The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
10 June 2021

Agenda item	128/21			
Report	Risk Management Strategy and Policy			
Executive Lead	Director of Governance & Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people	√	Effective	
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance			
	For decision / approval	√	**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	(Executive) Risk Management Committee Audit and Risk Assurance Committee			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	The Risk Management Strategy and Policy provided herewith set out a short / medium term strategy and methodology for the management, and mitigation of risks within the organisation. Both documents were originally drafted by our Risk Management Consultant at the beginning of the year and have been updated following feedback from our executive directors, and to bring the documents up to date with organisational matters, such as the change from Care Groups to Divisions, as noted in the documents. The Board is asked to approve the documentation.			
Appendices	Appendix 1 Risk Management Strategy Appendix 2 Risk Management Policy			

The Shrewsbury and Telford Hospital NHS Trust

Appendix A

RISK MANAGEMENT STRATEGY 2021/23

RM01

To be read in conjunction with: Risk Management Policy (RM02)

Version:	15.4
Originally issued	February 1994
Approved by:	*Trust Board of Directors*
Approval date:	*Tentatively, 10 June 2021*
Ratified by:	-
Date ratified:	-
Name of originator/author:	Chief Risk Officer
Lead Director	Director of Governance & Communications
Date issued:	June 2021
Review date:	June 2023
Target:	Overarching Strategy for specific Trust Risk Management Policies

Document Control Sheet

Author/Contact:	Dr Kevin Street, Chief Risk Officer
Document ID	RM01
Version	15.4
Status	Draft
Date Equality Impact Assessment	1/10/20 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 2023
Distribution	Please refer to the SATH intranet for the latest version. **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	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
V14.1	Jun-17	CJ	FINAL	Updated appendices

V14.2	Mar-18	CJ	FINAL	Change of Sustainability Committee to Finance and Performance Committee
V14.3	May-18	CJ	FINAL	Change of committee names, updated appendices
V15	Oct-20	KS	Draft	Root and branch rework to reflect updated approach and alignment to ISO31000
V15.1	Oct-20	KS	Draft	Formatting and minor administrative amendments. Addition of Appendix A
V15.2	Nov-20	KS	Draft	Formatting and minor administrative amendments. Addition of references
V15.3	Feb-20	AM	Draft	Further amendments following Executive Team feedback
V15.4	May-20	AM	Draft	Deletion of previous Appendix A and replacement with new Appendix A

Contents

1. Introduction and Scope of the Strategy

The Shrewsbury and Telford Hospital NHS Trust provides services to a diverse range of people across a wide footprint in an ever-changing environment. As such the potential for disruption to services, the impact on patient experience and the loss or damage to assets from a range of risks is inherent. Therefore, it is essential that the Trust takes appropriate action through active risk management to minimise the potential for this disruption, loss or damage.

This Strategy aims to create and protect value in the Trust by facilitating the management of risk, making decisions, setting and achieving objectives and improving performance.

- Managing risk is part of governance and leadership, and is fundamental to how the Trust is managed at all levels. It contributes to the improvement of management systems.
- Managing risk is part of all activities associated with and includes interaction with stakeholders.
- Managing risk considers the external and internal context of the Trust, including human behaviour and cultural factors.
- Managing risk is based on the principles, framework and process outlined in this Strategy. These components might already exist in full or in part within the Trust, however, they might need to be adapted or improved so that managing risk is efficient, effective and consistent.

This Strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

Managers at all levels are expected to make risk management a fundamental part of their approach to governance.

This Strategy sets out the Trust's objectives for further improving the management of risk at a strategic level; it describes the risk management assurance framework that is in place and aims to ensure that associated thinking and practice is embedded in everyday processes, policies and activity.

This Strategy will further develop the Trust's governance framework within which the Trust leads, directs and controls the risks to its key functions in order to:

- Comply with relevant legislation
- Monitor Strategic and Operational Risk, providing Assurance and Performance data
- Help the Trust to achieve its strategic objectives

The Risk Management Strategy is fully endorsed by the Trust Board to underpin:

- The Trust's ability to achieve strategic objectives
- Meet performance and the values of the Trust
- Protect its reputation

2. The purpose of the Strategy

The purpose of this Strategy is to:

- Define and set out the benefits of risk management and what drives risk management within the Trust
- Help the Trust to understand risk appetite and tolerances, and make the most out of risk opportunities
- Set out our ambition to continuously improve our risk management arrangements
- Outline how the strategy relates to the Trust's wider strategic aims and objectives
- Assess the current status of risk management within the Trust
- Identify a series of risk management objectives
- Outline the approach to implementation and monitoring
- Describe the relevant compliance and assurance arrangements regarding risk management within the Trust

The Risk Management Strategy does not aim to identify or manage specific risks, other than to use those for illustrative purposes. Risk Management is a dynamic process and risks will readily change to respond to internal, external and cultural influences. Risk Management is not a performance tool. All operational risks that can potentially affect the Trust can be found in relevant Risk Registers, with strategic risks being found in the Board Assurance Framework (BAF).

3. What is Risk Management?

Risk Management is the process of identifying significant risks[1] to the achievement of the organisation's strategic and operational objectives, evaluating their potential likelihood and consequences implementing the most effective way of controlling them.

When the management of risk goes well it often remains unnoticed. However, when it fails, the consequences can be significant and high profile. Effective risk management is fundamental to prevent such failures.

4. Risk Appetite & Tolerances

This strategy provides an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

The risk appetite of the Trust is the decision regarding the appropriate exposure to risk that it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

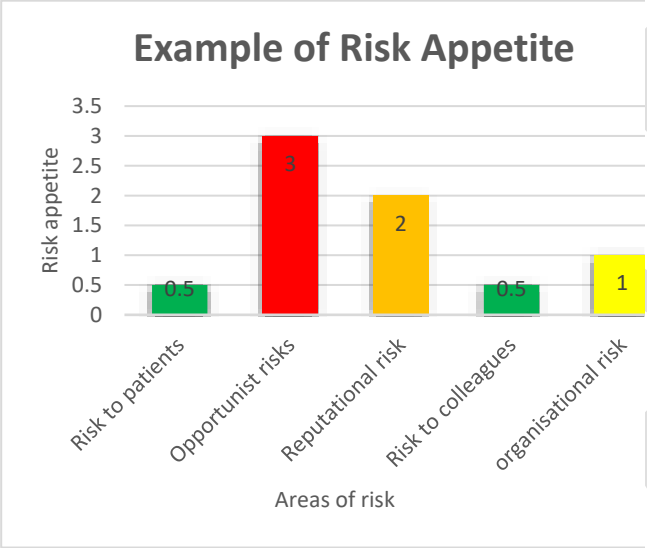
• The nature of the risks to be assumed;
• The amount of risk to be taken on;
• The desired balance of risk versus reward.

[1] A risk is something that is uncertain – it might happen or it might not. A risk matters, because if it does happen, it will have an effect on the organisations objectives, and what it hopes to achieve.

The Board will set boundaries to guide staff on the limits of risk they are able to in pursuit of achieving its strategic objectives. The Board will set these limits annually and review them as appropriate. The use of the Good Governance Appetite Matrix (**Appendix A**) provides a useful tool in setting appetite statements

Whilst risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can deal with. All organisations have to take some risks and they have to avoid others.

Typically, a health trust's risk appetite prioritises to safety, including both patient safety and employee health and safety, with a marginally higher risk appetite towards its strategic operational and financial objectives. This means that reducing to reasonably practicable levels the risks originating from various medical systems, products, equipment, and our work environment, and meeting our legal obligations may take priority over other business objectives.



Example risk appetite descriptions
<1= low
1 = moderate
2 = high
3 = extreme

low
Moderate
High
Extreme

5. Risk Opportunities

Risk should include both threat and opportunity, and mature risk management should also address both types of uncertainty, seeking to minimise threats and maximise opportunities.

This perspective is being reflected increasingly in risk management standards and professional guidelines, as well as in the practice of leading organisations.

Opportunity is not the absence of threat; some opportunities are created when threats are removed, and other opportunities are simply the inverse of related threats (instead of activity being lower than planned, it might be higher). But there are also "pure opportunities" unrelated to threats, uncertain events or circumstances which would produce real additional benefits, if they could be captured proactively and exploited. As well as identifying and addressing threats, it is equally important to seek and maximise opportunities, in order to optimise achievement of objectives; the risk management process can address both threats and opportunities.

6. How does the Risk Management Strategy support the Trust's Plans?

Risk management is a key component of the Trust's Strategic aims and objectives.

The Trust Strategies set out the future direction of the Trust, whilst highlighting how financial pressures are growing. At the same time it recognises that the public rightly expects continuing improvements in the safety and responsiveness of services to patients' needs and for the NHS to take advantage of clinical and technical developments.

The Risk Management Strategy underpins each of the Trust's six strategic aims and is focused on continuously improving the quality of our patient's experience. All members of staff have an important role to play in identifying, assessing and managing risk.

6.1 The Trust's strategic and operational aims

Table 1: the Trust's strategic aims

What are SaTH's short – medium term goals
Our Patients and Community: "we deliver safe and excellent care, first time, every time"
Our Patients and Community: "we work closely with our patients and communities to develop new models of care that will transform our services"
Our People: "our staff are highly skilled, motivated, engaged and 'live our values. SaTH is recognised as a great place to work"
Our People: "our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care"
Our Service Delivery: "our services are efficient, effective, sustainable and deliver value for money"

Our Service Delivery: "we deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure"

Our Partners: "we have outstanding relationships with our partners, and collectively strive to improve the quality and integration of health and case services

Our Governance: "we are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised

The risk assessment process enables risks, which may prevent realisation of any of the Trust's aims, to be appropriately managed. This Strategy will also help the Trust to manage risk opportunities as health and social care providers are expected to work together to find new ways to improve services at the same time as saving money.

Table 2: The Trust's operational plan setting out key corporate aims that energise the strategic objectives:

Our patients and community	Our people	Our service delivery	Our partners	Our governance
Quality improvement strategy and plan	Leadership capability and development	Urgent and Emergency Care	System improvement plan	Oversight, assurance, roles and accountabilities
Reducing mortality and excess deaths	Clinical standards, skills and capabilities	Restoration and recovery (incl. COVID19 learning)	Develop OBC for Hospital Transformation Programme	Financial controls
Quality / regulatory compliance	Culture and behaviours	Digital transformation and infrastructure	System long term plan	Performance data, quality, insight and analytics
Quality / regulatory compliance	Communication and Engagement	Physical capacity and estate developments		**Risk management**
Increasing community engagement	Recruitment and retention	Improving service sustainability		Programme and project management
Increasing community engagement				

**same day emergency care*

It is important to us that risk management contributes to improve patient safety by enhancing leadership in the Trust, the culture of quality of care and that it supports our ability to measure and to predict variance so that we can detect and act quickly as problems arise. Effective employee engagement is vital to our success and aspiration to become one of the safest and most effective NHS organisations in the country. By wholeheartedly embracing our core values and behaviours in all risk management activity, this strategy and underpinning risk policy supports high performance

and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation. The strategy aligns to our values:

- Partnership
- Ambition
- Caring
- Trusted

6.2 The Board Assurance Framework (BAF)

The BAF identifies and quantifies the strategic risks facing the Trust and its ability to achieve its strategic aims and objectives. It informs and provides assurance to the Trust Board on how each of these risks is being effectively managed and monitored.

Each of the strategic risks has an identified owner, who is a member of the executive team. It is their responsibility to manage and report on the risk overall. The achievement of this Strategy relies on the underpinning governance framework which consists of robust assurance mechanisms and quality governance arrangements – this is delivered through the direct and indirect assurance provided through the governance meetings structure to the Board and to external stakeholders, i.e. regulators, commissioners, external scrutineers, partner organisations and engagement groups. The strategy is also dependent on robust accountability arrangements that ensure actions will be taken should risk/ performance issues be judged as requiring escalation.

The Risk Management Strategy will enhance those arrangements and be delivered through the Risk Management Policy.

7. What are the objectives of the strategy?

Where do we want to be and what will success look like?

This Strategy stretches the ambition of the Trust in its management of risk in response to that context, via the following key performance Indicators (KPI's)

We will:

KPI 1 - Define the organisation's risk appetite.

We will further develop the Trust's risk appetite by:

- Reviewing the Trust's appetite statement on an annual basis as part of the business planning process
- Including risk appetite and risk assessment in the annual business planning process, including at Divisional and corporate levels.
- We will utilise the Board's agreed risk appetite measures (Appendix B)

KPI 2 - Ensure a single and comprehensive risk management process.

All risks relating to projects/initiatives will be subject to the risk management process and be managed locally with oversight from the governance department / Senior Risk Manager. This will seek to ensure risks associated with service Improvement and other programmes are monitored

and managed; ensuring that the structure and process for managing risk across the organisation is reviewed and monitored annually. This will require the development of systems and processes to facilitate risk management being integrated into the current functions, and in embedding a high performance culture.

KPI 3 - Increase the coverage and utilisation of appropriate risk assessments throughout the Trust.

The incident reporting process will identify where risk assessments have not been completed and remedial actions identified from the failures from each individual adverse event will be addressed by the relevant manager.

The Divisional meetings and underpinning structure will be used to monitor gaps in risk assessment, using monthly reports and the ward and department assurance reports to provide the relevant evidence.

KPI 4 - Increase the use of Trust wide data to inform the risk management process.

To use a full range of intelligent risk information from risk assessments, patient safety, workforce, patient experience and business data to improve the management of risk and improve quality. This information will also inform the overall business planning/investment process in the Trust.

KPI 5 - Enhance the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture.

We will further develop the mechanism for gaining feedback from those responsible for managing risk to ensure that lessons are fed back to those involved in all aspects of the Trusts activities.

As well as including training in the trust's risk management processes, we will use the organisation-wide programme to help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances, residual risk and proximity. We will therefore review the existing training programme, training materials and provide general communications regarding strategic and operational risks to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

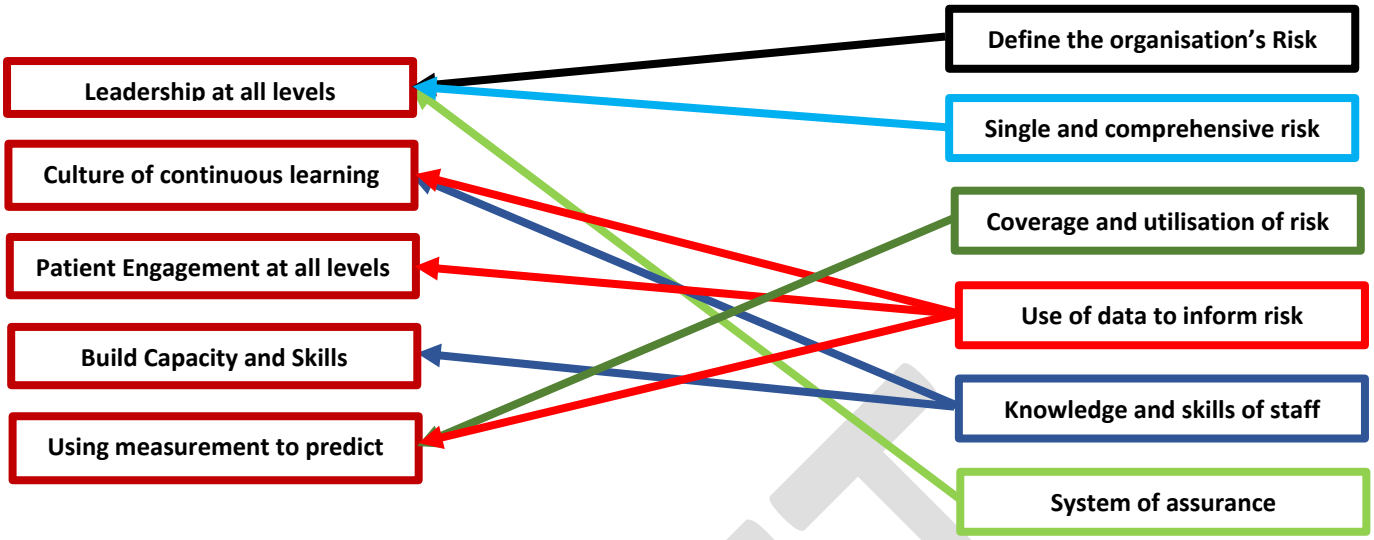
KPI 6 - Strengthen the system of assurance regarding risk through to Board level.

The Board Assurance Framework to provide a concise reporting tool which enables the reader to review a summary of the framework with a more in-depth analysis being provided if required.

The BAF will be subject to a rigorous annual review, which takes into consideration comments from the Board of Directors, senior management and other interested parties. The document will include a front page summary of the risk assessments, with specific detail listed on individual pages.

Links with the Trust Strategies

Diagram 1: how KPI's will support the Trust's overall Strategic direction.



8. Implementation and Monitoring

An action plan for this strategy will be approved by the Audit and Risk Assurance Committee. The Director of Governance & Communications as the Executive lead for risk will monitor the requirements of this strategy via the Executive Risk Management Committee, Audit and Risk Assurance Committee and the Trust Board. A report will be made no less than annually on progress and achievement of goals as set out in the action plan.

Compliance and Assurance

The Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

All NHS bodies are required to sign an Annual Governance Statement and must have the evidence to support this statement.

In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board is required to have a comprehensive Performance Management Reporting framework. The Trust Board agrees its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Assurance Framework and remedial action agreed.

The designated Assurance Committees of the Trust Board monitor the Assurance Framework process overall on a quarterly basis. It is the responsibility of the Assurance Committees to report to the Trust Board any new risks to the Trust's objectives, identified gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/ assurance is identified then this should be reported immediately via the Executive Directors. It is important for the Trust Board to be able to evaluate the quality and robustness of the Assurance Framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements.

The Trust Board and Audit and Risk Assurance Committee will formally review the Assurance Framework. The Director of Governance & Communications will ensure that the Risk Management Strategy remains dynamic and is integral to the Business Planning cycle.

Each Department will continue to carry out Risk Assessments which feed into the Divisional Risk Registers. A single framework for the assessment, rating, and management of risk is used throughout the Trust; this process is described in detail within the Risk Management Policy available on the intranet.

Each Division will continue to maintain a comprehensive risk register, which will be formally reviewed at monthly intervals through the Divisional Meetings. At these meetings the Divisions will be expected to report on their risk register, highlight any new or emerging risks to service delivery and present action plans for minimising and managing those risks. The meeting should identify those Divisional risks which also pose a corporate threat and so require inclusion on the Trust Risk Register.

The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. Any risks identified in Divisional meetings that score 15 or above and cannot be controlled locally, will be reviewed, ultimately, by the Board, thus allowing for a bottom up/top down approach to identifying the Trust's key risks and informing the Assurance Framework. This proactive approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisation-wide, health and safety, business, reputational and financial.

Horizon Scanning

Horizon scanning is an important element of the risk management framework and refers to the identifying, evaluating and managing changes in the external risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process.

The outputs from horizon scanning will be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development.

The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations • Socio-economic trends
- Trends in public attitude towards health
- Department of Health publications
- Local demographics
- Seeking stakeholders' views

Appendix A

Risk Appetite Statement 2021/2022

The Shrewsbury and Telford Hospital NHS Trust is committed to improving the health and wellbeing of the people of Shropshire, Telford & Wrekin and providing the best possible healthcare now and in the future. It has set itself a challenging transformation agenda that will deliver its vision of providing excellent care for the communities it serves and is committed to transforming care and strengthening its services by encouraging improvement, innovation, and a collaborative approach.

This statement sets out the Trust's strategic approach to risk-taking by defining its risk appetite thresholds. It is an iterative document that will be reviewed at least annually and modified, so that any changes to the organisations strategies, objectives or its capacity to manage risk are properly reflected. The risk appetite will also be reviewed if there are actual or proposed significant changes to the local healthcare environment. It will be communicated throughout the organisation in order to drive sound risk management and to ensure risks are properly identified and actively managed.

The Board is responsible for determining the nature and extent of the risks it is willing to accept to enable the Trust's objectives to be successfully achieved. Risk in day-to-day activity is unavoidable and the Board will seek to manage risks to a tolerable level. The risk appetite of The Shrewsbury and Telford Hospital NHS Trust is the amount of risk it is willing to accept, tolerate or justify. The Trust's risk appetite has been assessed in accordance with its Risk Management Framework / Strategy.

The Shrewsbury and Telford Hospital NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, the Trust has a low risk appetite to any risks that materially provide a negative impact on quality.

However, The Shrewsbury and Telford Hospital NHS Trust has a greater appetite to take considered risks in terms of transformation and their impact on organisational issues. The Trust has a higher appetite to partnerships and collaboration, digital transformation and innovation and Financial/Value for Money risks where positive gains can be anticipated for the local population, within the constraints of the regulatory environment and delivering on the goals and targets agreed.

Organisational Goals	Risk Appetite	Risk appetite Statement
SG1: We deliver safe and excellent care, first time, every time	LOW	SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.
SG2: We work closely with our patients and communities to develop new models of care that will transform our services	SIGNIFICANT	SATH is eager to seek original/creative/pioneering delivery options and to accept the associated SIGNIFICANT risk levels in order to secure successful outcomes and transformation reward/return.
SG3: Our staff are highly skilled, motivated, engaged and live our values. SATH is recognised as a great place to work.	MODERATE	SATH has a MODERATE risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice.
SG4: Our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care.	MODERATE	SATH has a MODERATE risk appetite for Clinical Innovation and improvement that does not compromise the quality of care
SG5: Our services are efficient, effective, sustainable and deliver value for money.	HIGH	SATH has a HIGH risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.
SG6: We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	HIGH	SATH is open to the HIGH risk appetite required to transform its digital systems and infrastructure to support better outcomes and experience for our patients and public.
SG7: We have outstanding relationships with our partners and collectively strive to improve the quality and integration of health and care services.	SIGNIFICANT	SATH has a SIGNIFICANT risk appetite for collaboration and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve.
SG8: We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised.	HIGH	SATH has a HIGH risk appetite for innovation and ideas which may affect the reputation of the organisation but are taken in the interest of ensuring we deliver our goals and targets.

References

- NHS England, Framework partnership agreement relating to the commissioning of health and social care services, 2016
- GGI, Risk Appetite Board Assurance Prompt, 2015
- GGI, Board Challenge: Fiduciary Duty, 2016
- GGI, Scrutiny the new assurance? A good governance discussion document, 2017
- ISO 31000 Risk Management (2018)
- National Audit Office, Good practice: Managing risks in government, 2011
- NHS England, Framework partnership agreement relating to the commissioning of health and social care services, 2016

The Shrewsbury and Telford Hospital NHS Trust

Appendix B

Risk Management Policy
RM02

Additionally, refer to:

- Clinical Incident Reporting Policy (CG04)
- Trust Fire Safety Policy (FS00)
- Health and Safety Policy (HS01)
- Incident reporting and investigation Policy (staff, contractors and members of the public) including RIDDOR (HS02)
- Control of Hazardous Substances (COSHH) Policy (HS06)
- Safe Moving and Handling policy (HS08)
- Risk Management Strategy (RM01)
- Violence and Aggression Policy (SY02)

Version:	V1.4
V1 issued	*June 2021 tentatively*
V1 approved by	*Trust Board of Directors*
V1 date approved	*10 June 2021 tentatively*
V1 Ratified by:	-
V1 Date ratified:	-
Document Lead	Director of Governance (was Chief Risk Officer)
Lead Director	Director of Governance
Date issued:	*June 2021*
Review date:	*June 2023*
Target audience:	All Trust staff

Document Control Sheet

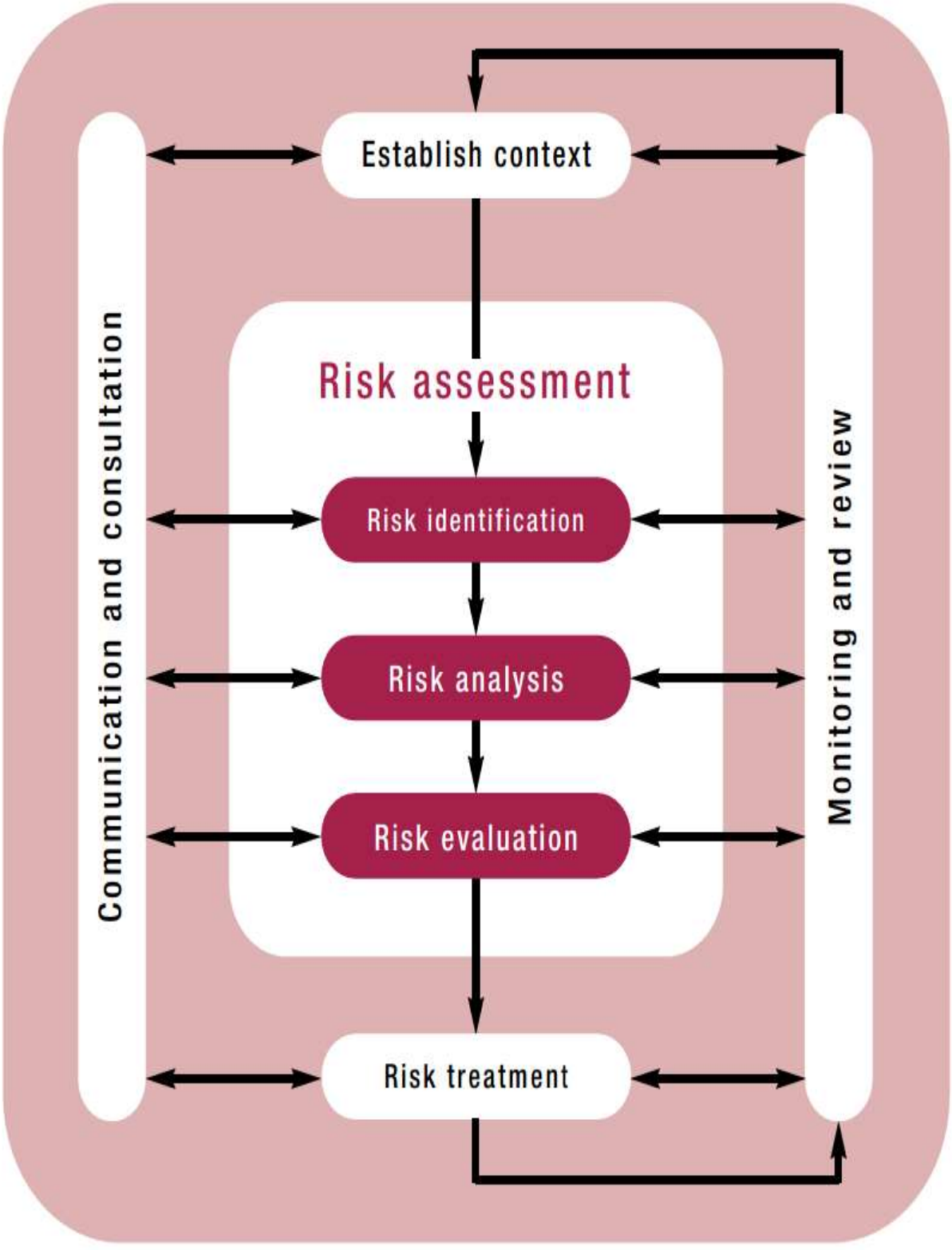
Document Lead/Contact:	Anna Milanec, Director of Governance & Communications
Version	V1.4
Status	Draft
Date Equality Impact Assessment completed	tbc
Issue Date	October 20
Review Date	October 2025
Distribution	Please refer to the intranet version for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key Words – including abbreviations if these would be reasonably expected to be used as search terms	Risk management, risk assessment, risk appetite, risk scoring, risk escalation
Dissemination plan	Trust intranet

Version history

Version	Date	Author	Status	Comment – include reference to Committee presentations and dates
1	October 2020	Chief Risk Officer	Draft	New document – aligned to ISO31000
1.1	October 2020	Chief Risk Officer	Draft	Minor amend to guidelines to identify, assess, action and monitor risks. Document reference number added.
1.2	October 2020	Chief Risk Officer	Draft	Formatting and other minor administrative amendments
1.3	November 2020	Chief Risk Officer	Draft	Further development of guidelines to identify, assess, action and monitor risks
1.4	May 2020	Director of Governance	Draft	Amendment to some sections following feedback from Executive Risk Management Committee

Contents

Policy on a Page: Risk Management process flowchart



1. Document Statement

The purpose of the Policy is to define the framework and systems the Trust will use to identify, manage and eliminate or reduce to a reasonable level, risks that threaten the Trust's ability to meet its objectives and achievement of its values.

This document should be read in conjunction with the Trust Risk Management Strategy (RM01).

2. Overview

The Trust is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal controls.

The Risk Management Policy is regularly reviewed and updated to ensure it continues to be consistent with the Trust Risk Strategy and reflects national guidance and relevant legislation.

2.1 Aims and objectives

2.1.1 The overarching aim of the Policy is to provide assurance that the Trust is providing high quality care in a safe environment, that it is complying with legal and regulatory requirements and that it is meeting its strategic objectives and promoting its values

2.1.2 Policy objectives are:

- To embed risk management systems and processes within the organisation and to promote the ethos that risk management is everyone's business.
- To clearly define roles and responsibilities for risk management.
- Create an environment which is safe as is reasonably practicable by ensuring that risks are continuously identified, assessed, and appropriately managed i.e. where possible eliminate, transfer, or reduce risks to an acceptable level.
- To establish clear and effective communication that enables a comprehensive understanding of risks at all levels of the organisation by developing the use of Divisional, specialist, and trust-wide risk registers.
- To maintain continued compliance with national standards, regulatory requirements, and legislation.
- In line with the Trust's commitment to integrated governance, to adopt an integrated approach to risk management which includes risks related to inter alia, clinical care, health and safety, financial and business planning, workforce planning, corporate and information governance, performance management, project/programme management, education and research.
- To foster an organisational culture of openness and willingness to report risks, incidents and near misses that is used for organisation-wide learning.
- To ensure training is provided to ensure effective implementation of this Policy as set out in the Training Needs Analysis.

3. Scope

The Policy applies to all staff including contractors and agency staff. The Policy applies equally to all areas of the Trust regarding all types of risk, both clinical and non-clinical.

4. Definitions

See Appendix B.

5. Duties

The Board of Directors

- Is responsible for ensuring the Trust has effective systems for managing risk to enable the organisation to deliver its objectives.

The Chief Executive

- as the Trust's Accountable Officer, is responsible for maintaining a sound system of internal control including risk management; and
- Has overall accountability to the Board for effective risk management.

The Director of Governance

- works closely with the Chair, Chief Executive, Executive Directors, Divisional Directors and Deputy Directors to implement and maintain appropriate risk management strategies and processes, ensuring that effective governance systems clinical and non-clinical risk processes are in place to assure the delivery of Trust objectives;
- On behalf of the Chief Executive, is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a Trust-wide basis;
- work closely with the Chief Executive and Directors to support the provision of strategic, corporate, and operational, level risk registers; and
- Develop and oversee the effective execution of the Board Assurance Framework and ensure effective processes are embedded to rigorously manage the risks therein, monitoring the action plans and reporting to the Board and relevant Committee.

Senior Information Risk Owner (SIRO)

- The Director of Governance is the SIRO and is the nominated executive lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms exist.

Executive Directors and Deputy Directors have delegated responsibility for:

- Managing risks in accordance with their portfolios;
- for risk management policy development, developing and communicating the Board's appetite for taking risk, establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these, and monitoring the management of risk across the Trust;
- ensuring effective systems for risk management, compatible with this Policy, are in place within their Divisions and Departments, specifically, they must ensure that:
    - staff are familiar with this Policy and aware of their responsibility for risk;
    - staff attend appropriate risk training (including induction and mandatory training);
    - risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to mitigate risks are developed, documented, and regularly reviewed.

Clinical Directors, of Operations/General Managers and Lead Nurses are responsible for ensuring:

- that there are effective systems for risk management are in place within their areas of operation; and
- that their staff are aware of this policy.

Ward Sisters/Charge Nurses, Senior Managers are responsible for:

- the operational implementation of this policy within their departments, wards and/or other clinical and non-clinical areas; and
- reviewing clinical and non-clinical incidents

Clinical Governance Leads

- ensure that there are effective systems in place to effectively manage risk across the Trust;
- ensure the Trust has a comprehensive and dynamic Risk Register and working with teams to ensure that they understand their accountability and responsibilities for managing risks in their areas; and
- ensure risks management reports, including monthly and annual governance and risk reports are available.

All staff must ensure:

- they are familiar and comply with the Trust's risk-related policies and relevant professional guidelines and standards; and
- if they identify a risk, they must escalate this to their line manager if they are unsure as to how to put this onto the risk register.

6. Organisational arrangements

The organisational management of risk forms part of the Trust's overall approach to governance. The key forums for the management of risk in the Trust are outlined below.

Trust Board of Directors

- The Trust Board of Directors has overall responsibility for ensuring that the Trust has processes and monitoring arrangements in place relating to Governance and Risk from within the Trust.

Audit & Risk Assurance Committee

- The Audit and Risk Committee is responsible for providing assurance to the Board of Directors that the systems of internal control are managing risks appropriately.

(Executive) Risk Management Committee

- The (Executive) Risk Management Committee will be responsible as for overseeing the most significant operational risks to the achievement of the Trust's objectives to ensure there are robust controls and mitigating actions in place.

Operational Risk Management Group

- The Operational Risk Management Group will monitor and moderate operational risks across the Trust, escalating significant risks to the (Executive) Risk Management Committee.

Divisions

- The Divisions are responsible for reviewing and controlling the risks within their areas.

7. Risk Management Process

7.1 Risk Management covers all the processes involved in identifying, assessing, and judging risks, assigning ownership, taking actions to mitigate or anticipate them and monitoring and reviewing progress. For the Trust to manage and control the risks it faces, it needs to identify and assess them.

8. Risk Registers

8.1 Operational risk register

Operational risks identified from risk assessment must be entered onto the 4Risk risk management system. Risks that are graded between 1 and 10 are the responsibility of the local ward/ department. Risk scoring 15 and above will be escalated risks to the Corporate Risk Register. The risk ownership is NOT transferable, risk identified by the owner remains with the owner throughout the escalation process.

8.2 Board Assurance Framework (BAF)

This is a register of all risks that have the potential to prevent the organisation from achieving its strategic objectives.

The BAF is presented to the Trust Board and scrutinised on a quarterly basis.

9. Specific risk assessments

9.1 Within the trust's Health & Safety Policy, there is a risk assessment process for general environmental risk assessments.

9.2 For specific risk assessments see the following policies:

- Health and Safety Policy (HS01)
- Incident reporting and investigation Policy (staff, contractors and members of the public) including RIDDOR (HS02)
- Control of Hazardous Substances (COSHH) Policy (HS06)
- Work with Display Screen Equipment (HS07)
- Safe Moving and Handling policy (HS08)
- Stress Management Policy (HS12)
- Risk Management Strategy (RM01)
- Violence and Aggression Policy (SY02)

10. Training Needs

A Training Needs Analysis has been undertaken in line with the Corporate Induction and Mandatory Training Policy. A standardised package of training for Risk Management will be made widely available to all staff and will be mandatory for any staff with a specific responsibility for creating and maintaining risk management records and/or reporting. To assure compliance, access the 4risk system will be contingent upon the requisite training being undertaken.

11. Review process

This document will be appraised annually to ensure it remains fit-for-purpose, and formally reviewed every 5 years unless there are significant changes at either at national policy level, or locally.

In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

12. Equality Impact Assessment

Outline a summary of the assessment. It is not necessary to include the entire EQIA in the document, but this should be completed and submitted to a Workforce Business Partner.

13. Standards of Business Conduct

The Trust follows good NHS Business practice as outlined in the Code of Conduct and Managing Conflicts of Interest in the NHS and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the review of this policy document and no specific risks were identified.

14. Process for monitoring compliance

Describe how this will be done including which elements will be monitored; by whom, frequency of monitoring; mechanism for reporting; and how action plans will be developed and monitored. It is recommended that the monitoring template (below) is used and advice on completion is sought from the Head of Assurance.

Minimum requirement to be monitored	**Process for monitoring e.g. audit/ review of incidents/ performance management**	**Job title of individual(s) responsible for monitoring and developing action plan**	**Minimum frequency of monitoring**	**Name of committee responsible for review of results and action plan**	**Job title of individual/ committee responsible for monitoring implementation of action plan**
Risks entered onto the risk register are completed according to Trust methodology	Audit	Line managers	Monthly	Divisions	• Divisional /Service Area Governance Lead
All risks are graded accordingly	Audit	As above	Monthly	As above	• As above
All risks have action plans	Audit	As above	Monthly	As above	• As above
Risks are entered onto 4Risk risk register.	Audit	As above	Monthly	As above	• As above

Minimum requirement to be monitored	Process for monitoring e.g. audit/ review of incidents/ performance management	Job title of individual(s) responsible for monitoring and developing action plan	Minimum frequency of monitoring	Name of committee responsible for review of results and action plan	Job title of individual/ committee responsible for monitoring implementation of action plan
Risk registers and associated action plans are monitored at the Divisions/Service Areas	Audit	Relevant chair of Division/Service Area Governance & Risk Group	Monthly	As above	• Relevant Division Director/ Head of Service

15. References

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Code of Conduct for NHS Managers Department of Health (2002)
- Risk Management Standards NHSLA
- Code of Governance Monitor
- ISO31000 (2018)

16. Associated Documentation

- Clinical Incident Reporting Policy (CG04)
- Trust Fire Safety Policy (FS00)
- Health and Safety Policy (HS01)
- Incident reporting and investigation Policy (staff, contractors and members of the public) including RIDDOR (HS02)
- Control of Hazardous Substances (COSHH) Policy (HS06)
- Work with Display Screen Equipment (HS07)
- Safe Moving and Handling policy (HS08)
- Stress Management Policy (HS12)
- Risk Management Strategy (RM01)
- Violence and Aggression Policy (SY02)

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Appendix A Guidelines to identify, assess, action and monitor risks

Appendix B Definitions

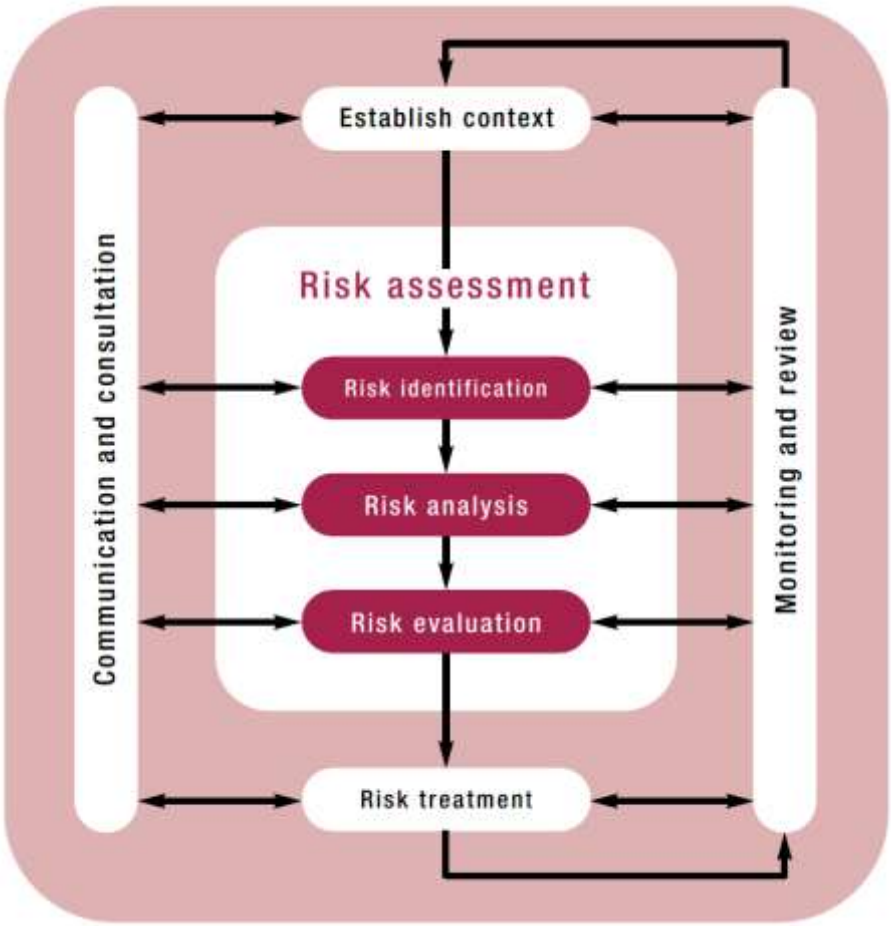
Appendix A - Guidelines to identify, assess, action and monitor risks

i) Introduction

This document provides a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

Risk Management covers all the processes involved in assessing, identifying, analysing and the treatment of risks.

The diagram below provides a simplified version of the essential steps in the implementation and ongoing support of the risk management process.



ii) Establish the context

The first stage of the risk management process requires the organisation to establish the context of the risk assessment as it relates to both internal and external factors e.g.:

- internal factors include the organisational structure, corporate governance, business processes and technologies
- external factors include legal and regulatory environment, political considerations, economic circumstances, and the views of external stakeholders

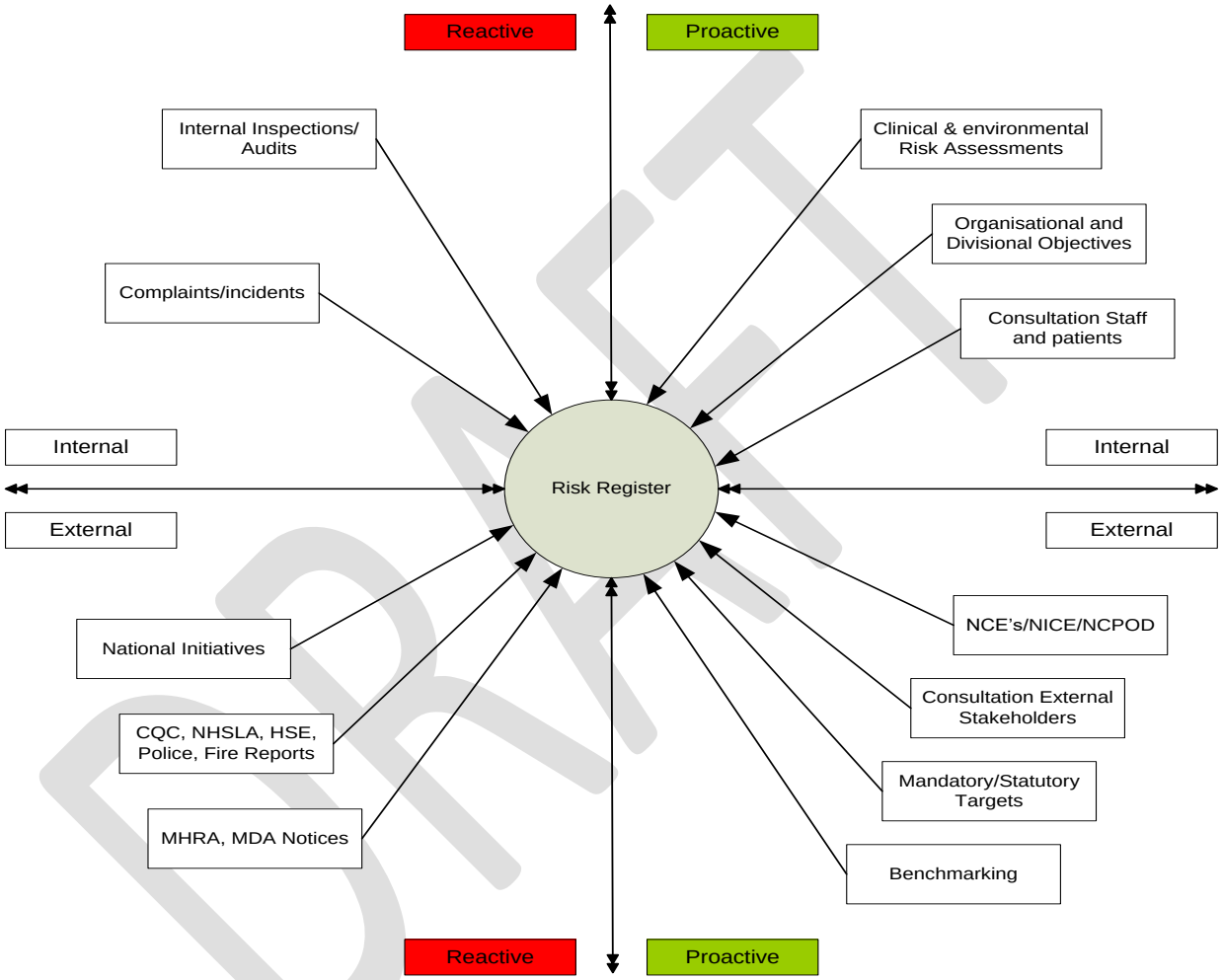
iii) Risk Assessment

The risk assessment phase has three phases: risk identification, risk analysis and risk evaluation. During the risk identification phase, the organisation develops a comprehensive list of the risks that might prevent it from achieving its objectives, as well as the causes and possible outcomes of those risks materialising. This information is considered carefully during

the risk analysis, where the organisation conducts qualitative and/or quantitative assessments of those risks. The risk assessment stage culminates in the risk evaluation step, where the organisation decides which risks are significant enough to require active management and prioritises that list.

iv) Risk identification

There is no unique method for identifying risks. Risks may be identified in several ways and from a variety of sources; the diagram below illustrates common areas of information that can be used to identify both reactive and proactive risks.



v) Risk Analysis/evaluation

Addresses the likelihood and consequence. Currently the 4Risk web Risk Management system is used to collect information to enable simple risk analysis.

vi) Risk treatment

Is the activity of selecting and implementing appropriate actions to reduce/control the risk? Risk treatment includes as its major element, risk control (or mitigation), but extends further to, for example:

- risk avoidance is the elimination of hazards, activities and exposures that can negatively affect an organisation's assets

- risk transfer the purpose of this action is to take a specific **risk**, which is detailed in the insurance contract, and pass it from one party who does not wish to have this **risk** (the insured) to a party who is willing to take on the **risk** for a fee, or premium (the insurer)
- risk financing is concerned with providing funds to cover the financial effect of unexpected losses experienced by a trust

vii) Procedure

The following procedure is used by all staff to ensure a continual systematic approach to risk assessments throughout the Trust.

viii) Risk Assessment

An assessment of the risks associated to a particular practice or activity may be undertaken using the Trust's Generic Risk Assessment Tool

- Table 1 (below) provides examples of consequence by domain
- Table 2 provides information on likelihood
- Table 3 provides information to assist in determining the risk grading or score.

ix) Management of Identified Risk

There are four response options on identifying a risk as outlined in the table below.

Table 1 'The four Ts'

	Meaning	**Notes**
Tolerate	Accept and live with the risk, reviewing the controls occasionally	Appropriate when the risk rating is consistent with the organisation's risk tolerance level or 'Risk Appetite'. (Usually reviewed annually).
Treat	Take action to mitigate the impact of the unintended situation / condition and or reduce the likelihood of it happening	The risk is not yet controlled to a level meeting the Organisation's Risk Appetite and further strengthening of the controls is warranted. Review and work up actions to reduce the likelihood and or severity of impact or even eliminate the risk by process re-design.
Transfer	Pass the risky activity/ process / function to another person, department, or organisation.	If there is an option to transfer the activity process or function elsewhere that is feasible, offers cost effective benefits compared to in house options then transfer is appropriate.
Terminate	Cease the risky activity	When the risks inherent in the activity / process/function cannot be mitigated to a level that is sustainable and that justifies continuation the termination is the appropriate treatment.

x) Risk Handling

Risks should always be managed or handled as close to the risk as possible that is, by the manager in the affected departments or service and controls implemented, maintained and adhered to by the people engaged in the activity involved. Hence, they are the ones responsible for effecting change in controls, monitoring their effectiveness and providing assurance to the Board through the Risk Management Framework. Hence, if the manager has the necessary resources and authority to act then they remain accountable for gaining control of the risk.

It is recognised that actions to mitigate may exceed the resources available to the manager and or their authority to act. In this situation, the manager is expected to escalate the risk through the risk management hierarchy providing a risk description and assessment together with the risk treatment options and highlighting the preferred option. The paper should explain the limiting resource / authority and seek support and enablement from the next layer of management. With this granted and or provided the manager is then enabled and expected to progress the preferred treatment option. Hence, escalation is a transient enabling state and NOT a transfer of responsibility and accountability.

Rarely, the risk may impact directly on the Trust's strategic aims or reflect a regional or national issue, which the Board will want direct sight of, in which case this may be added to the Board's Assurance Framework (BAF) Risks and warrant Executive Director Leadership.

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

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

		Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Critical report	Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Exceptionally low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency-based How often might / does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Time Framed Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	<0.1% (<1in 1000)	%0.1-1% (1 in 1000 to 1 in 100)	1-10% (1 in 100 to 1 in 10)	10-50% (1 in 10 – 1 in 2)	> 50% (More than 1 in 2)

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability, see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 15) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

[1] Organisational reputation risks can relate to impact on how the organisation is viewed by staff within the organisation, by other organisations in the health and social care economy, by elected representatives and by patients and the public.

Appendix B - Definitions

- ***Governance*** - is the systems and processes by which the Trust leads, directs and controls its functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.
- ***Risk*** - is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.
- ***Hazard*** - the HSE defines a hazard as "anything that may cause harm."
- ***Risk management*** - is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing, and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.
- ***Risk Assessment*** - is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk happens (impact or magnitude).
- ***Strategic risks*** - are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
- ***Risk Registers*** - are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.
- ***Board Assurance Framework*** - The BAF identifies and quantifies the strategic risks facing the Trust and its ability to achieve its strategic aims and objectives. It informs and provides assurance to the Trust Board on how each of these risks is being effectively managed and monitored.
- ***Operational risks*** - are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the Division or Service that is responsible for delivering services.
- ***Risk appetite*** - is the type and amount of risk that the Trust is prepared to tolerate and explain in the context of its strategy.
- ***Internal controls*** - are Trust policies, procedures, practices, behaviours, or organisational structures to manage risks and achieve objectives.
- ***Assurance*** - is the confidence the Trust has, based on sufficient evidence, that controls are in place, operating effectively and its objectives are being achieved.