatest benefit to patients. (*'Together we achieve'* and *'Proud to care'*)

The Trust takes an integrated approach to risk management, irrespective of whether risks are clinical, non-clinical, financial, operational, business, or strategic with the aim of minimising its exposure to risk in line with the current risk appetite of the organisation. Risk management is embedded within the Trust's overall performance management framework, and linked to business planning. As Accountable Officers, the Board of Directors has legal and statutory obligations which demand that risk is managed in a strategic and methodical manner. In view of these statutory duties, it is important that staff are empowered to manage risk at a local level wherever possible and that clear arrangements are in place to escalate risk issues when it is appropriate.

The Board is committed to an open and honest approach in all matters. It expects all staff to acknowledge that risks within the Trust can be identified and managed if everyone adopts an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support rather than blame and recrimination. (*'We value respect'*) The Trust's Whistleblowing Policy complements this approach by providing an alternative mechanism for raising concerns if staff do not feel able to raise these through the usual routes. The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

The Trust Board has delegated authority to the Risk Committee for overseeing the development, implementation and monitoring of this strategy. The Audit Committee undertakes a scrutiny role to ensure that the systems, structures, and processes for managing strategic risks are in place.

The maternity service has a complementary approved risk management strategy which describes the processes in place in the Women's and Children's Care Group for managing risk in this high risk environment as this was required by the CNST standards published by the NHSLA¹.

2 Definition of Risk Management

Risk management is the process by which the Trust will manage the safety of its patients, staff, resources (including information) and environment. The risk management process encompasses the identification and assessment of risks, assigning ownership and monitoring and reviewing progress with the actions taken to mitigate them.

2.1 Definition of Risk

There are many definitions of risk, but most imply that risk is something which should always be avoided. However, without any risk there would be very few opportunities or innovations. Modernising and improving our services requires the Trust to take opportunities whilst managing the risks. For the purpose of this strategy "**risk**" is defined as -

"an uncertain event or set of events which, should it occur, will adversely affect an organisation's ability to achieve its objectives or successfully execute its strategies"

Risk has two main components: **consequence** and **likelihood**. Consequence is a reflection of the damage or loss which may occur. Likelihood is an indication of how often the event might occur.

Taken together, they give an indication of how much damage could be caused as a result of unwanted or unplanned events.

Control is the mitigating action put in place to reduce the risk; further actions may be required to reduce the risk to an acceptable level.

Note that:

An **incident** is an event that has occurred and which has had an effect on the achievement of objectives

An **issue** is a certain, or on-going circumstance, which will have, or is already having, an effect upon the achievement of objectives.

2.2 Risk Appetite

The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the “risk appetite”.

The risk appetite of the organisation therefore determines the balance between not adequately managing risks, therefore leaving the organisation exposed; and over managing risks, stifling creativity and causing loss of opportunity.

By taking a positive approach to risk, the Trust will create greater opportunities, increasing the chances of success. The Trust recognises that it must take risks in order to achieve its objectives. It must however take these risks in a controlled manner, thus reducing exposure to a level deemed acceptable by the Board.

Methods of controlling risks must be balanced in order to support innovation and the creative use of resources, especially when it is to achieve substantial benefit. In addition, the organisation may choose to accept some high risks because of the cost of controlling them. As a general principle the Trust will seek to control all likely risks which have the potential to:

- cause serious harm to patients, staff or visitors
- cause a serious and long term impact on the Trust’s reputation
- have financial consequences which could jeopardise the Trust’s viability

The organisation’s current overall risk appetite is described as ‘open’ as the Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even where there are elevated levels of associated risk.

For a more detailed examination of risk appetite linked to the Trust objectives, please refer to appendix A.

3 Strategy Aims and objectives

The Board needs to be able to demonstrate that they have been properly informed, through the Board Assurance Framework, about all strategic risks facing the organisation, and that they arrived at their conclusions on the totality of risk based on all the evidence presented to them. The purpose of the Risk Management Strategy is to detail the Trust’s framework for setting objectives, providing assurance and managing risk.

The Trust’s key strategic risk management aims are to:

- Minimise the potential for harm to patients, staff and visitors, to the lowest reasonably practicable level

- Ensure an integrated approach to the management of risk, ensuring risk management is embedded within the organisational culture
- Encourage the open reporting of mistakes, within a 'just' culture and that lessons are learnt and actions promptly implemented to prevent recurrence.
- Comply with national standards including health and safety, and legal requirements
- Embed the risk management process supported by the governance committee structure
- Accept that risk management is the responsibility of each and every member of staff
- Protect valuable assets including high standards of care, staff safety, reputation and physical assets and income streams
- Horizon scan in order to anticipate and respond to changing circumstances (eg social, political, environmental, financial etc)

The Trust's key risk management objectives for the coming year are:

- Agree risk appetite levels developed further and communicated to management teams
- The Risk Management Strategy and accompanying Risk Management Handbook will be updated and issued to staff with 'Risk Management on a page'
- Additional guidance on assurance to be developed linked to the risk register upgrade
- Closer relationships with Local Health Economy
- Working with Health Economy to develop schemes we can all support each other in achieving to promote a cultural shift from sickness to health
- Sustained performance standards
- Developing and implementing an Information Management and Technology strategy.
- Delivering estates strategy
- Delivering planned financial outcomes

The risk management action plan is appendix B.

A list of associated policies is at appendix J.

4 Strategic Objectives

The Trust believes it is essential to develop a strategy that is balanced between strategic domains and updates its strategy annually. Each objective has a designated lead Director, responsible for assessing and monitoring the risks associated with delivery of the objective. This assessment forms part of the trust risk register and assurance framework. For 2015/16 the strategic objectives are:

- Reduce harm, deliver best clinical outcomes and improve patient experience.
- Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards.
- Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme.
- Undertake a review of all current services at specialty level to inform future service and business decisions.
- Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme.
- Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work.
- Support service transformation and increased productivity through technology and continuous improvement strategies.
- Develop the principle of 'agency' in our community to support prevention agenda and improve the health and well-being of the population.
- Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies.
- Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme.

5 Roles and Responsibilities

All members of staff have an individual responsibility for the management of risk and all levels of management must understand and implement the Trust's risk management strategy. This section details specific lines of accountability and communication, through which the Trust manages risk.

5.1 Chief Executive

The Chief Executive is the Accountable Officer for the Trust and has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance. This responsibility requires the inclusion in Annual Reports of an Annual Governance Statement. This outlines the controls in place for management of the Trust's risk exposure. In order to sign this statement on behalf of the Board, the Chief Executive will need to review evidence that the Risk Management Strategy is being implemented, and there is an effective system of internal control.

5.2 Director of Corporate Governance

The Director of Corporate Governance is the lead director for risk management and fulfils the role of Board Secretary. The Director develops corporate risk management strategies and policies interpreting national guidance to fit the local context and the Board Assurance Framework in conjunction with the Trust Board

5.3 Chief Operating Officer

The Chief Operating Officer is the executive lead for emergency planning and business continuity.

5.4 Finance Director

The Finance Director is responsible for financial risk management and for providing regular, timely, and accurate financial reports to the Board in line with requirements and accounting standards

5.5 Directors

Each Director has delegated authority for the delivery of specific objectives and therefore for assessing the risks associated with the delivery of those objectives. This includes a Quality Impact Assessment on all CIP schemes. It is the responsibility of each Director and their management team to implement local arrangements which accord with the principles and the objectives set out in this strategy. Each Director has overall responsibility for ensuring that information held on the risk register and Board Assurance Framework is up to date and accurately reflects the current status.

5.6 Head of Assurance

The Head of Assurance is responsible for the coordination of risk management issues on behalf of the Director of Corporate Governance. This includes supporting the Risk Committee and Operational Risk Group and development of the risk registers.

5.7 Management Teams

The Management Teams are responsible for ensuring participation in the Trust's Governance systems by ensuring Groups and Centres have local risk management systems in place detailing arrangements in their areas of responsibility including on-going risk assessment and management of the local risk registers

Specific responsibilities are outlined in an appendix F to this document.

6 Risk Management Organisational Structure

The Trust governance (committee) structure is shown at appendix C. Terms of reference are reviewed annually and approved by the relevant committee to which they report. The following committees have specific functions relating to risk management:

6.1 Trust Board

The Trust Board is responsible for ensuring that the Trust follows the principles of sound governance. The Board is required to produce statements of assurance that it is doing its “reasonable best” to ensure the Trust meets its objectives and protect against risks of all kinds. In relation to this strategy the Trust Board will:

- Have a structured risk identification system covering all possible risks to its objectives, with robust controls in place for the management of identified risks including action and contingency plans
- Develop appropriate monitoring and review mechanisms that provide independent assurance to the Board that the system of risk management across the trust is effective

6.2 Risk Committee

The Trust Board has delegated authority for risk management to the Risk Committee which is the Trust committee with overarching responsibility for risk. The Risk Committee provides assurance to the Trust Board that the systems for risk management and internal control are effective. The Risk Committee is responsible for ensuring that **all** significant risks are properly considered and communicated to the Trust Board. The Terms of Reference are at appendix D.

6.3 Operational Risk Group

The Operational Risk Group is tasked with collating risk assessments from throughout the Trust and presenting them in coherent and robust risk registers. The group will ensure that assessments are normed and that the information gathered is complete and up-to-date. The Terms of Reference are at appendix E.

6.4 Clinical Governance Executive

This committee is chaired by the Medical Director and meets monthly. Clinical risks will be monitored by this group

6.5 Health, Safety, Fire and Security Committee

The committee is chaired by the Director of Corporate Governance and meets quarterly. Non-clinical risks relevant to the terms of reference will be monitored by this group.

6.6 Trust Audit Committee

The Audit Committee, a formal sub-committee of the Board, provides overview and scrutiny of risk management. The terms of reference have been devised in line with the Audit Committee Handbook to reflect its role as the senior Board committee taking a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisation’s business including oversight and scrutiny of the Trust’s systems of internal control and risk management.

6.7 Quality and Safety Committee

This Committee is a formal sub-committee of the Board established to provide assurance to the Board on clinical Quality & Safety, (including Clinical Effectiveness, Patient Safety, and Patient Experience) utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care. Any risks to quality would be referred to this Committee by the Clinical Governance Executive for oversight.

7 The Risk Management System

The Trust embeds risk management through the full and formal adoption of the national NHS framework, the Australian / New Zealand Risk Management Standard 4360:2004.² A summary of the risk management process in at appendix F.

In order to comply with this standard a continuous risk management process with an agreed methodology to analyse the range of potential consequences and likelihood of occurrence of risks is in place. The Trust uses the national NPSA classification 5 x 5 matrix (Appendix H)

7.1 Risk Types

The main types of risk facing by the Trust fall into two categories:

Strategic Risks: are those that represent major threats to achieving the Trust's strategic objectives, or to its continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of the strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

Operational Risks: These concern the day to day issues that the Trust faces as it strives to deliver its strategic objectives. Operational risks include a broad range of risks including clinical risks, fraud, financial risks etc. These risks therefore have the potential to stop the Trust achieving nationally or locally agreed targets or may have such an impact on service delivery that the Trust is in breach of contract with the commissioners, or risks which impact on more than one area. These risks are the responsibility of line management and should be identified and managed by managers and only considered by the Board in a high level summary form in order that they have an overview of the totality of risk facing the Trust.

Risks on the Board Assurance Framework are usually strategic risks as these are the risks which will most impact on achievement of corporate objectives; some operational risks may be considered by the Board to be so significant, if they materialise, that they will be included on the Board Assurance Framework.

7.2 Risk Identification

Risk identification is the process of identifying what could happen to prevent achievement of objectives. The first step is to review business plan objectives, identifying the key risks that may impact upon the ability of the Trust, Care Group or Centre to achieve its objectives. The Trust has produced a risk management handbook which includes guidance for risk assessment to assist line managers. The approach to risk identification should be both pro-active and reactive.

7.2.1 Proactive risk identification

Proactive risk assessment enables the Trust to identify actual or potential hazards and ensure adequate control measures are in place to mitigate the risk. Proactive risk assessment fulfils the Trust's statutory duty in terms of Health and Safety risk assessments. On-going proactive risk assessment will minimise the likelihood of incidents occurring and will support safety improvements across the Trust. There are several processes in place to allow this to be undertaken for example: internal inspections carried out by specialist advisers eg infection control, fire, health and safety; audits and benchmarking.

7.2.2 Reactive risk identification

Reactive risk assessments should take place after adverse events to minimise the likelihood of these events recurring. For example, following incident reports, complaints and claims, root cause analysis takes place and can result in risks being identified for inclusion on risk registers. Similarly, an external assessment or review of Trust services could result in risks being identified.

7.2.3 Quality Impact Assessment (QIA) of Improvement Programme schemes

In assessing the impact of proposed improvement programme schemes on the ability to deliver commitments to quality as defined within the Annual Corporate Plan, the Quality KPIs, and the Monitor requirements of clinical outcomes; patient experience and patient safety, each scheme will need to be risk scored for its potential to have an adverse impact on these three dimensions of quality.

7.3 Risk Evaluation

All risks, independent of their origin, are evaluated using the Trust's risk matrix (appendix H). Risk scores have two components: consequence and likelihood. The evaluation is the assessment of the "likelihood" that the controls put in to manage a risk are likely to fail, and determining the

“consequences” arising from that failure. The two scores are multiplied together to give a risk score of between 1 and 25. The subsequent colour rating, from the risk matrix, identifies the level at which risks will be managed within the Trust.

7.3.2 Risk Owners

The risk management process specifies risks which need to be actively managed. These are assigned a risk owner who is accountable for owning and reporting on the risk and overseeing the development and maintenance of appropriate controls and mitigation. While the risk owner has overall accountability for the management of the risk, they may not own or operate the control(s) which relates to the risk. In this case, the role of the risk owner is to oversee that the control(s) are owned, are fit for purpose and operate effectively and that identified actions are implemented by the action owners.

7.3.3 Risk Controls

As part of risk assessment it is essential to describe the controls in place i.e. policies, procedures, protocols, training or physical safeguards in place to mitigate or manage the risk and secure the delivery of an objective. The risk owner should also consider what level of assurance is required to understand whether the stated controls are effective and how these assurances will be obtained and evaluated. This includes identifying who can provide assurance on the adequacy and continued application of the controls identified and, mapping the actual assurance obtained over a period, or at a point, in time. For more information on assurance please refer to the Risk Management Handbook

7.4 Addressing Risks – Action plans

Once a risk has been identified, it is important to consider the additional control measures which can be put in place to reduce the risk. A balance must be found between the potential impact if the risk comes to fruition and the costs of additional controls. The Trust is required to manage its risks in such a way that people are not harmed and losses are minimised to the lowest acceptable level. Action plans are required for all high and medium risks (scoring 8 or above). These action plans will be monitored through Care Group and Centre governance systems. For high risks, progress against action plans will be monitored by the Operational Risk Group. There are several possible courses of action:

Treat the risk (risk elimination or risk reduction)

It is expected that most risks identified will be treated. The purpose of treatment is not necessarily to eliminate the risk completely but, more likely, to put in place a plan of mitigating actions to contain the risk to an acceptable level in line with the organisation’s current risk appetite.

Terminate the risk

This is a variation of the “treat” approach, and involves quick and decisive action to eliminate or avoid a risk altogether. The introduction of new technology may remove certain existing risks, although it will often result in a new set of risks to be addressed.

Transfer the risk

This may be done through insurance or by asking a third party to take on the risk in another way. Contracting out some of the Trust’s services, for example, transfers some, but not all risks (and often introduces a new set of risks to be managed)

Tolerate the risk

The ability to take effective action against some risks may be limited, or the cost of taking action may be disproportionate to the potential benefit gained. In this instance, the only management action required is to monitor the risk to ensure that its likelihood or impact does not increase. If new management options arise, it may become appropriate to treat this risk in the future.

Avoid the risk

This an informed decision not to become involved in a risk situation or to cease activities in a particular area because the risk is too high

Exploit the risk

The potential to exploit opportunities when actions are taken to mitigate or transfer the risk, as should the opportunity to redeploy resources where risks are terminated

It should be noted that there are some instances where a risk may be deemed unacceptable and yet still be tolerated by the organisation. For example the cost of treating the risk may be prohibitive or the risk may be untreatable.

7.3.1 Action Owners

Risk owners may not be in a position to take all the necessary actions to mitigate a risk. Action owners are nominated individuals with responsibility for taken the required actions. An individual risk may have several identified actions – and each of these may have a different action owner.

7.3.2 Funding of Control Measures

Groups and departments are responsible for funding the cost of control measures, which relate to risks identified as being within the control of the Care Group/Department.

7.3.3 Risk Contingencies

For risks that may occur contingency plans should be developed in case they do. Contingency plans should be appropriate and proportional to the impact of the original risk. In many cases it is more cost effective to allocate a certain amount of resources to mitigate a risk rather than start by developing a contingency plan which, if necessary to implement, is likely to be more expensive.

7.3.4 Reassessment

All risks must be periodically reviewed and re-assessed in view of contextual changes. It is recommended that reviews of risk assessments take place at least quarterly within the Care Groups, and anytime a process change is about to occur, or a new hazard is identified. However, throughout the Trust, risk assessment is an on-going process with the risk registers being constantly updated.

8 Managing the Trust Risk Registers

Registers of risks are held on the web-based risk register system (Insight4grc). This allows risk and action owners to update the status of assigned risks and actions. The system holds a structured set of risk registers for each area and corporate department, as well as strategic and trust-wide risks.

8.1 Responsibility and accountability arrangements

The trust aims to empower staff to assume responsibility for effective risk management by setting out a framework that meets the needs of the day to day management practice and encourages a freedom to act hierarchy. This means that risk assessment can take place throughout the hierarchy; for example individual staff can undertake risk assessments, within a ward or department; ward or department heads may undertake assessment for their department. The results of this feed into local action plans or risk reduction programmes, or Care Group / Centre / service level risk registers in circumstances where the outcome suggests the need for involvement outside the immediate team.

The level at which risks will be managed / escalated is shown below:

Risk Colour (score)	Remedial Action	Action	Decision to accept risk	Risk Sign off	Level of Monitoring
Very low (0-3)	Individual	watching brief	Ward / Service Manager	Service Head	Ward / Service
Low (4 – 6)	Ward/ Service Manager	retain and manage risk	Service Head	Service Head	Service Line
Medium (8 – 12)	Service Head	attempt to manage avoid or transfer risk	Centre Management Team	Assistant COO* / Centre Manager	Centre / Care Group Governance meeting
High (15–16)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Risk Committee (strategic risks - BAF)	Assistant COO or Care Group Director*, (operational areas) or relevant Director	Centre, Care Group, Operational Risk Group. Risk Committee & Trust Board
Very High (20-25)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Risk Committee (strategic risks - BAF)	COO or relevant Director	Centre, Care Group, Operational Risk Group. Risk Committee & Trust Board

* Assistant COO must sign off risks for Scheduled and Unscheduled Care Groups, Care Group Director must sign of risks for Women and Children's and Support Services Care Groups.

NB Risks scoring 5 for impact (critical/catastrophic) will now be reviewed at ORG even if likelihood low (1 or 2). ORG may recommend to Risk Committee that risks are included on the corporate risk register to give greater oversight of potentially critical risks

8.2 Risk tolerance

Risk tolerance is 'the specific maximum risk that an organization is willing to take regarding each relevant risk'.

The acceptability of risk is a complex issue and will vary according to local circumstances. Acceptable risk can be defined as the residual risk remaining after controls have been applied to known hazards. In relation to operational risks, it will be the responsibility of individual Care Groups to decide what level of risk is acceptable in line with the current risk appetite statement. In respect of strategic risks, it will be the responsibility of the Trust Board, to determine the acceptability of a risk. The tolerance of a risk is its target risk score.

- Green risks are within tolerance and do not require any *additional* actions or controls
- Amber risks require additional controls
- Red risks require urgent action

8.3 Local Risk Registers

Each service and corporate department must maintain a comprehensive risk register of its identified risks with agreed action plans. The responsibility for maintaining the local risk register will be that of the service head who has responsibility for clearly delegating actions to named individuals. It is expected that local registers will contain risks identified from a number of sources including analysis of incidents (clinical and non-clinical), complaints and claims; benchmarking against national guidance

and national reports; patient safety alerts; patient and staff surveys; business planning and performance. The registers should be discussed at local governance meetings where clinical and non clinical risks should be identified and discussed and progress towards mitigating the risks monitored. .

8.4 Local Management of Risk

Responsibility for the management, control, and funding of a particular risk lies within the Care Group/Department concerned. However, when action to control a risk falls outside the remit of a Care Group or cannot be dealt with at that level, it will be escalated. All Care Groups and Centres will have a mechanism for signing off all medium and high risks. Risks scoring 15 or over must be signed off by the appropriate Director/ Assistant Chief Operating Officer For Care Groups, this will be the Chief Operating Officer for very high risks (scoring 20 or 25); and the Assistant Chief Operating Office or Care Group Director for risks scoring 15 or 16. The risk should then be forwarded with a risk reduction plan to the Operational Risk Group (ORG). The ORG will discuss the risk and agree the risk scoring taking account of all known factors. An outcome summary of the ORG will be reported to the Risk Committee which will include any amendments to the register. If appropriate, ORG will recommend that the risk owner be invited to the Risk Committee to present the risk.

The Operational Risk Group will produce a prioritised summary of risks rated 15 or above for ratification at Risk Committee.

8.5 Risk Profiles

Each quarter at Operational Risk Group, services and departments will be expected to report on their top red risks and by exception update on action plans for minimising those risks. In addition to the top risks, the ORG will also discuss the following items quarterly:

- Overall risk profile
- Risks which have been red for more than a year
- Risks where action plans are behind target
- Medium / High Risks without action plans (risks scoring 8 or above)
- Medium risks / high risks without controls (risks scoring 8 or above)

8.6 Process for the Executive Review of Risk and Board Assurance Framework

The escalation process outlined in section 8.4 will ensure executive oversight of high risks.

The Risk Committee will review the Board Assurance Framework (BAF) quarterly and will receive a high level extract of the risk register at this meeting.

8.6.1 Managing the Trust Board Assurance Framework

The Board Assurance Framework (BAF) represents all the agreed strategic risks of the trust. It is developed annually by the Board who will review quarterly known and potential strategic risks. Whilst strategic risks will automatically migrate to the BAF, the trust management team, with assistance from the Operational Risk Group and sub-committees, will determine whether or not any other risks from the risk registers should be considered at the Risk Committee for inclusion in the BAF.

Any significant operational risks which cannot be controlled within the Care Groups and corporate departments will be considered for inclusion on the Trust's Board Assurance Framework (BAF) following discussion with the appropriate director and ORG. Risk Owners will present such risks at the Risk Committee for discussion and consideration and explain the reason why the risk cannot be managed, together with a suggested course of action. This will provide a structure to aid the analysis of risks and the process of making decisions about risk treatment.

The Board Assurance Framework will be discussed four times a year by Risk Committee and presented to the subsequent Trust Board by the Chief Executive Officer. The Director of Corporate Governance will present the Board Assurance Framework to the Audit Committee at least twice a year

9 Sub-certification of Annual Governance Statement

As part of the Annual Governance Statement Care Groups and corporate Heads of Department will be required to sub certify (see appendix I) that, at year end, local risk register:

- is up-to-date,
- reflects all risks rated at 8 or above in their areas of responsibility
- identifies the controls currently in place for the identified risks
- identifies actions to mitigate the risk (with dates and named individuals)
- Identifies the assurances (received or planned) that will demonstrate that the risk is adequately managed.

10 Training, development and appraisal

Training and education are key elements in establishing and maintaining the risk management culture. It provides staff with the necessary knowledge and skills to work safely and to minimise risks at all levels. This process starts at induction: all staff must have a local induction and are required to attend a corporate induction programme on joining the Trust. This includes an introduction to the risk management culture within the Trust.

A corporate training plan is drawn up and regularly reviewed comprising training required under legislation and any other training deemed to be mandatory by the Trust for an individual to undertake the duties. Advice and information on training is available from the Learning Zone on the Intranet. Every employee will have personal objectives linked to the corporate objectives, including training reviewed annually at the time of appraisal. Where appropriate personal objective and development plans will link to identified risks.

10.1 Risk awareness training for senior managers and Board Members

Board members and other identified senior managers¹ will be appropriately trained and skilled in risk management for their role. They will be provided with bespoke risk awareness training to ensure they have a clear understanding of their role and responsibilities for risk management.

The Executive and Non-Executive Directors will receive training as part of the annual Board Development Programme. The content is likely to vary from year to year but will include presentations and discussions of new developments, legislation or standards in risk management

Senior managers and Care Group management teams (excluding admin support) will receive risk management training as part of the annual Trust Leadership Team training. The content is likely to vary from year to year but will cover updates on relevant risk management issues and clarification of roles and responsibilities in relation to risk management

11 Communication and Consultation

Managers are responsible for communicating the Risk Management Strategy and associated documents to all their staff. The strategy and associated documents can be accessed through the Trust Intranet (risk management pages) so that they are readily available in departments.

12 Monitoring Mechanisms

The Risk Committee has responsibility for overseeing the implementation of this strategy. This will include production of an annual report to demonstrate the continuing effectiveness of the risk management system. Risk Committee will be supported by Operational Risk Group who will monitor compliance with the Risk Register process by undertaking quarterly risk reviews.

Internal Audit and the Audit Committee have responsibility for monitoring the risk management system and providing appropriate verification to the Chief Executive and Board. Each year the Trust will be

¹ see Trust 'Who's Who on a Page'

required to develop an Annual Governance Statement that confirms that action has been taken to manage risk and to publish this statement in its annual report.

13 Approval and Review Mechanisms

The policy has been developed in the light of currently available information, guidance and legislation that may be subject to review. In order that the Risk Management Strategy remains current, any of the appendices to the strategy can be amended and approved during the lifetime of the strategy without the entire strategy having to return to the Board. The strategy as a whole will be reviewed and ratified annually by the Board (or sooner if there are significant changes at national policy level).

Trust Board approved the policy on _____

And becomes effective on _____

Chief Executive

Trust Chair

Signed _____
Dated _____

Signed _____
Dated _____

Appendix 1 Risk Appetite Statement by objective

Risk appetite is *'the total exposed amount that an organisation wishes to undertake on the basis of risk-return trade-offs for one or more desired and expected outcomes'* ie risk appetite relates to the level of risk the Trust will take in pursuit of its objectives

Objective	Risk appetite statement	Risk appetite (level)
1 Reduce harm, deliver best clinical outcomes and improve patient experience.	The Trust will support innovation with demonstration of commensurate improvements in outcomes	Moderate (3)
2 Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards.	The Trust is keen to consider all delivery options and select those with the highest probability of productive outcomes even when there are elevated levels of associated risk	Open (4)
3 Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
4 Undertake a review of all current services at specialty level to inform future service and business decisions.	The Trust is keen to consider all delivery options and will encourage new thinking and ideas that could lead to enhanced profitability	Open (4)
5 Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
6 Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work.	The Trust will encourage new thinking and ideas that could lead to enhanced staff engagement.	Open (4)
7 Support service transformation and increased productivity through technology and continuous improvement strategies.	The Trust is eager to be innovative and to pursue options that offer potentially substantial rewards, despite also having greater levels of risk	Hungry (5)
8 Develop the principle of 'agency' in our community to support prevention agenda and improve the health and well-being of the population.	The Trust is prepared to take decisions that are likely to bring scrutiny but where the potential benefits outweigh the risks. Value and health benefits will be considered, not just cost and resources allocated to capitalise on opportunities.	Open (4)
9 Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies.	The Trust has limited tolerance for risk taking, limited to those events where there is only a small chance of any significant repercussion for the Trust should there be a failure.	Cautious (2)
10 Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme	The Trust is 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.	Moderate (3)

Appendix B Risk Management Action Plan

Ref	Recommendation	Priority (low, medium, high)	Exec Director	Action Owner	Implementation Date	Update on position	Prev period RAG	Rec'ded RAG
1.1	Risk appetite levels to be developed and communicated to management teams	Medium	Director of Corporate Governance	Head of Assurance	Jun-15	<ul style="list-style-type: none"> Risk Management Healthcheck score: "I understand what risk I am allowed to take" has improved from 1.5 in 2011 to 3.6 in 2015 (on -3 to 6 point scale) Target risk scores are included on risk registers which describes the amount of risk the areas are willing to accept after effective mitigation. Formal Risk Appetite statement agreed at Feb Risk Committee and included in updated risk management strategy (Aug 15) All new red risk scores are approved at appropriate level in line with Risk Management Strategy 	AG	G
1.1.1 NEW	Update Risk Management Handbook with guidance on using risk appetite	Medium	Director of Corporate Governance	Head of Assurance	Sep-15	Risk management Strategy updated and undergoing consultation. This contains more guidance on risk appetite and an appendix outlining risk appetite by corporate objective		AG
3.1	Deliver tailored programme for centre managers on risk management strategy and risk registers	High	Director of Corporate Governance	Head of Assurance	Sep-15	Care Groups and departments are assisted with their on-going risks through regular meetings with Assurance team to update their registers. Arrangements are made to meet with areas where they fail to maintain their register on an scheduled basis. Rolling training sessions with new managers within Centres as required. On-going process due to turnover of staff.	AG	G
4.1	Closer relationships with Local Health Economy – CEO/Chair meetings, Director meetings	High	CEO	n/a	Sep-15	<ul style="list-style-type: none"> Facilitated 'Relationship Meetings' with CCGs undertaken to identify key issues and possible solutions. CCGs invited to attend SaTH Board to present their 5yr plan. SaTH Exec Directors available to attend CCG Boards to discuss issues as they arise. Closer working through FutureFit workstreams Discussions to take place about shared risks eg FTT 	A	A
4.2	Working with Health Economy to develop schemes we can all support each other in achieving to promote a cultural shift from sickness to health where we begin to focus much more proactively on admission avoidance, care closer to home	High	CEO	n/a	Nov-15	<ul style="list-style-type: none"> Chairman discussion with health economy re: Healthiest half million FutureFit modelling involves LHE clinicians/key stakeholders and focuses on care closer to home. Agreement on preferred model expected late 2015. However, the Health Gateway Review undertaken Feb-15 rated delivery confidence as AMBER. New Strategic Priority agreed which supports this recommendation 	A	A

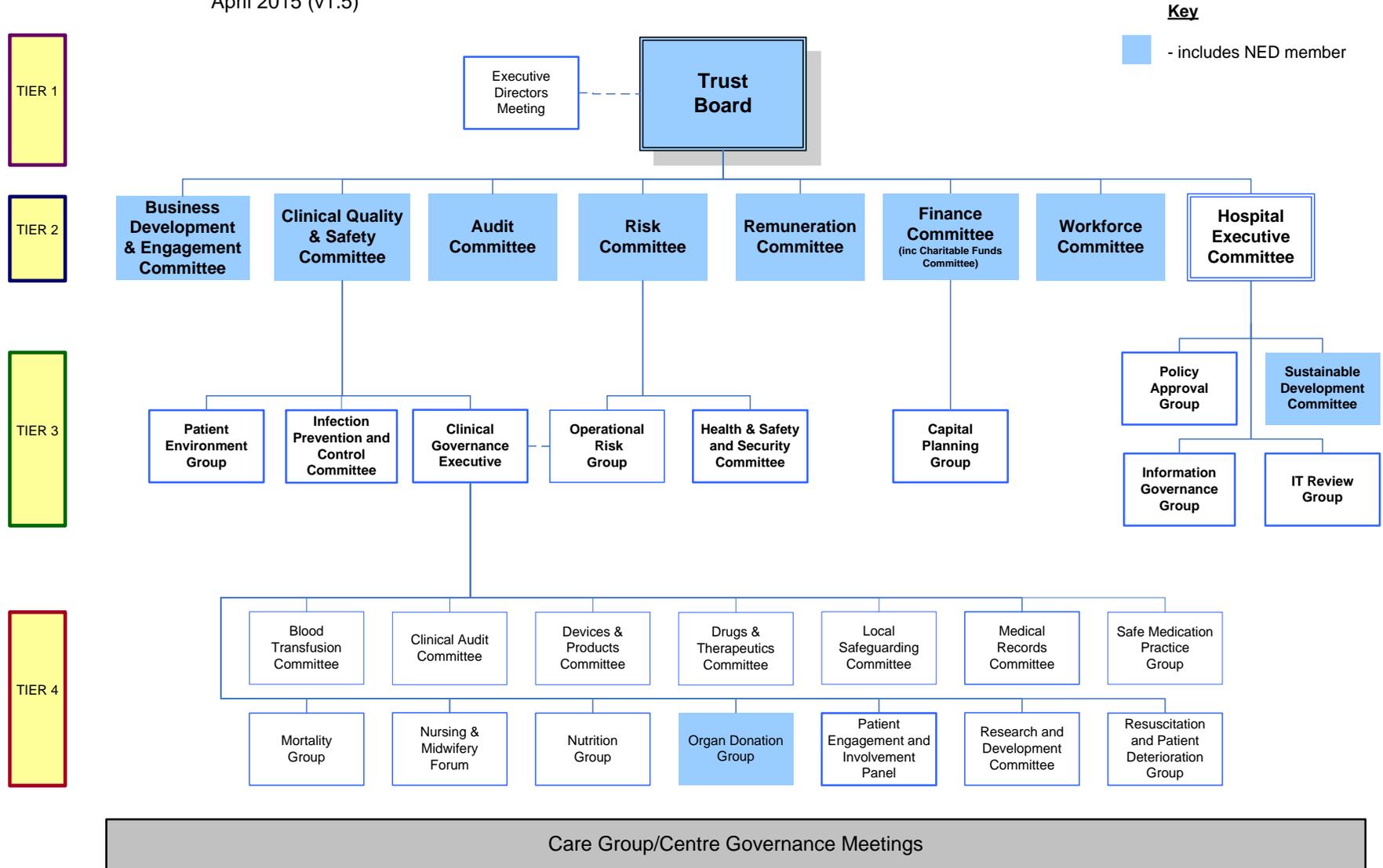
Risk Management Strategy v13

5.1 6.1	Better understanding of risk management at ward/department level (measured by RM Healthcheck)	High	Director of Corporate Governance	Head of Assurance	Jun-15	Annual Risk Management Healthcheck by Centres shows improvement across all measures since 2011. Further 'Healthcheck' sent out late April 2015. Compared with 2014, 4 measures had deteriorated, 2 had improved, and 18 had stayed the same. Main area of deterioration related to understanding of risk management strategy - see action below	AG	AG
5.1.1 NEW	Publish 'Risk Management Strategy' on a page for staff	Medium	Director of Corporate Governance	Head of Assurance	Oct-15	Risk Management Strategy updated and undergoing consultation. Risk Management Strategy 'on a page' in draft		A
5.1.2 NEW	Develop guidance on assurance linked to new Insight4GRC upgrade (risk register)	Medium	Director of Corporate Governance	Head of Assurance	Oct-15	Insight4GRC upgrade includes facility to include '3 levels' of assurance against each control. This will be rolled out starting with the highest scoring risks.		R
7.1	Sustained performance standards	High	Chief Operating Officer	Asst COOs	Sep-15	Performance at end of July 15 <ul style="list-style-type: none"> A&E - 90.74% against 95% target Incomplete RTT - 91.25% against 92% target CQC IMR June-15 - Trust risk score=Band 3	AG	AR
7.2	Developing and implementing an Information Management & Technology Strategy	Medium	Finance Director	Head of IT	Sep-15	<ul style="list-style-type: none"> Clear project management arrangements in place to prioritise competing demands. To link investment strategy to strong clinical sustainability argument to drive efficiencies to attract any external modernisation funding (for Pathology, Radiology, Pharmacy, EPR, GP comms) Successful allocation/drawdown from technology fund to facilitate developments New Strategic Priority agreed 	AR	A
7.3	Delivering estates strategy	Medium	Finance Director	Assoc Director of Estates	Mar-16	<ul style="list-style-type: none"> Appointed Head of Estates who takes up post in Oct 15. Appointed Interim Head of Capital Nov-14 8 Facet Survey commissioned to inform future work plan and underpin strategy A number of risks identified including asbestos, fire and water safety and progress being made Approval given to appointing Health and Safety Advisor to work with Estates 	AR	A
7.4	Delivering planned financial outcomes	Medium	Finance Director	Deputy Finance Director	Mar-16	The in-year financial forecast for 14/15 outturn deteriorated from £8.2m deficit to £12.2 deficit Permanent PDC secured in 14/15 to improve liquidity position Underlying deficit remains with forecast for 15/16 currently £18.2m deficit	R	R

Appendix C Trust Governance Structure

SaTH Committee Structure

April 2015 (v1.5)



Appendix D Risk Committee Terms of Reference

Terms of Reference

Risk Committee

Constitution

The Risk Committee reports to the Trust Board and oversees the on-going development, implementation and monitoring of the Trust's Risk Management Strategy. This includes overview of the most significant risks to the achievement of the Trust's objectives to ensure there are robust controls and mitigation actions in place.

The Committee will be required to adhere to the Standing Orders of the Trust.

Membership

Member	Nominated Deputy
Chief Executive (Chair)	Director of Nursing & Quality (Deputy Chair)
Director of Nursing & Quality	Deputy Director of Nursing & Quality
Medical Director	Unscheduled Care Governance Lead
Director of Corporate Governance	Head of Assurance
Chief Operating Officer	Assistant Chief Operating Officer – Scheduled Care Assistant Chief Operating Officer – Unscheduled Care
Non-Executive Director	Non-Executive Director
Head of Assurance	Health & Safety Manager
Attendance when required:	
Finance Director	Deputy Finance Director
Workforce Director	Deputy Workforce Director
Director of Communications	Communications Officer
Director of Strategy	Head of Planning

Quorum

For the Committee to be quorate, the presence of at least 4 members or their nominated deputy is required.

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix

Frequency

The Risk Committee shall meet quarterly. Additional meetings may be held at the discretion of the Chair

Authority

Authority for all decisions relating to risk management lies with the Trust Board of the Shrewsbury and Telford Hospital NHS Trust. The Committee has delegated powers from the Trust Board to oversee the risk management arrangements within the Trust and is authorised to investigate any activity within its terms of reference

Duties

- Oversee the implementation and further development of the Trust's Risk Management Strategy ensuring it supports the achievement of the Trust's objectives and business plan
- Provide a clear statement of the risk appetite for the management of risk throughout the organisation.
- Assess and review the composition and on-going development of the Board Assurance Framework ensuring it provides a robust tool through which the Board can monitor management of the organisation's key strategic risks, ensuring effective control and assurance mechanisms in place and that effective actions are being taken to address gaps in controls and assurance.

- Provide the Trust Board with assurance that a comprehensive Trust wide Risk Register is maintained which will enable the Board to have a shared and clear understanding of the key risks in the Trust; what mitigations are in place to manage risks and which risks are being tolerated
- Identify and validate new strategic risks and consider whether they pose a principle risk to the Trust's strategic objectives and should be included on the Board Assurance Framework
- Ensuring Director risk owners and risk action owners have plans in place to control identified risks and to take necessary action to ensure remedial plans are put into place should mitigation fall behind plan
- Identify potential threats and opportunities that may impact on the achievement of the Trust's objectives
- Receive and review the following items:
 - Draft Annual Governance Statement
 - CQC Intelligent Monitoring Reports
 - Internal and External Audits of Risk Management and Board Assurance Framework

Reporting from the Committee

The Committee will be directly accountable to Trust Board.

The Chairman of the Committee will report on the proceedings of each meeting to the next meeting and will draw to the attention of the Trust Board any matters of concern in relation to the effective management of the organisation's risks

The Chairman of the Committee will ensure that the Trust Board receives the Trust's Board Assurance framework.

The Risk Committee will produce an annual risk management report for the Trust Board

Reporting to the Committee

The Operational Risk Group and Health & Safety and Security Committee will report to the Risk Committee

Review

The Terms of Reference will be reviewed by the Board of Directors annually.

March 2015
V8

Appendix E Operational Risk Group Terms of Reference

Constitution

The Operational Risk Group (ORG) reports to the Risk Committee and supports the Trust's governance Committees in ensuring risk assessment and risk reduction plans are in place across the Trust. ORG will be required to adhere to the Standing Orders of the Trust.

Membership

	Member	Nominated Deputy
Core Members		
Director of Corporate Governance (Chair)	J Clarke	C Jowett
Head of Assurance (Deputy Chair)	C Jowett	K Titley
Assistant Chief Operating Officer – Scheduled Care	S Biffen	L Gill / K Malpass
Assistant Chief Operating Officer – Unscheduled Care	I Donnelly	H Davies
Support Services Care Group	D Jones	
Deputy Director of Nursing & Quality		J Banks
Women & Children Care Group	C Smith	T Kirby
MES Manager	T Penrose	
Health and Safety Team Manager	K Titley	H Watkiss
Head of Contracts & Performance	P Hodson	S Taylor
Head of IT	N Appleton	G Madin
IPC Lead	P O'Neill	J Pritchard
Head of Estates	T Cullinane	T Penrose
Deputy Director of Finance	J Price	
Capital Accountant	A Parkinson	
Deputy Workforce Director	S Hayes	K Hudson
Head of Planning	T Finch	
Security Manager	J Simpson	-
Legal & Compliance Manager	S Mashadi	-
Care Group Medical Directors / Clinical Directors / Centre Managers	Can attend any meeting. Must attend to present new risks. Must attend if outstanding actions for Care Group and as required to present updates to action plans.	
Risk Owners	Must attend a minimum of 1 meeting per quarter. Will receive agenda and minutes.	
Directors (or Nominated Deputy)	Must attend to present new risks. Can attend any meeting. Will receive agenda and minutes.	
The Group can call upon any member of staff to attend to discuss specific issues.		

Quorum

The Chair or Vice-Chair should be present, plus five members or their nominated deputy. At least one Care Group must be represented.

Attendance

Core members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a core member or their nominated deputy will attend for a minimum of 75% of meetings in a year. New risks will not be discussed if the relevant Care Group /Department is not represented at the meeting. Attendance will be monitored by an attendance matrix.

Frequency

ORG shall meet monthly. Additional meetings may be held at the discretion of the Chair

Authority

The meeting will consider risks identified by Care Groups /centres /departments and through corporate incidents e.g. serious untoward incidents, CQC inspections, MHRA/SABs alerts/ H&S and audit recommendations.

The Trust Risk Register (scores of 15 or above) will be presented quarterly to the Risk Committee with any changes to the highest risks being reported in-year.

New risks will not be considered unless they have gone through due process as described in the risk register procedure. All new risks should have an associated action(s) and this will be reviewed quarterly.

Duties

ORG will:

1. Identify and validate new risks and consider whether they should be forwarded for inclusion on the Board Assurance Framework
2. Review all risks with a risk score of 15 or above and all risks with a risk consequence score of 5...
3. Ensuring risk owners and risk action owners have plans in place to review all risks and rank them to ensure remedial plans are put into place should mitigation fall behind plan by quarterly review of action plans.
4. Oversee the maintenance and further development of the Care Group/Centre/Departments Risk Registers as key tools to support achievement of high levels of internal control, patient safety, and clinical quality to inform risk based decision making and specifically promote local level responsibilities and accountability for identifying and mitigating the organisations risks.
5. If ORG are not happy with progress, refer matter to COO/Director meeting, highlighting:
 - The top 3 risks for each Centre/Corporate Department
 - High (red) risks with unchanged scores for more than 12 months
 - Any risk not mitigated in line with the target date including risks with actions past their original implementation date
 - Risks (other than 'green' risks) with no actions recorded on 4Risk within 1 month of identification
6. Review findings and ensure implementation of recommendations arising from internal audits of Trust risk and compliance processes
7. Review and monitor actions arising from Regulation 28 letters from the Coroner, inquests, claims, and solicitor's risk management reports
8. Ensure the CQC framework is up to date and any outstanding actions are being progressed by the relevant area, and receive the CQC Intelligent Monitoring Report.
9. To receive BAF on a quarterly basis.

Reporting from the Committee

The Committee reports to the Risk Committee and supports the work of the Clinical Governance Executive.

Reporting to the Committee

All risks from tier 3 and tier 4 committees, along with Care Group risks will be discussed at ORG.

Review

The Terms of Reference will be reviewed annually.

Updated July 2015 – V13

Appendix F Responsibilities

Trust Board of Directors

The Board as a whole is responsible for reviewing the effectiveness of internal controls and for managing the Trust efficiently and effectively.

Chief Executive

The Chief Executive has overall responsibility for ensuring the implementation of an effective risk management system, supported by the Director of Corporate Governance and other key individuals (see below) with delegated authority.

Non-Executive Directors

The Non-Executives are accountable to the Secretary of State. They are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

Directors

Whilst the Chief Executive has overall responsibility he delegates various aspects of risk management, including implementation of this strategy as follows:

Director	Area of Risk Management Responsibility	
Executive Directors		
Chief Operating Officer	<ul style="list-style-type: none"> Business Continuity Care Groups 	<ul style="list-style-type: none"> Major Incident Planning
Director of Nursing and Quality	<ul style="list-style-type: none"> Child and Adult Protection Clinical Governance (with Medical Director) Infection Prevention and Control 	<ul style="list-style-type: none"> Nursing and Midwifery Practice Patient Experience Patient Safety
Finance Director	<ul style="list-style-type: none"> Finance Fraud prevention Information Governance SIRO 	<ul style="list-style-type: none"> Performance and Contracts Estates and Facilities Environmental Information and Information Technology
Medical Director	<ul style="list-style-type: none"> Caldicott Guardian Clinical Safety Officer Patient Outcomes Clinical Governance (with Director of Nursing & Quality) Information Technology 	<ul style="list-style-type: none"> Medical Practice Medicines Management Research and Development Revalidation Medical Education
Directors		
Communications Director	<ul style="list-style-type: none"> Media 	<ul style="list-style-type: none"> Reputation Management
Director of Corporate Governance	<ul style="list-style-type: none"> Risk and Assurance Framework Foundation Trust programme Health and Safety 	<ul style="list-style-type: none"> Legal Services Security Management Sustainability
Director of Business and Enterprise	<ul style="list-style-type: none"> Future Configuration of Hospital Services 	<ul style="list-style-type: none"> Strategy Business planning
Workforce Director	<ul style="list-style-type: none"> Human Resources Organisational Development 	<ul style="list-style-type: none"> Training and Development

Director of Corporate Governance

- Lead Director for risk management
- Fulfils the role of Board Secretary
- Develop corporate risk management strategies and policies interpreting national guidance to fit the local context
- Develop the Board Assurance Framework (BAF) in conjunction with the Trust Board

Head of Assurance

- Develop and maintain the risk registers, providing advice and guidance on use of the electronic risk register (Insight4grc)
- Maintain the BAF
- Oversee the running of the Operational Risk Group and Risk Committee ensuring risks are reported, assessed and managed through the submission of the risk registers
- Produce an annual risk management report for the Risk Committee
- Keep an up to date assurance schedule of planned external visits and audits (clinical and non-clinical)

Head of Legal and Security Services

The Head of Legal and Security Services is responsible for claims management, liaising with solicitors and insurers to ensure timely and cost effective claims handling. They are also responsible for liaison with HM Coroner and the Police. They ensure that any risk management issues/actions identified during a claim, or inquest is referred for action.

Security Manager

The Trust's Security Manager is accountable to the Director of Corporate Governance in their role as Local Security Management Specialist (LSMS) and is responsible for developing systems for the security of staff, patients, property and assets

Health & Safety Team Manager

The Trust Health & Safety Team Managers reports to the Head of Assurance and is the Trust lead for Health and Safety. Their duties include planning, advising and monitoring the Trust's day to day compliance with:

- The Health and Safety at Work etc, Act 1974 and the relevant statutory Regulations and provisions of appropriate Approved Code Of Practice
- All procedures that comprise The Shrewsbury and Telford NHS Trust's Health and Safety Framework (See Policy on Intranet for more details)

Associate Director of Patient Safety

Reports to the Director of Nursing and Quality and is responsible for;

- Developing and maintaining effective clinical risk systems. Specifically ensuring effective systems for reporting incidents and near misses, appropriate investigations (including root cause analysis) are carried out, feedback is given, and an accurate database is maintained.
- Trend analysis and the identification and notification of serious incidents to the Board and external stakeholders.
- Supporting the Care Groups through education and communication in their Clinical Governance programmes

Associate Director of Patient Experience

Reports to the Director of Nursing and Quality and is responsible for;

- Management and coordination of formal complaints ensuring that required follow up action is taken to prevent a recurrence
- Trend analysis and the identification and notification complaints to the Board
- Oversees the Patient Advice and Liaison Services (PALS).

Research and Development Director

The Research and Development Director is responsible for management of research, and research governance processes. Incidents arising from research will be reported via the Trust's incident reporting procedure.

Head of Education

The Head of Education is responsible for coordinating education, development and training activities within the Trust and leads on the use of the NHS Knowledge and Skills Framework

Associate Director of Estates

The Associate Director of Estates has corporate responsibility for all relevant fire safety legislation and NHS Fire Code; and compliance with the Environmental Protection Act 1990, together with associated Acts & Regulations;

Head of Facilities

The Trust's Head of Facilities is accountable for:

- The Food Safety Act 1990 and Food Safety (General Food Hygiene) Regulations 1995 together with other associated Acts and Regulations

Other specialist support

For managers or staff who need specialist support, it is available from the following post holders for their respective area of expertise:

- Director of Infection Prevention and Control (DIPC)
- Fire Safety Advisor
- Occupational Health Service
- Estates Professionals
- Catering/Food Hygiene Professionals
- Medical Equipment Professional
- Union Safety Representatives
- Moving & Handling Advisors
- Human Resources Advisors
- Finance Manager
- Local Counter Fraud Specialist
- Information Governance Manager
- Child Protection Lead
- Vulnerable Adults Lead
- Chief Pharmacist

Care Group / Centre Management Teams

The Management Teams have delegated authority for assessment, management and reporting of risks within their areas and engaging all staff in this process. In particular, they will be responsible for:

- Ensuring all areas have local risk management systems in place and that all staff are made aware of the risks within their work area and of their personal responsibilities in relation to risk management.
- Ensuring there are effective systems in place for the identification, management and review of risks including risks to the achievement of CQC standards
- Ensuring risk registers are in place and escalate identified risks to the Operational Risk Group in line with the requirements of this strategy.
- Ensuring risk assessments are taken forward and appropriate and sufficient controls are established and maintained to ensure that the risk is managed at the lowest reasonably practicable level.
- Ensuring that their staff receive the required level of information and training to enable them to work safely and comply with Trust policies and that they are competent to identify, assess and manage risk within their areas.
- Completing sub certification to support the Annual Governance Statement
- Ensuring the promotion of an open, reporting and learning culture
- Establish a local risk assurance group to monitor the local risk register (this could be a standalone meeting, or part of a wider meeting to suit local needs)

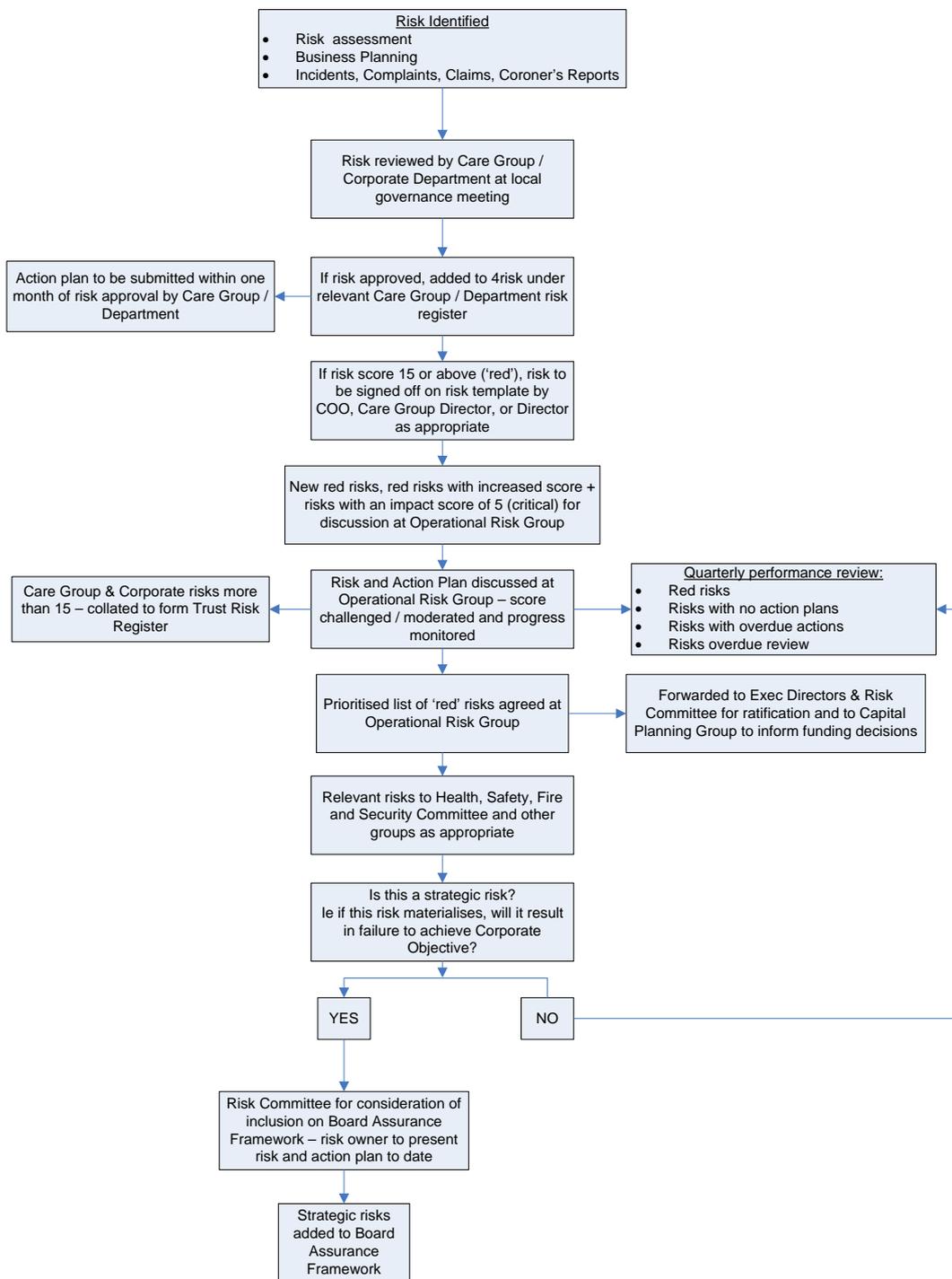
Responsibilities of all Employees

All staff are expected to:

- Report to their line manager any perceived risk in the area which requires assessment and management and participate in risk assessment and risk control as required
- Report incidents/accidents and near misses using Datix.
- Attend training as identified by their manager through appraisal, or as stated in the Trust risk management training policy.

Appendix G Information Flows for Risk

Risk Management Process



Appendix H Risk Matrix
RISK CONSEQUENCE SCORE

	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Severe	Critical
Safety	None or minimal harm – no intervention required H&S – Little chance of injury or illness due to lack of maintenance or process.	Minor avoidable injury or illness, requiring minor intervention H&S – small chance of injury or illness	Moderate avoidable injury requiring professional intervention (RIDDOR reportable) H&S – moderate chance of injury or illness due to lack of maintenance or failure in process	Major avoidable injury leading to long term incapacity / disability H&S – Probable serious injury due to lack of maintenance or failure in practice.	Incident leading to avoidable death or serious permanent harm (for example e.g. wrong site surgery or loss of vision.) H&S – Probable fatality due to lack of maintenance or failure in practice.
Quality	Peripheral element of treatment or service sub optimal Informal complaint	Clinical outcome not affected OR increase in length of stay 3 – 10 days (department level) Overall treatment or service suboptimal Minor implications for patient safety if unresolved	Individual consultant clinical outcome in lower 25% for up to a month OR increase in length of stay for large number of patients <15 days (Centre level) Repeated failure to meet internal standards Patient safety implications if findings are not acted on	Individual consultant clinical outcome in lower 10% for up to a month OR speciality clinical outcomes in lower 25% for up to one month OR increase in length of stay for large number of patients >10 days (Trust level) Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent critical report	Individual consultant clinical outcome in lower 10% for in-excess of 3 months OR speciality clinical outcomes in lower 25% for over one month OR increase in length of stay for significant number of patients >10 days (Trust level) Gross failure of patient safety if findings are not acted on Inquest PFD potential/ ombudsmen inquiry Gross failure to meet national standards
Finance	Costs within the remit of individual employees as set by the Scheme of delegation	0.5% of budget OR Major impact on budget holder's financial position	Financial impact £100k - £250k	Financial impact £250k - £1million	Financial impact £1million+
Inspection / Audit	Minor recommendations. Minor non-compliance with standards. No breach of guidance	Single breach of statutory duty.	Challenging external recommendations / improvement notice issued	Multiple breach and prosecution notice issued Enforcement Action Prohibition notice.	Multiple breach and prosecution Severely critical report
Service / Business Interruption Environmental impact	Loss / interruption > 1 hour OR Minimal / no impact on environment OR Little damage to machinery / equipment	Loss / interruption < 1 day (department level) OR Minor impact on environment OR Moderate damage to machinery, easily repairable	Loss / interruption > 1 day (Centre level) OR Moderate impact on environment OR Machinery shut down immediately and restarted in less than half a day	Loss / interruption > 1 week OR Major impact on environment OR Machinery will be out of action more than a week to repair	Permanent loss of service or facility (Trust level) OR Catastrophic impact on environment OR Damage will spread beyond one item of machinery and take over one week to repair
Service Delivery / business management	Failure to meet individual objectives set out in KSF process or minimal impact	Failure to meet internal standards with some impact on overall performance of business unit	Failure to meet internal standards with some impact on overall performance of Trust	Major impact on overall performance which puts achievement of standards or ability to meet Monitor risk rating and national requirements at risk	Sustained failure to meet standards or failure to meet Monitor risk rating and national requirements. Serious impact on overall performance and possible intervention
Adverse Publicity / Reputation	Minimal impact	Short term local interest and impact from an issue (e.g. leading to reduced public confidence in a service)	Moderate or short term impact on reputation leading to moderately reduced public confidence in the Trust	Major or medium term impact on reputation leading to significantly reduced public confidence in the Trust	Serious and long term impact on reputation leading to total loss of public confidence in the Trust
Human Resources / Organisational Development	Nil	Low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). OR Unsafe staffing level or competence (>1 day).OR OR Low staff morale OR Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff OR Unsafe staffing level or competence >5 days) OR Loss of key staff. Very low staff morale. OR No staff attendance for mandatory / key training. OR Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff OR On-going unsafe staffing levels or competence OR Loss of several key staff OR No staff attending mandatory / key training on an on-going basis

Risk Likelihood : Frequency or Probability Score

Descriptor	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
Frequency <i>How often might it/does it happen?</i>	Highly unlikely but it may occur in exceptional circumstances. It could happen but probably never will.	Not expected but there's a slight possibility it may occur at some time	The event might occur at some time as there is a history of casual occurrence at the Trust or within the NHS	There is a strong possibility the event will occur as there is a history of frequent occurrence at the Trust or within the NHS	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the Trust or within the NHS
Probability <i>ie will it happen or not within given time frame?</i>	<0.1 percent	0.1 – 1 percent	1 – 10 percent	10 – 50 percent	> 50 percent

Risk Quantification Matrix

Insert Consequence and likelihood scores on the risk assessment form and consult matrix below

Likelihood	Consequence				
	1 Insignificant	2 Minor	3 Moderate	4 Severe/Major	5 Critical
5 - Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10*
1 - Rare	1	2	3	4	5*

Risk Rating: level at which risks will be managed

High - Prompt action is required, so far as is reasonably practicable. Risk MUST be signed off by COO or deputy and then notify OPERATIONAL RISK GROUP. MANAGEMENT BY CARE GROUP Strategic risks only for consideration of inclusion on BAF via RISK COMMITTEE.
Medium - Risk reduction is required, so far as is reasonably practicable. PROACTIVE REVIEW and MANAGEMENT BY CENTRE with assurance through local governance.
Low - Risk within tolerance. Risk reduction is required, so far as is reasonably practicable ONGOING REVIEW & MANAGEMENT by DEPARTMENTS with assurance through local governance.
Very Low - Risk within tolerance and further risk reduction may not be feasible or cost effective. MONITORING AT OPERATIONAL LEVEL.

NB *Any risks that score a 5 in the impact category ie 'critical' will also be discussed at Operational Risk Group and may be escalated to the Risk Committee.

Risks which directly threaten the Corporate Objectives are strategic risks and must be escalated to Risk Committee. All other risks are operational and will be managed in line with RM Strategy

V22 July 2015



Annual Governance Statement

Subcertification Process

I certify that the [] Risk Register:

- is up-to-date,
- reflects all risks rated at 8 or above in my areas of responsibility
- identifies all the controls currently in place for the identified risks
- identifies timed actions for mitigation of all identified risks
- Identifies the assurances (received or planned) that will enable [] to demonstrate that the risk is adequately managed.

For any lapses please provide details of action taken:

Signature

Date

Position

Appendix J Related Policies and Procedures

Reservation of Powers to the Board and Delegation of Authority
Standing Financial Instructions and Standing Orders

Risk Management Handbook
Risk Register
Board Assurance Framework
Women and Children's Risk Management Strategy

An Organisation-wide Policy for the Development and Management of Procedural Documents (Gov 01)

Procedure for the reporting and Investigation of incidents, complaints and claims
Serious Incident policy
Learning from adverse events policy

Health and Safety Policy
Health and Safety Risk Assessment Templates
Claims Management policy
Concerns and Complaints policy and procedure
Fire Policy
Security Management Policy
Major Incident Plan

Management of Corporate and Local Induction Policy
Whistleblowing policy HR05
Maintaining high standards of performance

Infection Control Policies
Medical Devices Training Policy

Appendix K References

¹ *CNST maternity Clinical Risk Management Standards NHSLA (January 2011)*

² *Australian/ New Zealand Standard. Risk Management: AS/NZS 4360 19. (19) Copyright Standards Association of Australia, Strathfield, New South Wales, Australia*