NHS
The Shrewsbury and Telford Hospital
NHS Trust

Recommendation ☑ **DECISION** ☐ **NOTE**	The Trust Board is asked to **approve** the Risk Management Strategy
Reporting to:	Trust Board
Date	June 29 2017
Paper Title	Risk Management Strategy
Brief Description	In line with best practice, the Risk Management Strategy is reviewed regularly. 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 March 2017 gave an opinion of substantial assurance on the processes in place in the Trust for the fifth consecutive year. The main changes to the strategy are: • Addition of a 'strategy on a page' • Updated definition of risk (4.1) to "the effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies" • Addition to Statement of Intent (2) to include reference to Duty of Candour. • Addition of tactical and compliance risks (section 8.1) • Updated information on risk profiles to map to Operational Risk Group Terms of Reference • Updated appendices The complete document can be found in the Information Pack.
Sponsoring Director	Director of Corporate Governance
Author(s)	Head of Assurance
Recommended / escalated by	
Previously considered by	Operational Risk Group All Trust Senior and Operational Managers
Link to strategic objectives	
Link to Board Assurance Framework	
Equality Impact Assessment	● **Stage 1 only (no negative impacts identified)** ● **Stage 2 recommended (negative impacts identified)** ● negative impacts have been mitigated ● negative impacts balanced against overall positive impacts

The Shrewsbury and Telford Hospital NHS Trust

Freedom of Information Act (2000) status	● **This document is for full publication** ● **This document includes FOIA exempt information** ● **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Paper 23

RISK MANAGEMENT STRATEGY

RM01

To be read in conjunction with: Risk Management Handbook

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Lead Director	Director of Corporate Governance
Date issued:	
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Target:	Overarching Strategy for specific Trust Risk Management Policies

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Document Control Sheet

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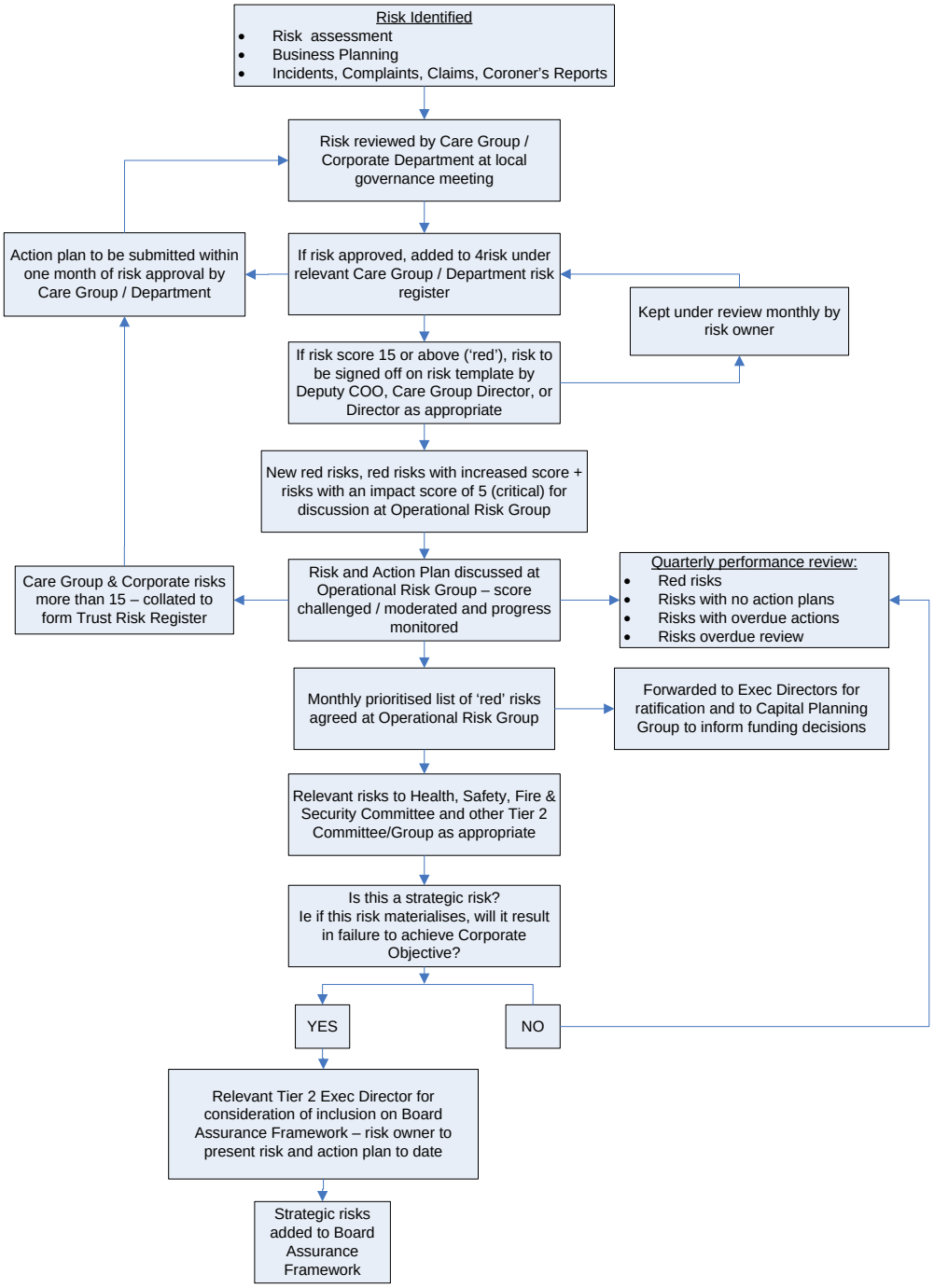
V13	July 15	CJ	Final	
V13.1	Aug 16	CJ	Draft	Updated to reflect changes to Committee Structure All appendices updated with current versions
V14	Mar 17	CJ	Draft	Sections reordered Updated all appendices Addition to Statement of Intent to reference Duty of Candour Incorporating the Women and Children's Care Group Risk Management Strategy - integrated with Corporate Risk Management Strategy

Contents

Strategy on a page



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 achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. The Trust Board recognises that effective risk management is central to achieving the Trust objectives 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'*) Promoting a culture of openness and truthfulness is a prerequisite to improving the safety as well as the quality of healthcare. The culture of "Being Open" should be fundamental in relationships with and between patients, the public, staff and other healthcare organisations. The Duty of Candour (introduced from 1 April 2013) is the contractual requirement to ensure that the Being Open process is followed when a patient safety incident results in moderate harm, severe harm or death. The Trust's Whistleblowing Policy also 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 Quality and Safety 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.

2 Strategy Aims

The aim of this strategy is to describe the Trust's process for managing risks so that threats are minimised whilst opportunities are maximised. 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 strategy aims to:

- Ensure the potential for harm to patients, staff and visitors, is minimised to the lowest reasonably practicable level
- Ensure the well-being of patients, staff and visitors is optimised (healthiest 05 million on the planet)
- Protect valuable assets including high standards of care, staff safety, reputation and physical assets and income streams
- Deliver an integrated approach to the management of risk, ensuring risk management is embedded within the organisational culture

- Promote the open reporting of mistakes, within a 'just' culture and that lessons are learnt and actions promptly implemented to prevent recurrence.
- Embrace and explore relevant strategic and business risks as opportunities to develop the service

A list of associated documents is at appendix F.

3 Scope

- The strategy applies to all Care Groups and Trust staff, contractors and other third parties, including those with honorary contracts, working in all areas of the Trust.

- Risk management is the responsibility of all staff

- All managers are expected to take an active lead to ensure that risk management is a fundamental part of their approach to clinical and corporate governance.

4 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.

4.1 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 -

"the effect of uncertainty on the 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.

5 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.

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.

On a regular basis, the Trust will agree its risk appetite statement as a separate document for each of the Trust objectives. Further guidance on risk appetite is at Appendix D.

6 Responsibilities and accountabilities for risk management

Each area of the Trust must undertake an on-going assessment of risks that may have an impact upon the Trust objectives

Risk management is the responsibility of all staff and formal governance processes throughout the Trust map out the escalation route of risks. Appendix C sets out specific risk management responsibilities throughout the Trust.

7 Risk Management Organisational Structure

The Trust governance (committee) structure is shown at appendix A. 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:

7.1 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

7.2 Audit Committee

The Audit Committee 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.

7.3 Tier 2 Committees (Quality and Safety, Workforce, and Sustainability)

These Committee are formal sub-committees of the Board established to provide assurance to the Board on their areas of delegated responsibility. The Tier 2 Committees (Quality and Safety, Workforce, and Sustainability Committee) are responsible for monitoring the relevant Board Assurance Risks which they receive at each meeting, along with the prioritised risk register. These committees

provides assurance to the Trust Board that the systems for risk management and internal control are effective.

7.4 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 B.

7.5 Health, Safety, Fire and Security Committee

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

7.6 Care Group Boards

Each care group board is responsible for receiving risks identified via their governance groups and receive monthly reporting on risks; with associated mitigation and actions completed. Likewise, any Standard Operating Procedures in relation to the practical application of risk management within the care group are agreed and ratified by the Care Group Board.

8 The Risk Management System

The Trust adopts a structured risk management process, whereby risks are identified, assessed and controlled, and escalated or de-escalated as appropriate through the governance structures of the Trust. There is an agreed methodology to analyse the range of potential consequences and likelihood of occurrence of risks. The Trust uses the national NPSA classification 5 x 5 matrix (appendix E)

A summary of the risk management process shown on the strategy on a page.

8.1 Risk Types

Risks are events that ‘might’ happen, which could stop the Trust from achieving its objectives. Risk management also includes issues which have happened and were not planned, but require management action to mitigate the consequence. 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 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.

Other important types of risk are:

Tactical Risks: These relate to the risks which may be affected by the changes in business conditions on a real time bases and may result in losses. For example if one of the computer servers was identified as having a security vulnerability and acitons had to be taken immediately to rectify this or a major Health and Safety risk is identified and actions must be taken to ensure safety of the staff and patients. It is important for these risks to be highlighted as soon as they are made known, and controlled.

Compliance Risks:- These risks relate to issues which may result in the Trust failing to comply with Legislation or National Standards or Regulations. These usually attract financial penalties against the Organisation if they are not met. An example of these are Health and Safety Risks but there are other areas for example where failing to meet certain CQC standards may result in finiancial penalty.

9 Risk Management Process

Risks are managed through the following key stages:

- Agreeing objectives
- Identifying risks that relate to objectives
- Evaluating risks
- Entry onto the risk register
- Identifying mitigating actions
- Escalation, de-escalation and archiving of risks

9.1 Agreeing objectives

The Trust believes it is essential to develop a strategy that is balanced between strategic domains. 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.

Agreeing objectives is the first step in risk management. This allows staff to recognise and manage potential risks that may prevent the achievement of strategic or local objectives.

9.2 Identifying risks to objectives

Risk identification is the process of identifying what could happen to prevent achievement of objectives. The first step is for teams 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.

9.2.1 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.

9.2.2 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.

9.2.3 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.

9.3 Evaluating risks

All risks, independent of their origin, are evaluated using the Trust's risk matrix (appendix E). 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.

Risks should be described in a clear and concise manner to ensure common understanding. It is helpful to describe the risk, the cause and effect, and the wider impact on the objectives if no action is taken to control the risk.

9.4 Entry onto the Risk Register

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. All staff with permission to access risk registers are able to see the risks for the whole organisation.

The process for completing risk registers:

- Assign an owner, and ideally a delegated owner, for the risk.
- Describe the risk
- Rate the likelihood and consequence of the risk materialising
- List the key controls
- Rate the likelihood and consequence of the risk materialising with the current controls in place
- Detail the planned actions to mitigate the risk to an acceptable level. All actions must have a named action owner and realistic completion date.
- Rate the target score for the risk

9.4.1 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 might 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.

9.4.2 Risk Controls

Controls are the actions put in place as preventative measures to reduce the likelihood or consequence of the risk happening, and the severity if it does. I.e. policies, procedures, protocols, training or physical safeguards 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

9.5 Identifying mitigating actions

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 though 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.

9.5.1 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.

9.5.2 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.

9.5.3 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.

9.5.4 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 monthly* 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. (*the Insight4GRC risk register system requires monthly review of all risks)

9.6 Escalation, de-escalation and archiving of risks as appropriate

The consequences of some risks, or the action needed to mitigate them, can require escalation of the risk to a higher management level. For example from a centre to a care group risk register. Risks will be escalated and de-escalated within the defined tolerances for each level.

The risk owner should discuss and seek approval from their manager, who in turn should consult their manager before escalation to the next level.
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) & Tier 2 Committees (strategic risks - BAF)	Assistant COO or Care Group Director*, (operational areas) or relevant Director	Centre, Care Group, Operational Risk Group. Tier 2 Committees & Trust Board
Very High (20-25)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Tier 2 Committees (strategic risks - BAF)	COO or relevant Director	Centre, Care Group, Operational Risk Group. Tier 2 Committees & Trust Board

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

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

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

When risks have been controlled to the target level, the risk owner should close the risk on the Insight4GRC system with a closing statement. This archives the risk but it is remains available for viewing.

10 Managing the Trust Risk Registers

10.1 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.

10.2 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 / 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

10.3 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. .

10.4 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. If appropriate, ORG will recommend that the risk owner be invited to the relevant Tier 2 Committee to present the risk.

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

10.5 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. A summary risk profile is a simple visual mechanism which can be used for reporting. The diagram shows the number of risks in each inherent risk category, with the risk tolerance for reporting to Operational Risk Group shown:

	Insignificant	Minor	Moderate	Severe / Major	Critical
Almost certain		3	2	2	
Likely		1	10	7	1
Possible		1	9	26	1
Unlikely	1	2	4	4	6
Rare		1			1

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 scoring 8 or more where action plans are behind target
- Medium / high Risks without action plans (risks scoring 8 or above)
- Medium / high risks without controls (risks scoring 8 or above)
- Risks overdue review by 2 months

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

The escalation process outlined in section 9.6 will ensure executive oversight of high risks. The Tier 2 Committees will review the Board Assurance Framework (BAF) at least quarterly and will receive a high level extract of the risk register at this meeting.

10.6.1 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 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 to Executive Directors 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 at least four times a year by the Tier 2 Committees and presented to the 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

11 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.

11.1 Risk awareness training for senior managers and Board Members

Board members and other identified senior managers[1] 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, on risk assessment, particularly the scoring or grading of risks and how to use the risk register.

12 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.

13 Monitoring Mechanisms

Item monitored	Monitoring method	Responsibility for monitoring	Frequency of monitoring	Group or Committee
Risk Management Strategy	Review of risk management / BAF	Internal Audit	Annual	Audit Committee
Annual Governance Statement	Review	Internal and External Audit	Annual	Audit Committee
Risk Profiles	Risk profile report	Head of Assurance	Quarterly	Operational Risk Group

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 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.

[1] see Trust 'Who's Who on a Page'

14 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 every three years by the Board (or sooner if there are significant changes locally or at national policy level).

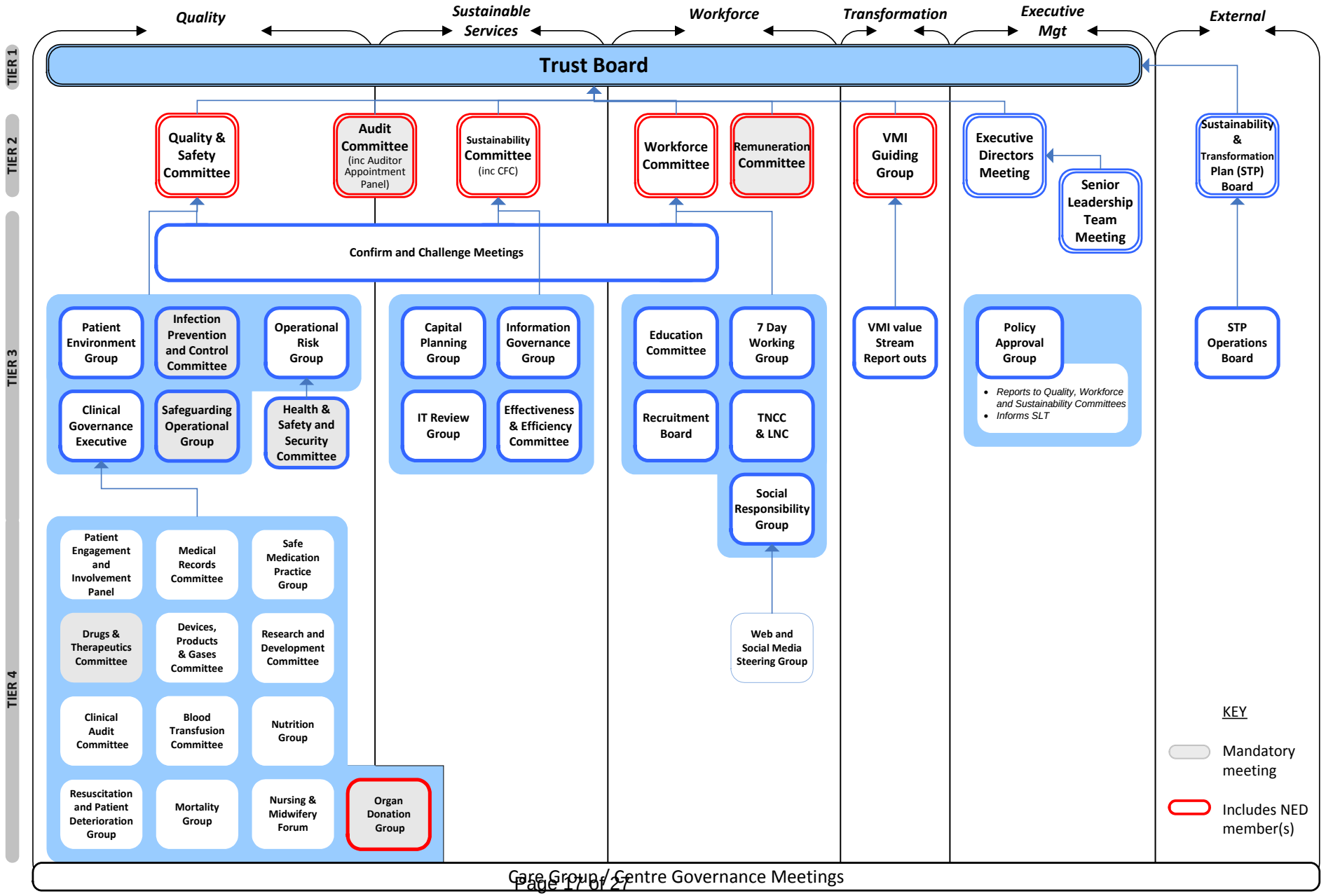
Trust Board approved the policy on _____

And becomes effective on _____

Chief Executive	***Trust Chair***
Signed _____	***Signed*** _____
Dated _____	***Dated*** _____

Appendix A Trust Governance Structure

SaTH Committee Structure – May 2017



Appendix B Terms of Reference

The Shrewsbury and Telford Hospital NHS Trust

Operational Risk Group Terms of Reference

Constitution

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

Membership

	Member	Nominated Deputy
Core Members		
Head of Assurance (Chair)	C Jowett	S Mashadi
Assistant Chief Operating Officer – Scheduled Care	C Scott	L Gill / K Malpass
Assistant Chief Operating Officer – Unscheduled Care	C McInnes	
Deputy Director of Nursing & Quality	H Jenkinson	G Mitchell
Support Services Care Group	D Jones	S Fryer / G Whitehouse
Women & Children Care Group	J Banks	T Kirby
MES Manager	N Watkinson	Marion Tench
Health and Safety Team Manager	K Titley	Elinor Jones
Head of Contracts & Performance	P Hodson	Sean Taylor / R Pearson
Head of IT	N Appleton	G Madin
Infection Prevention Control	P O'Neill	J Pritchard
Associate Director of Estates	M Foster	Dave Thomas
Deputy Director of Finance	J Price	Sarah Edmonds
Capital Accountant	A Parkinson	Sarah Taylor
Deputy Workforce Director	A Brett	K Hudson
Head of Planning	K Shaw	Louise Jones
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.	
Directors (or Nominated Deputy)	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 are 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 Executive Directors 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. Ensure new risks have appropriate controls and actions in place, and a have considered a business continuity plan

3. Review all risks with a risk score of 15 or above; and all risks with a risk consequence score of 5.

4. Ensuring risk owners and risk action owners have plans in place to review all risks and ensure remedial actions are put into place to mitigate risks

5. Rank the validated risks in priority order to inform Executive Directors, Tier 2 Committees, Capital Planning Group and Trust Board.

6. 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.

7. Carry out quarterly review of risk profiles :
   - The top risks for each Centre/Corporate Department
   - High (red) risks with unchanged scores for more than 12 months
   - Any 'high' or 'medium' risks not mitigated in line with the target date including risks with actions past their original implementation date (risk score 8 or above)
   - Risks (other than 'very low', and 'low' risks) with no actions recorded on 4Risk within 1 month of identification
   - Risks without identified controls

   If ORG are not happy with progress, refer matter to COO/Director,

8. Review findings and ensure implementation of recommendations arising from internal audits of Trust risk and compliance processes

9. Review and monitor actions arising from Regulation 28 letters from the Coroner, inquests, claims, and solicitor's risk management reports

10. To receive BAF on a quarterly basis.

Reporting from the Committee
The Committee reports to the Executive Directors and the Quality 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 March 2017 ORG (V17)

Appendix C 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 is the Accountable Officer for the Trust and for ensuring the Trust meets its statutory and legal requirements. 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. The Chief Executive is supported by the Director of Corporate Governance and other key individuals (see below) with delegated authority.

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

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

Director	**Area of Risk Management Responsibility**	
Executive Directors		
Chief Operating Officer	• Business Continuity • Care Groups	• Major Incident Planning
Director of Nursing and Quality	• Child and Adult Protection • Clinical Governance (with Medical Director) • Infection Prevention and Control	• Nursing and Midwifery Practice • Patient Experience • Patient Safety
Finance Director	• Finance • Fraud prevention • Information Governance • SIRO • Future Configuration of Hospital Services	• Performance and Contracts • Estates • Environmental • Information and Information Technology • Strategy • Business planning
Medical Director	• Caldicott Guardian • Clinical Safety Officer • Patient Outcomes • Clinical Governance (with Director of Nursing & Quality) • Clinical Information	• Medical Practice • Medicines Management • Research and Development • Revalidation • Medical Education
Directors		
Director of Corporate Governance	• Risk and Assurance Framework • Health and Safety • Facilities • Volunteers • Public Engagement • Complaints	• Legal Services • Security Management • Sustainability • Media and Communications • Freedom of Information
Workforce Director	• Human Resources • Organisational Development	• Training and Development

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.

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 Trust Tier 2 Committees and Operational Risk Group and development of the risk registers.

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:

- Taking personal responsibility for manging risk
- 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.
- Identifying the actions needed to reduce risk and assign action owners
- Ensuring staff are suitably trained in risk management.
- Ensuring the promotion of an open, reporting and learning culture, including learning from incidents, complaints and claims
- 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)
- Implement a local process to escalate the most severe risks
- Ensuring the risk management is included in appraisals and development plans were appropriate

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

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

Head 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

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.
- Where staff feel that raising issues may compromise them or may not be effective they should use the Trust Whistleblowing Policy (HR05)

Appendix D Developing a risk appetite statement

Introduction

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".

There are a number of definitions in the literature for the terms 'risk appetite' and 'risk tolerance' and these terms are often used interchangeably.[2]

HM Treasury, in their Orange Book[3] define risk appetite as *'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.'*

The Risk Management Society (RIMS) further develops this definition to distinguish between risk appetite and risk tolerance as follows:

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'*

Risk tolerance is '*the amount of uncertainty an organisation is prepared to accept in total or more narrowly within a certain business unit, a particular risk category or for a specific measure'.*

The concept of a 'risk appetite' is therefore intrinsically linked to an organisation's objectives and expresses how much risk the organisation is prepared to take to in pursuit of these objectives, particularly in relation to taking opportunities.

Risk tolerance could be said to describe the specific minimum and maximum levels which the organisation is prepared to accept in relation to identified risks. This is importance as exceeding the organisation's risk tolerance levels, for example, by over-managing a risk, could have negative consequences in terms of cost, or diversion of effort from higher priorities.

Why is this important?

The Trust needs to know about risk appetite because:

- If we don't know what our organisation's collective appetite for risk is this may lead to risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development (see risk appetite – 3.1)

- If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected (see risk tolerance – 3.2)

A well-defined risk appetite enables people to take well calculated risks when opportunities arise but also to identify those instances when a more cautious approach is needed.

3 The risk appetite statement

The importance of having a documented statement is emphasised within the new British Standard: "The organisation should prepare a risk appetite statement, which may provide direction and boundaries on the risk that can be accepted at various levels of the organisation, how the risk and any associated reward are to be balanced and the likely response." (BS31100)

At least once a year, the Trust Board should review its appetite for, and attitude to risk. This should include the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act.

[2] *Exploring Risk Appetite and Risk Tolerance* RIMS 2012
[3] *The Orange Book: Management of Risk – Principles and Concepts* HM Treasury, 2004

The board should define the Trust's risk appetite i.e. the risk limits that the board desires, or is willing, to take. Risk appetite, therefore, is a series of boundaries, appropriately authorised by the board, which guide staff on the limits of risk that they can take.

3.1 Risk Appetite

The Good Governance Institute have produced a risk appetite matrix which is attached at appendix 1. It is recommended that the risk appetite matrix is used to determine the Board's attitude to risks in relation to the key elements of this matrix. These risk appetites can then be mapped to the strategic objectives to give guidance to managers.

The guidance is available here: https://www.good-governance.org.uk/services/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/

The matrix covers the following risk categories, and gives examples of risk statements for each of the risk appetites (none – low – moderate – high – significant):

- Financial / VFM
- Compliance / Regulatory
- Innovation / Quality / Outcomes
- Reputation

Once the appetite to each type of risk has been agreed, a short risk appetite statement will be drafted. For example,

Reputation
The board is prepared to take decisions with the potential to bring additional scrutiny of the organisation, provided that the potential benefits outweigh the risks and by prospectively managing the organisation's reputation.

3.2 Risk tolerance

Risk tolerance is already an established part of the risk management process. The risk registers contain target risk scores which describe the desired risk after all mitigations and actions have been completed and therefore expresses the level of risk, in relation to a particular issue, that the organisation will tolerate. This is reasonably well embedded at operational level.

Appendix E 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 – very minor injury or illness due to lack of maintenance or process.	Minor avoidable injury or illness, requiring minor intervention H&S – minor injury or illness	Moderate avoidable injury requiring professional intervention (RIDDOR reportable) H&S – moderate injury or illness due to lack of maintenance or failure in process	Major avoidable injury leading to long term incapacity / disability H&S –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 –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 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency ***How often might it/does it happen?***	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 ***ie will it happen or not within given time frame?***	<0.1 percent	0.1 – 1 percent	1 – 10 percent	10 – 50 percent	> 50 percent
Replacement Priority Index*	0 – 25	26-49	50 - 65	66 - 79	>80

***for assessing medical (and other) equipment / infrastructure to give objective measure of likelihood of failure**

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

Insert Consequence and likelihood scores on the risk assessment form and consult matrix below
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 Exec Directors and Tier 2 Committees.
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 appropriate Tier 2 Assurance Committee.

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

Appendix F Related Policies, Procedures and Documents

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

Risk Management Handbook
Risk Register
Board Assurance Framework

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

Being Open and Duty of Candour Policy
Clinical incident /near-miss reporting and investigation policy (including Serious Incidents and Never Events)

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

Infection Control Policies
Medical Devices Training Policy

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