RISK MANAGEMENT STRATEGY
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Introduction
Effective risk management processes are essential to the delivery of high quality and safe healthcare services. The Trust believes that due attention to risk management will not only reduce harm to patients and staff as well as create safer environments of care, but is essential for the achievement of the organisation’s strategic goals and corporate and clinical objectives.

This strategy provides the overarching framework within which risk is managed by the organisation and is fully endorsed by the Trust Board. The Board consider it a contemporary strategy that reflects currently available information, guidance and legislation governing the NHS. The strategy focuses on risk management arrangements from an organisational rather than an individual perspective.

External requirements
The Trust must ensure that its risk management arrangements meet the requirements of the following national bodies; NHS Improvement (NHSI), NHS Counter Fraud Authority (NHSCFA) and the Care Quality Commission (CQC). The Trust also adheres to standards and guidance from the NHS Resolution (previously NHSLA) and NHS England to ensure good risk management practise.

Risk Management Process
The overall risk management process adopted by the NHS is shown pictorially below. There are 7 major elements in the process.

Figure 1: The Risk Management Process

The Trust uses risk registers as a means of describing risks, scoring and ranking them, identifying who owns them, identifying controls that are in place, identifying whether the risk needs to be reduced further and, if so, recording what additional controls need to be put in place.
The Trust Risk Register is comprised of the highest scoring risks (15+) from across all risk registers. All risks have an identified Director Lead, who is ultimately accountable for ensuring the risk is managed appropriately, a Risk Owner who is the senior manager accountable for ensuring suitable plans are in place to mitigate the risk and Risk Lead who is the person with direct responsibility and oversight of the activities to manage the risk.

Risk Registers are maintained by each division and corporate department and are mainly populated by risks that affect the achievement of objectives and/or the particular local service operation.

All risk registers are viewed as ‘live documents’ and are routinely populated, updated and reviewed.

The Board Assurance Framework (BAF) provides the Board with a simple but comprehensive method for the effective and focused management of the strategic risks that could affect the delivery of its principal objectives.

The Trust is also required to provide annual submissions to NHSI as well as undertake periodic exception reporting to confirm that risk management processes meet required standards.

**Responsibilities**

All Trust staff are responsible for reporting risks and incidents, following Trust risk management policies and procedures, attending appropriate training and following health and safety procedures.

More detail and specific risk management responsibilities for individuals and Board members can be found in section 7 of the strategy.

The Audit and Risk Committee is accountable to the Board for ensuring that the risk management process is implemented across the Trust in line with the overall Risk Management Strategy.

**Training**

The principles of risk management are an integrated part of how the Trust delivers services and how staff are expected to discharge their duties. It is the Trust policy that all staff will receive training and guidance as appropriate to fulfilling the responsibilities of their role, including any responsibility for managing risk within their own working environment. The Core Skills Training Policy will clearly identify training courses relevant for all staff groups. In addition, ad hoc training will be provided as needed by the Governance & Quality Assurance Department for staff with key risk management responsibilities.

**Monitoring and Review**

Compliance with the standards set out in the Risk Management Strategy will be reviewed locally by management groups, the divisional performance meetings, assessed routinely by the Audit and Risk Committee and by the Trust Board and scrutinised annually by internal audit.
1.0 INTRODUCTION

1.1 Camden and Islington NHS Foundation Trust recognises that providing mental health and social care services and the activities associated with employing staff, providing premises and managing finances are an inherently risky business, but that risk, properly managed can bring with it advantages, benefits and opportunities. Understanding the risks we face and managing them appropriately will enhance our ability to make better decisions, deliver on objectives and improve our performance.

1.2 Risk influences every aspect of our organisation and the continued delivery of high-quality care requires identification, management and minimising of events or activities which could result in unnecessary risks to service users, staff and visitors/members of the public. The continued changes in the healthcare environment, increasing competition and the increased regulatory and statutory pressures that we face create considerable challenge, uncertainty and opportunity.

1.3 Continuing authorisation as a foundation trust introduces the imperative of strategic business risk management, in addition to risks associated with service delivery. Maintaining foundation trust status is dependent on regular 'self-certification' by the Trust Board that clinical service, governance and financial standards are met. In turn, self-certification requires access to high quality risk and assurance reports that are the product of an effective risk management strategy and processes.

1.4 Risk management activities undertaken within the Trust operate at a number of levels: for example, a health or social care professional creating a risk management plan for a service user; corporate planning around the organisational response to a major incident; risk assessment and mitigation for business expansion and development. This strategy and its related procedures serve to set these various risk management activities within a broader corporate framework and to identify consistent processes for risk management across the Trust.

1.5 The management of risk is a key organisational responsibility and is the responsibility of all staff employed by the Trust. Risk management is thus an integral part of good clinical and corporate governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical or non-clinical. Risk management is embedded within the Trust’s overall performance management framework and links with business planning and investment decisions.

1.6 There is clear responsibility of the Trust Board in response to the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust (2013) and the subsequent Berwick Report (2013), to provide assurance that patient safety and recovery is at the top of the agenda. Lessons learned from the Francis Inquiry, both on a national and local level, demonstrate the importance of an overarching assessment of risk to the Trust. The Trust aims to ensure that patient safety and quality risk assessment continue to follow the consistent risk management process outlined within the strategy. Francis and Berwick also specifically emphasised the importance of Board responsibilities and an open and fair culture to ensure the best possible patient safety principles within Trusts. These are clearly set out within this strategy.

1.7 The Risk Management Strategy confirms the organisational framework for the management of risk within Camden and Islington NHS Foundation Trust.
2.0 STATEMENT OF INTENT

2.1 Effective risk management processes are essential to the delivery of high quality and safe healthcare services. The Trust believes that due attention to risk management will not only reduce harm to patients and staff as well as create safer environments of care but is essential for the achievement of the organisation’s strategic goals and corporate and clinical objectives.

2.2 The Trust:

- ensures that risk management forms an integral part of the organisation’s thinking, performance management and business planning, rather than being viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation;

- recognises the importance of involving local stakeholders (for example, members, service users, governors) in its risk management process, not only in terms of identifying risk but also by involving them, where possible, in the decision-making and prioritisation arrangements;

- is committed to building and sustaining an organisational culture that encourages appropriate risk taking, effective performance management and organisational learning in order to improve continuously the quality of the services provided, improve safety and reduce harm.

3.0 SCOPE AND OBJECTIVES

3.1 This strategy provides the overarching framework within which risk is managed by the organisation and is fully endorsed by the Trust Board. The Board consider it a contemporary strategy that reflects currently available information, guidance and legislation governing the NHS. The strategy focuses on risk management arrangements from an organisational rather than an individual perspective.

3.2 A significant risk management activity undertaken by the Trust is clinical risk assessment and management of individual service users. This process is part of the Care Programme Approach (CPA), the outcome of which is an individual plan of care for the service user. Although the basic principles described in this strategy are applicable to individual clinical risk assessment and management, this particular activity is complex and therefore is supported by additional systems and processes and a dedicated policy document. Risk management for service users is, for that reason, addressed thoroughly in the Clinical Risk Assessment and Management Policy that is available on the Trust Intranet. This document fully complements the Risk Strategy and should be read in conjunction with this document in order to provide a complete overview of Trust risk management arrangements. Cumulative clinical risks however (for example suicide) are addressed via the framework specified below.

3.3 Camden and Islington NHS Foundation Trust's Risk Management Strategy will:

- Actively pursue the identification of uncertainties in order that threat can be mitigated and opportunity utilised;

- Continue to develop a risk and safety aware culture throughout the Trust;
• Ensure that a consistent and integrated approach to risk management is embedded in the day-to-day working practices of the organisation at all levels, embracing clinical, non-clinical and corporate risks;

• Ensure that the risk management process covers the full range of the Trust activities;

• Continue developing the systems and structures in place for identifying, assessing, mitigating, and reporting risk;

• Ensure that the Board and senior management are provided with adequate assurance that risks are being appropriately identified, assessed, and mitigated;

• Comply with all external requirements and standards in relation to risk management.

4.0 EXTERNAL REQUIREMENTS

4.1 The Trust must ensure that its risk management arrangements meet the requirements of a number of national bodies which are described below:

4.2 NHS Improvement (NHSI) is the operational name for an organisation that from the 1 April 2016 brings together the Monitor Risk Assessment Framework and the NHS Trust Development Authority (TDA) Accountability Framework. The statutory obligations of Monitor and TDA continue within NHS Improvement. Therefore, NHS Improvement must ensure the operation of a licensing regime and oversight of the governance of NHS trusts.

In October 2016 NHSI’s Single Oversight Framework replaced Monitor’s Risk Assessment Framework. The purpose of the new framework is to identify where providers may benefit from, or require, improvement support across a range of areas:

- Quality of care;
- Finance and use of resources;
- Operational performance;
- Strategic change;
- Leadership and improvement capability;

NHSI use information from data monitoring processes and insights gathered through work with providers, to identify where providers have a potential support need under one or more of the five themes above. Providers are placed in one of four segments according to the level of support each provider needs:

1. Providers with maximum autonomy − no potential support needs identified across our five themes − lowest level of oversight and expectation that provider will support providers in other segments
2. Providers offered targeted support − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3. Providers receiving mandated support for significant concerns − the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4. Special measures − the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measure

NHSI will generally review the segmentation of the provider on a quarterly basis, unless there is information giving cause for concern.
4.3 **The Care Quality Commission (CQC)** includes risk management as part of its essential standards (which cover clinical and non-clinical issues). All healthcare providers, including NHS Trusts, must achieve these minimum standards. In 2014, the CQC replaced Quality Risk Profiles (QRPs) with a new surveillance model which trigger inspection timetables against performance. The new surveillance model is built on a suite of indicators that relate to the five key questions the CQC inspection teams will ask of all services: are they safe, effective, caring, responsive to people’s needs and well led? Ratings are given at four levels; Outstanding, Good, Requires Improvement or Inadequate. Trusts can have all four ratings, or any combination, simultaneously. Ratings are published to help patients compare services and increasingly make choices about providers.

4.4 **The National Health Service Litigation Authority (NHSLA)** provides insurance cover to the NHS for most incidents, both clinical and non-clinical. The NHSLA has previously assessed all NHS Trusts for compliance against a unified set of risk management standards. However, following a change in approach, they no longer carry out assessments. In their place the NHSLA have introduced the ‘Safety and Learning Service’, which supports Trusts to build a safety and learning culture through their work in learning from claims.

The NHSLA risk management standards however, reflect good risk management practice, and the Trust will continue to use them as a basis to address relevant areas of risk for as long as they apply to the Trust and reflect current processes and practice.

4.5 **The National Patient Safety Agency (NPSA)** functions were transferred to NHS England in 2012 and then to NHS Improvement in April 2016. This particular function does not set specific requirements that are assessed. However, it works closely with agencies across the NHS and with Trusts to implement and establish solutions to problems and to support a safety aware culture. For example, NHSI issue national patient safety alerts and monitor all patient safety incidents via the National Reporting and Learning Service (NRLS).

4.6 **The NHS Counter Fraud Authority** is a special health authority tasked to lead the fight against fraud, bribery and corruption in the NHS. It sets the national standards for NHS providers counter fraud work. Standard 1.4 requires NHS organisations to carry out ‘comprehensive local risk assessments to identify fraud, bribery and corruption risks, and [have] counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.’

4.7 **The Ministry of Justice** requires that the Trust has adequate procedures which are proportionate to the risk of bribery and corruption in accordance with the Bribery Act 2010 and the guidance on the Bribery Act 2010 published by the Ministry of Justice.

### 5.0 TYPES OF RISK EXPOSURE

5.1 The Trust is exposed to a wide range of risks, which are best characterised by setting out a taxonomy of risks. Risks impacting on the business of the Trust fall into the broad headings outlined below. The Board must self-certify that risks identified in these areas are being successfully mitigated, or else declare and provide an action plan where this is not the case. Risk categories are as follows:

1) **Quality, Governance and Performance Risk:**
   This covers risks to compliance with the Trust’s licence and includes:
   
   a. Third party investigations that could suggest material issues with governance, e.g. CQC concerns, fraud;
b. CQC reviews, planned or unannounced, and its outcomes / findings;

c. Other patient safety issues which may impact compliance with the licence (e.g. serious incidents, complaints)

2) **Continuity of Services Risk:**
This encompasses risks to the Trust being able to provide ongoing availability of key services. For example, future transactions potentially affecting the continuity of services risk rating, risk of a failure to maintain registration with the CQC for Commissioner Requested Services (CRS), proposed disposal of CRS-related assets.

3) **Information Security Risk:**
This is the potential for unauthorised use, disruption, modification or destruction of C&I’s information assets. Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Without effective cyber security, incidents can threaten health, breach privacy, disrupt business continuity, damage assets and facilitate other crimes such as fraud. The Trust has a legal obligation to ensure that appropriate security management arrangements are in place for the protection of data.

4) **Operational Risks:** These are risks concerned directly with the operational activity of the Trust. This category of risk would, therefore, include a number of sub-divisions such as staffing, health and safety, security and fire.

5) **Financial Risk** This encompasses risks arising from financial planning and management and includes: credit risk, market risk, liquidity risk, budget risk, accounting risk, fraud risk etc. It would also include requirements for additional working capital facilities, failure to comply with the statutory reporting guidance and an adverse report from internal or external auditors or any independent review.

6) **Business Risk** The Trust is also exposed to commercial risks as a result of operating in a dynamic and competitive health and social care market. Within this environment the Trust faces risk from loss of referrals or contracts, changes in commissioner strategy or procurement actions, threats arising from major transactions such as mergers and acquisitions, and loss of business through patient choice.

7) **Reputational Risk** This encompasses current or prospective risk arising from the adverse perception of the image of the Trust by commissioners, partners, individuals, the local community or regulators. Consideration of how clinical and non-clinical risks may adversely affect the Trust’s reputation should be made as part of the overall assessment of a risk at its initial assessment and following mitigation when considering residual risk.

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**6.0 RISK APPETITE**

**6.1 DEFINITION OF RISK APPETITE**

Every organisation will have a different perception of the level of risk it is comfortable with and needs to be clear about what is and is not acceptable. An organisation’s risk appetite is defined as “the amount and type of risk that an organisation is prepared to seek, accept or tolerate.”

Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but may have more
appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation.

Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board.

6.2 RISK APPETITE STATEMENTS

6.2.1 These risk appetite statements will form part of the overall risk management strategy setting the tolerance level to be considered when managing risks arising within each of the categories.

Risks will be assessed using the Risk Appetite Matrix for NHS organisations (see Appendix 10) and these ratings will be recorded within the Trust Risk Register.

- **Quality, Governance and Performance and Operational Risk**
  The quality of our services, measured by clinical outcome, patient safety and patient experience is at the heart of everything we do. We will put quality at risk only if, on balance, the benefits are justifiable and the potential for mitigating actions are strong.

- **Financial Risk**
  The Board is prepared to accept possibility of some limited financial loss. Value for money is still the primary concern, but the board will consider other benefits or constraints.

- **Continuity of Services Risk (Regulation and Compliance)**
  The Board acknowledges that healthcare and the NHS operates within a highly regulated environment, and that, as a Foundation Trust, it has to meet high levels of compliance expectations from a large number of regulatory sources. It will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against pragmatic operational imperatives.

- **Business Risk**
  The Trust is supportive of opportunity and innovation, with demonstration of commensurate improvements in management control. It supports a focus on growth and service development and innovation, but priority will be given to improvements that protect current operations.

- **Reputational Risk**
  The Board is prepared to take decisions that have the potential to bring scrutiny of the organisation, provided that potential benefits outweigh the risks and by prospectively managing any reputational consequences.
6.3 EXPRESSING RISK APPETITE

The approaches the Trust will use to express risk appetite are described below. The first provides a standardised approach to identifying a potentially unacceptable level of risk, the second provides a more flexible approach which takes account of the nature of the risk and the circumstances in which it was identified and the third provides a rating of risk appetite using the Risk Appetite Matrix for NHS organisations (see Appendix 10).

- **Setting a boundary on the risk matrix (likelihood and consequence):** As described in Section 7, the Trust will use a 5 x 5 matrix to identify risk ratings. The Trust’s “risk appetite” line is set at 15; any risks rated at or above this level are reported to the Audit and Risk Committee and the Board on a quarterly basis. A risk score of 15 or above should therefore be treated as a trigger for a discussion as to whether the trust is willing to accept this level of risk.

- **Target risk ratings:** Target risk ratings should be set for all risks. This risk rating is a means of expressing a target for the highest acceptable (tolerated) level for that risk. When setting target risk ratings, risk leads should consider what level of tolerated risk they are willing to retain. For some risks, the target risk rating could be high, especially where the consequences are potentially severe or some elements of the risk lie outside the direct control of the Trust.

- **Risk Appetite rating:** All risks will have a risk appetite rating which will be derived from the Risk Appetite Matrix for NHS organisations (see Appendix 10).

7.0 RISK MANAGEMENT PROCESS OVERVIEW

7.1 PROCESS OVERVIEW

7.1.1 This section briefly outlines the overall risk management process embodied by the Trust, examines the risk rating and ranking process, discusses risk treatment, explains what a risk register is and outlines how risk assessment, monitoring and review is undertaken within the Trust.

7.1.2 The overall risk management process is shown pictorially in *Figure 1*. There are seven major elements within the process.

*Figure 1: The Risk Management Process*
Step 1: Establish the context: Establish the external, internal and risk management context in which the rest of the process will take place. Criteria against which risk will be evaluated should be established, the structure of the analysis defined and the boundaries of the analysis established.

Step 2: Identify risk: Identify what, why and how things can arise as the basis for further analysis. Sources of information that can be used in order to identify risk include the following:

**Reactive Information Sources**
- Incident management and investigation
- Complaints
- Claims
- Inquests
- Criminal investigation
- Reviews / inspections
- Trust Governors/Members/Employees
- Safety alerts (received through the Central Alerting System (CAS))

**Proactive Information Sources**
- Health and safety risk assessments
- Audit (internal or external)
- Local Proactive Exercises (LCFS)
- Other third party service providers
- Service user and staff surveys
- Clinical governance reviews
- Advice and Complaints Service
- NICE guidance and Technology appraisals
- External Inquiries e.g. Domestic Homicide Reviews
- Self assessment
- Trust Governors/Members/Employees
- Performance reports
- Market intelligence
- Due diligence for new business
- NHS Improvement
- CQC
- National Quality Board
- Public Health England
- Committee and group meeting minutes

Step 3: Analyse risk: Determining the relative importance of individual risks is a key element of the risk management process, enabling risk control priorities to be identified and appropriate action to be taken in response. This is achieved by:

A: Assigning a score to the ‘likelihood’ of a risk event occurring;
B: Assigning a score to the ‘severity’ or ‘impact’ of the consequences of the risk event;
C: Identifying the risk rating via a risk matrix (5X5). The risk rating is calculated as the likelihood (probability or frequency) X severity of consequence.

This process is fundamental to the Trust’s Risk Management Strategy and is outlined in detail in Appendix 2.

Step 4: Evaluate risks: Compare estimated levels of risk against the pre-established criteria. This enables risks to be ranked so as to identify management priorities. If the levels of risk established are low, then risks may fall into an acceptable category and treatment may not be required.

In simple terms, action should always be taken to reduce risks unless this involves measures that are clearly disproportionate in relation to the risk. Applying this requires the application of common sense and judgment, rather than a formal cost-benefit analysis. However, some risks

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1 Refer to the Incident Reporting Policy and the Management of Serious Incident Policy available on the intranet.
2 Refer to the Advice and Complaints Policy available on the intranet.
3 Refer to the Claims Management Policy available on the intranet.
4 Refer to the Anti-Fraud and Bribery policy available on the intranet.
will remain more than minimal even after being mitigated in this way. Such risks may be deemed acceptable provided:

- the risk is maintained at a level which is both ‘as low as reasonably practicable’ and acceptably low in absolute terms;
- the risk and the control measures are communicated to staff/management/service users;
- the risk is reviewed regularly;
- it does not lead the Trust to breach its terms of authorisation.

If a risk is not accepted, the scale and urgency of the risk treatment is determined using Appendix 2 as a guide.

**Step 5: Treat risks:** Risk treatment involves identifying the range of options for controlling or treating risk, assessing those options, preparing risk treatment plans and implementing them. The options available for the treatment of risks include:

- **Accept the risk** - if, after controls are put in place, the remaining risk is deemed acceptable to the organisation, the risk can be retained;

- **Reduce the likelihood of the risk occurring** - by preventative maintenance, market assessment, relationship management, audit and compliance programs, supervision, policies and procedures, testing, investment, training of staff, technical controls and quality assurance programmes etc;

- **Reduce the consequences of the risk occurring** - through financial reserves, contingency planning, disaster recovery & business continuity plans, off-site back-up, public relations, emergency procedures and staff training etc;

- **Transfer the risk** - this involves another party bearing or sharing some part of the risk by the use of contracts, insurance, outsourcing, joint ventures or partnerships etc;

- **Avoid the risk** - decide not to proceed with the activity likely to generate the risk, where this is practicable;

**Step 6: Constant monitoring and review:** Monitor and review the performance of the risk management system and changes which might affect it.

**Step 7: Communicate, consult, learn and adapt:** Communicate and consult widely, including with external stakeholders as appropriate, at each stage of the risk management process. Ensure learning and appropriate adaptation occurs in order to minimise recurrence of risks.

### 7.2 RISK MONITORING AND REPORTING

#### 7.2.1 Risk Registers

A risk register provides the means of describing, scoring and ranking risks. It identifies ownership, controls in place, the need for further reduction and the recording of additional controls that are to be put in place. The overall aim of the risk register is not to document all the risks faced by the Trust, but the more significant ones and to record the action plans to mitigate those risks to acceptable levels.

A robust risk management tool is essential to a successful risk management process. Risk registers should be easy to access, and real time reporting should be possible. The Trust uses the Datix system to hold risk registers, allowing multiple users to access the
information in a shared location, and to review real time data. The process for recording risks on Datix is set out in Appendix 3.

7.2.2 Trust Risk Register (TRR)

The Trust Risk Register is comprised of the highest scoring risks (15+) from across all risk registers. All risks have an identified Director Lead, who is ultimately accountable for ensuring the risk is managed appropriately, a Risk Owner, who is the senior manager accountable for ensuring suitable plans are in place to mitigate the risk and a Risk Lead, who is the person with direct responsibility and oversight of the activities to manage the risk. Oversight of the TRR is maintained by the Risk and Patient Safety Manager.

The TRR is routinely populated, reviewed and updated through the quarterly risk monitoring cycle using three streams of information:

**Stream 1: Operational Risk Registers**
Risks meeting the threshold of risk score 15+ from any risk register are automatically included on the TRR. Risks that require consideration for inclusion on the TRR will be escalated upwards via the Senior Leadership Team (SLT) and reviewed by the Executive Risk Scrutiny Group during the quarterly risk scrutiny exercise. (see Appendix 9).

**Stream 2: Objectives Stream**
Executive Directors review the TRR every quarter ensuring any risks to their objectives are identified through the relevant risk registers. Risks noted via this stream would directly relate to the principal objectives that are broken down by Director lead.

**Stream 3: Committee Stream**
Risks identified by committees and sub-committees set out in Appendix 4 are referred on to the appropriate ‘parent committee’ by way of their minutes. Risks that require consideration for inclusion on the TRR are escalated upwards via the committee structure and reviewed by the Executive Risk Scrutiny Group during the quarterly risk scrutiny exercise. (see Appendix 9).

The TRR is a live, working document. Many of the risks will have a limited life span, since it should be possible to reduce the risk to an acceptable level through the implementation of planned actions. Risks should be removed from the register once they have been mitigated sufficiently.

The contents of the TRR are validated and scrutinised on a quarterly basis, prior to being submitted to the Audit and Risk Committee, to ensure consistency of reporting and scoring. This risk scrutiny exercise is undertaken by the Executive Risk Scrutiny Group, chaired by the Chief Executive and attended by all the executive directors.

The purpose of the quarterly risk scrutiny exercise is to:
- Fulfil the role of scrutiny and verification of the management of the Trust Risk Register;
- Review and agree the highest scoring risks (15+) from across all risk registers to be included on the TRR prior to submission to the Audit and Risk Committee;
- Ensure that there is appropriate in-depth scrutiny and challenge applied, including review of overdue action plans; and
- Agree risk scores, and ensure consistency of scoring within, and across risk registers.

The TRR is presented quarterly to the Audit and Risk Committee. Action plans are given a ‘red’, ‘amber’ or ‘green’ status depending on their level of completion and narrative describing key mitigation for each of the risks is also provided. The Board monitors the contents of the TRR via the minutes of the Audit and Risk Committee.
A full guide to all the information contained in the TRR is set out at Appendix 5. The process for completing the TRR is detailed in Appendix 6.

7.2.3 Divisional Risk Registers (DRRs)
In order to manage risk effectively at a local service level, each operating Division maintains a risk register as part of their management responsibility. These registers are mainly populated by risks that affect the achievement of divisional objectives and/or the particular local operation.

Risks identified at local team level should be escalated through the divisional management structure for inclusion on the DRR where appropriate. Where locally identified risks are not appropriate for the DRR suitable action plans should be put in place to manage these risks locally. Reporting and monitoring risk at individual team level is an area of risk management overview for further development within the Trust.

Associate Divisional Directors and Divisional Clinical Leads should maintain and review their Divisional risks at least quarterly. The Chief Operating Officer has responsibility for maintaining an overview and ensuring consistency across all DRRs.

DRRs feeds into the TRR where applicable if risks meet the scoring threshold of 15+ and have been validated by the Executive Risk Scrutiny Group. This does not necessarily exclude other risks which are thought serious enough to be discussed by the Audit and Risk Committee.

The DRRs are viewed, discussed and validated quarterly by the SLT Risk Scrutiny Group which is chaired by the Chief Operating Officer and attended by Associate Divisional Directors and Heads of corporate departments. The highest scoring risks (15+) from the DRRs are escalated to the Executive Risk Scrutiny Group for inclusion on the TRR.

The purpose of the quarterly Divisional risk scrutiny exercise is to:

- Fulfil the role of scrutiny and verification of the management of the Divisional risk Registers;
- Review the Divisional Risk Registers and agree high level risks (15+) for escalation to the Executive Risk Scrutiny Group for inclusion on the TRR;
- Ensure that there is appropriate in-depth scrutiny and challenge applied, including review of overdue action plans; and
- Agree risk scores, and ensure consistency of scoring within, and across risk registers.

The DRRs are presented in full to the Audit and Risk Committee at least once a year. Appendices 4 and 5 are also applicable to DRRs.

7.2.4 Corporate Department Risk Registers (CDRRs)
The Trust will consider which corporate departments should maintain a risk register and each identified head of department will maintain a risk register as part of their management responsibility. These registers are mainly populated by risks that affect the achievement of departmental objectives and/or the particular specialist operation.

Risks identified at team level should be escalated through the department management structure for inclusion on the CDRR where appropriate. Where locally identified risks are not appropriate for the CDRR suitable action plans should be put in place to manage these risks locally.
Heads of departments should maintain and review their risks at least quarterly. The responsible Director for each area is accountable for maintaining an overview of CDRRs for their area.

CDRRs feeds into the TRR where applicable if risks meet the scoring threshold of 15+ and have been validated by the Executive Risk Scrutiny Group. This does not necessarily exclude other risks which are thought serious enough to be discussed by the Audit and Risk Committee.

The CDRRs is viewed, discussed and validated quarterly by the SLT Risk Scrutiny Group which is chaired by the Chief Operating Officer and attended by Associate Divisional Directors and Heads of corporate departments. The highest scoring risks (15+) from the CDRRs are escalated to the Executive Risk Scrutiny Group for inclusion on the TRR.

The purpose of the quarterly corporate department risk scrutiny exercise is to:

• Fulfil the role of scrutiny and verification of the management of the corporate department risk registers;
• Review the corporate department risk registers and agree high level risks (15+) for escalation to the Executive Risk Scrutiny Group for inclusion on the TRR;
• Ensure that there is appropriate in-depth scrutiny and challenge applied, including review of overdue action plans; and
• Agree risk scores, and ensure consistency of scoring within, and across risk registers.

The CDRRs are presented in full to the Audit and Risk Committee at least once a year. Appendices 4 and 5 are also applicable to CDRRs.

7.2.5 Trust Wide Risks Registers (TWRRs)

The Risk and Patient Safety Manager maintains a register of trust wide risk. This register is populated by risks that do not fit neatly into one Division or corporate department risk register but affect the achievement of trust wide objectives.

Risks should be maintained and reviewed by Risk Owners at least quarterly. The responsible Director for each area is accountable for maintaining an overview of trust wide risks for their area.

The TWRR feeds into the TRR where applicable if risks meet the scoring threshold of 15+ and have been validated by the Executive Risk Scrutiny Group. This does not necessarily exclude other risks which are thought serious enough to be discussed by the Audit and Risk Committee.

The TWRR is viewed, discussed and validated quarterly by the SLT Risk Scrutiny Group which is chaired by the Chief Operating Officer and attended by Associate Divisional Directors and Heads of corporate departments. The highest scoring risks (15+) from the TWRR are escalated to the Executive Risk Scrutiny Group for inclusion on the TRR.

The purpose of the quarterly Trust wide risks register scrutiny exercise is to:

• Fulfil the role of scrutiny and verification of the management of the Trust wide risks register;
• Review the Trust wide risks register and agree high level risks (15+) for escalation to the Executive Risk Scrutiny Group for inclusion on the TRR;
• Ensure that there is appropriate in-depth scrutiny and challenge applied, including review of overdue action plans; and
• Agree risk scores, and ensure consistency of scoring within, and across risk registers.
The TWRR is presented in full to the Audit and Risk Committee at least once a year. Appendices 4 and 5 are also applicable to TWRR.

7.2.6 Board Assurance Framework (BAF)
The BAF provides the Board with a simple but comprehensive method for the effective and focused management of the strategic risks that could affect the delivery of the Trust’s principal objectives. Risks to the principal objectives are proactively identified during the business planning cycle at an annual Board risk seminar and action plans are developed where controls are seen to be insufficient.

Ongoing monitoring of the BAF risks occurs quarterly with each responsible executive director providing updates on their risks prior to the BAF being reported to the Audit and Risk Committee and then to the Board. Executives must sign off on their risk updates in each reporting cycle. If new risks are identified, the BAF and TRR will be cross referenced to ensure that there is no duplication and a decision made as to where the risk should sit, with the BAF focusing on overarching strategic level risks. Any additional BAF risks must be notified of by an executive director and agreed by the Trust Executive.

The BAF is reported in the same format as the TRR, with controls, actions, scores and relevant dates. Each quarter, the Board will be asked to review and approve the BAF as an accurate representation of the current status of strategic risks facing the Trust and to use it as an assurance tool in holding the executive team to account.

The BAF is not intended to be a finalised document and will remain live on an ongoing basis. There will be a direct link between the risks on the TRR and the strategic level risks on the BAF.

7.2.7 Risk Scrutiny
Operational risk registers and the BAF are routinely monitored, reviewed and updated through the quarterly risk monitoring cycle, with each Director Lead, Risk Owner and Risk Lead providing updates on their risks prior to them undergoing scrutiny in preparation for them being reported to the Audit and Risk Committee.

The DRRs, CDRRs and TWRR are viewed, discussed and validated quarterly by the SLT Risk Scrutiny Group which is chaired by the Chief Operating Officer and attended by Associate Divisional Directors and Heads of corporate departments. The highest scoring risks (15+) from these registers are escalated to the Executive Risk Scrutiny Group for inclusion on the TRR.

The contents of the TRR and the BAF are validated and scrutinised on a quarterly basis, prior to being submitted to the Audit and Risk Committee, to ensure consistency of reporting and scoring. This risk scrutiny exercise is undertaken by the Executive Risk Scrutiny Group, chaired by the Chief Executive and attended by all the executive directors.

The purpose of the quarterly scrutiny exercise is to:
- Fulfil the role of scrutiny and verification of the management of all Trust risks registers;
- Review and agree the highest scoring risks (15+) from across all Trust risk registers to be included on the TRR prior to submission to the Audit and Risk Committee;
- Ensure that there is appropriate in-depth scrutiny and challenge applied, including review of overdue action plans; and
- Agree risk scores, and ensure consistency of scoring within, and across risk registers.
7.2.8 NHSI annual submissions and in-year submissions
The Trust has to make the following annual submissions to NHSI:
- A 2 year detailed operational plan plus a 5 year strategic plan;
- availability of resources statement;
- corporate governance statement to confirm compliance with the governance conditions of the provider licence;
- annual report and accounts;
- governor and membership report.

The amount and frequency of information that NHSI require in-year varies depending on the level of risk to compliance with the Trust's licence. Where no risk to compliance has been identified, the Trust will generally submit in-year information on a quarterly basis. This will include a financial submission and a non-financial submission including care quality, service performance, and information about member engagement and governor elections.

7.2.9 Exception reporting to NHSI
NHSI expects NHS foundation trusts to notify them of any incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with their licence. NHSI also requires licence holders to inform them of particular occurrences that could have an impact on the operation of the Trust's business such as:
- undertaking a major acquisition, investment or disinvestment;
- losing a significant contract or a significant chance in capital structure
- a material deterioration in financial performance or an immediate need to spend significant sums to meet regulatory requirements;
- other exceptional financial events;
- CQC responsive or planned reviews and their outcomes;
- Other patterns of patient safety issues which may reflect poor governance (e.g. serious incidents, complaints).

8.0 ACCOUNTABILITY AND RESPONSIBILITY
This section defines the responsibilities for risk management within the Trust. Specific responsibilities reside both with individuals and with committees and sub-committees. These responsibilities are set out below.

8.1 RESPONSIBILITIES OF INDIVIDUAL OFFICERS / BOARD MEMBERS

8.1.1 Trust Directors
Executive Directors are responsible for the identification, assessment and management of risk within their own area of responsibility. The Board, as a whole, is required to provide leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed. The Board is required to approve an annual self-certification confirming that risk management systems are effective and fit for purpose. This self-certification includes an assessment of risks which could adversely effect on the terms of our authorisation and their mitigation plans.

8.1.2 Non-executive Directors (NEDs)
NEDs are responsible for providing an additional layer of scrutiny in order to seek assurance of the effectiveness of the Trust risk management and risk reporting systems. Via the Board level committee structure it is the responsibility of the NEDs to assure that
risk issues are appropriately reflected in the delivery of Trust strategic priorities and business objectives.

8.1.3 Trust Governors
Trust Governors provide an additional layer of assurance that strategic decisions taken by the Board are informed by the views and opinions of local people, service users and staff.

8.1.4 Chief Executive
The Chief Executive has overall accountability for risk management across the Trust and exercises this responsibility through membership of the Trust Board and attendance at the Audit and Risk Committee. The Chief Executive delegates general risk management responsibilities to all executive directors, and specific responsibility to those listed below. It is the Chief Executive who signs off the annual governance statement on behalf of the Board.

8.1.5 Director of Nursing
The Director of Nursing has responsibility for managing the strategic development and implementation of risk management processes within the Trust. Specific responsibilities in relation to risk management include:

- Lead on Board Assurance Framework;
- Lead Director and line management responsibility for the Governance and Quality Assurance Department (including the Risk and Patient Safety Team);
- Named Director for CQC registration and CQC reviews;
- Lead Director to assure compliance against quality standards, external regulatory expectations, commissioner requirements as well as internal compliance against standards;
- Co-Lead Director for suicide prevention;
- Lead Director for clinical policy development and implementation;
- Director for Infection Prevention and Control;
- Co-Lead Director for work stream focusing on violence, aggression and harassment;
- Lead Director for Information Governance;
- Responsible for professional nursing practice including revalidation;

8.1.6 Medical Director
Specific responsibilities in relation to risk management include:

- Responsible for professional medical practice including appraisal and revalidation
- Nominated Caldicott Guardian;
- Lead Director for medicines management;
- Co-Lead Director for suicide prevention.

8.1.7 Director of Finance
Specific responsibilities in relation to risk management include:

- Lead Director for co-ordinating and reporting on External / Internal Audit reviews;
- Lead Director for Estates and Facilities;
- Lead Director for Health and Safety;
- Lead Director for Counter Fraud.
- Lead Director for Security Management.

8.1.8 Director of Digital Services & Informatics
- Lead Director for ICT;
- Lead on NHSI reporting and assurance;
- Nominated SIRO (Senior Information Risk Owner);
8.1.9 Chief Operating Officer
The Chief Operating Officer is charged with responsibility for operational services and is accountable for the day-to-day management of services and the risks inherent within that operation. Such risks are far reaching but include overseeing the divisional budgets, the delivery of all commissioned services, the practical implementation of policy and guidance and modernisation of services. Specific responsibilities in relation to risk management include:

- Lead for emergency planning;
- Operational performance management;
- Divisional Risk Register overview;
- Responsible for professional social work, psychology and occupational therapy practice.

8.1.10 Director of Human Resources
Specific responsibilities in relation to risk management include:

- Lead Director for Learning and Development;
- Lead Director for Human Resources;
- Lead Director for Equality and Diversity;
- Co-Lead Director for work stream focusing on violence, aggression and harassment.

8.1.11 Director of Strategy and Business Development
Specific responsibilities in relation to risk management include:

- Lead for annual planning.

8.1.12 Trust Company Secretary
Specific responsibilities in relation to risk management include:

- Maintaining, updating and reporting on the Board Assurance Framework (BAF).

8.1.13 Head of Governance and Quality Assurance
The Head of Governance and Quality Assurance is responsible for all aspects of quality (patient safety, effectiveness and experience) and leads the strategic development, operationalisation, reporting, analysis and monitoring of quality assurance and compliance against quality standards, risk management and external regulation.

8.1.14 Risk and Patient Safety Manager/s
The Risk and Patient Safety Manager is responsible for the ongoing development and co-ordination of the system of risk management and the consolidation and reporting of all risk management information to ensure the principles and requirements of managing risk are consistently adopted throughout the organisation. The Risk and Patient Safety Manager has an open line of communication to the Chair of the Audit and Risk Committee. Specific responsibilities in relation to risk management include:

- Managing the process for reporting, investigating and learning from incidents, complaints and claims;
- Oversight of the quarterly risk monitoring cycle;
- Maintaining, updating and reporting on the Trust Risk Register (TRR);
- Providing advice and guidance on risk related issues to Trust staff and the Audit and Risk Committee.
8.2 RESPONSIBILITIES OF MANAGERS AND STAFF

8.2.1 Managers
Managers are responsible for the management of day-to-day risks of all types, including health and safety, within their remit and budget allocation. They are charged with ensuring that risk assessments are undertaken throughout their area of responsibility on a proactive basis and that remedial action is carried out where problems are identified. They are also responsible for reporting difficulties in reducing risk to their Associate Divisional Director and/or Executive Director.

Individual managers should:

- Ensure that Trust risk management policies and procedures are implemented within their area of responsibility, and adapted as necessary to reflect local risk profiles;
- Contribute to operational risk registers where appropriate;
- Foster a supportive environment to facilitate the reporting of risks and incidents;
- Keep staff informed about the risks faced by the Trust and what is being done to address them;
- Ensure that staff under their management have access to opportunities for training and development, including attendance at core skills training events.
- Ensure that incidents of fraud and bribery are reported to the Trust’s LCFS or NHS Counter Fraud Authority.

8.2.2 Trust Staff
It is the duty of all staff to ensure that identified risks are reported to their immediate line manager, in order that effective controls may be considered and actioned where necessary. In addition to their responsibilities for health and safety, staff have a general responsibility for wider risk management issues and should follow Trust procedures in their work. This responsibility is explicit in all staff job descriptions.

Individual members of staff should:

- Work to Trust policies and procedures;
- Maintain safe systems of work;
- Safeguard confidentiality;
- Take care of their own safety and that of their colleagues and anyone else who may be affected by their actions or omissions;
- Ensure equality is part of practice and human rights are respected;
- Take care of the Trust’s buildings, equipment and other assets;
- Report risks, incidents and near misses and take remedial action in accordance with the Trust’s risk management policies and procedures;
- Attend Core Skills training.
- Ensure that they meet professional registration requirements, including those relating to continuing professional development.
- Ensure that incidents of fraud and bribery are reported to the Trust’s LCFS or NHS Counter Fraud Authority.

Staff with specialist responsibility for areas of risk management.
There are some Trust staff who have specialist responsibilities in relation to Risk Management. A list of contacts and their responsibilities may be found at Appendix 8.
8.3 COMMITTEE STRUCTURE AND RESPONSIBILITIES

The Trust has constituted a number of committees and sub-committees that are totally, or partially, responsible for risk management issues; relationships between these committees and sub-committees are shown in Appendix 4.

All Trust committees and sub-committees are accountable for the oversight and management of risks that fall within their remit, as set out in their terms of reference. Committees will review their section of the TRR at each meeting, as well as identify new risks and assess those referred from sub-committees. Where responsibility for a risk on the TRR has been devolved to a sub-committee, both the committee and sub-committee should apply this process. This process supports the integration of risk management into Trust core business. (See Appendix 9).

8.3.1 The Trust Board of Directors
The Board’s unique contribution to risk management is to set the risk culture within the organisation. It should reflect the required balance between the “taking of risks” to achieve the benefits of objectives, and the management of those risks which are unacceptable. The Board will fulfil their role by:

- Making its Self-Declaration and annual governance statement, assuring the public and other external stakeholders that it is doing “its best” to meet its objectives and protect against risks of all kinds;
- Keeping under review the Trust's risk exposure as recorded in the Trust Risk Register. This may involve requesting more detailed reports where concern is raised;
- Receiving independent assurances on internal control effectiveness from the Audit and Risk Committee, in part through the Single Oversight Framework;
- Contributing to strategic risk identification through its finalisation of the BAF and approval of any consequent re-scoping of internal audit’s work, on Audit and Risk Committee advice;
- Annually reviewing the Trust's approach to managing risk;
- Delegating authority to the Audit and Risk Committee to approve detailed procedures, so that it can keep a strategic overview of the key risks facing the organisation.

8.3.2 The Audit and Risk Committee
The Audit and Risk Committee, chaired by a Non-Executive Director, is at the heart of risk management arrangements within the Trust. The Committee is a committee of the Board of directors and provides the Board with an independent and objective review of the effectiveness of Financial Accounting, Governance, Risk Management and Internal Controls within the Trust. It is accountable to the Board for ensuring that the risk management process is implemented across the Trust in line with the overall Risk Management Strategy. The Committee also takes the role of quasi-independent scrutineer. It relies on the work of internal and external audit to inform its view about whether the Trust's risk management systems and procedures are appropriate and operating effectively. Its view assists the Board in coming to a conclusion about the accuracy of the annual governance statement.

There are a number of sub-committees that report into the Audit and Risk Committee whose remits include elements of risk management (see the Committee structure at Appendix 4). All reporting sub-committees refer risks to the parent committee in accordance with the guidance at Appendix 9. Terms of Reference for the Audit and Risk Committee are detailed within the Board and Sub-committee Handbook.

8.3.3 All Other Board Level Committees
These committees have responsibilities for overseeing the management of risks in line with the committees individual remit, as set out in their terms of reference. Committees should ensure that risk issues are reflected in meeting agenda, annual works plans and
information provided to the committee. All reporting sub-committees refer risks to the parent committee in accordance with the guidance at Appendix 9.

8.3.4 Trust Executive
The Trust Executive meeting is chaired by the Chief Executive and is collectively accountable for the management of the Trust and the delivery of its strategic objectives, as set by the Board. The Trust Executive assist the Chief Executive in the development and implementation of strategy, the effective delivery of the Business Plan, the management of strategic programmes, ensuring effective programmes for risk management are in place and achieving improvements in mental health outcomes.

9.0 STAKEHOLDERS

There is a range of organisations and individuals which require information on adverse events or significant risks facing the Trust – for example, service users, governors and members, commissioners, regulators, local government and central government. The main local stakeholders are all represented in the Foundation Trust Governors, part of whose role is to ensure that the Trust operates in a way that is consistent with its statement of purpose. To ensure that all interested parties can keep themselves fully informed, this Risk Management Strategy is available on the Trust’s website.

The Trust will also consider how to integrate its risk management process with key local organisations such as the London borough of Camden and the London Borough of Islington.

10.0 A FAIR AND OPEN CULTURE

10.1 All members of staff have important roles to play in identifying, assessing and managing risk. To support staff in this role the Trust provides a fair, open and consistent environment and does not seek to apportion blame. In turn, this encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report any situation where things have, or could have gone wrong. However, appropriate action in accordance with Trust policies will be taken when an employee has acted:

- Illegally - against the law (e.g. assaulting a colleague, committing fraud, theft);
- Maliciously - intending to cause harm, which s/he knew was likely to result (e.g. deliberately releasing confidential information);
- Recklessly - deliberately taking an unjustifiable risk where s/he either knew of the risk or s/he deliberately closed his/her mind to its existence (e.g. working while under the influence of alcohol or repeatedly making the same careless mistake).

10.2 Concerns regarding unsafe practice may be reported by staff through a confidential route under the ‘Raising Concerns at Work Policy’.

11.0 RISK MANAGEMENT TRAINING

11.1 The training and development of its staff is integral to the Trust’s approach to risk management.

11.2 Training needs analysis will continue to be undertaken by the Head of Learning and Development, in conjunction with the widest possible range of subject matter experts in
the organisation (including the Head of Governance and Quality Assurance), on an annual basis so that:

- All new staff attend an Induction programme which includes risk management training (as part of the Governance and Quality Assurance Overview);

- All Board members, non-voting Executives Divisional Managers and Divisional Clinical Managers will receive annual risk management training in the format of a risk management awareness seminar. This will be co-ordinated by the Head of Governance and Quality Assurance in conjunction with Learning and Development;

- The Trust will provide appropriate training and guidance to enable staff to take responsibility for managing risk within their own working environment. The Core Skills Training Matrix will be updated regularly and published on the Trust Intranet, identifying which course is relevant to which staff groups. Details of all relevant face to face training will be available on the Training Calendar on the Trust Intranet. Basic Risk Management training will also be available as an e-learning module.

**12.0 DISSEMINATION AND IMPLEMENTATION**

The effective implementation of this Risk Management Strategy will facilitate the Trust in delivering quality services and, alongside staff training and support, will provide an improved awareness of the measures needed to prevent, control and contain risk. In order to support this strategy the Trust will:

a) Ensure all staff and stakeholders have access to a copy of this Risk Management Strategy as well as access to other key risk documents identified in Section 12. The revised strategy will be communicated to all Trust staff via the Communications Bulletin and Divisional Management meetings;

b) Use a generic risk grading process (Appendix 2);

c) Maintain risk registers across the Trust, which will be subject to regular review by the Board and Audit and Risk Committee;

d) Ensure risk registers are accessible to staff and real time reporting is made possible by using effective risks management tools such as Datix.

e) Maintain an active incident and near miss reporting system that will allow the Trust to monitor incidents and near misses, learn from their occurrence and introduce changes to minimise their re-occurrence;

f) Draw-up annual prioritised risk management objectives (as part of the Risk Management Annual Report).

g) Support management in carrying out any treatment plans identified;

h) Develop policies, procedures and guidelines based on the results of assessments and all identified risks to assist in the implementation of this Strategy;

i) Provide sufficient financial and human resources to implement this strategy;

j) Ensure that training programmes raise and sustain awareness throughout the Trust about the importance of identifying, managing and learning from risk;
k) Ensure that the Trust risk management statement is incorporated into all job descriptions and that relevant risk management issues are incorporated into individual staff objectives;

l) Ensure that all members of staff have the knowledge, skills, support and access to expert advice necessary to implement the policies and procedures associated with this strategy;

m) Monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

13.0 RELATED POLICIES

There are a number of key policies in place that relate to this Strategy and which are available to staff on the intranet:

- Absent Without Leave (AWOL) and Missing Persons Policy;
- Advice and Complaints policy;
- Anti-fraud and Bribery Policy
- Board of Directors responsibilities and code of conduct;
- Business Continuity Plans;
- Business Response Plan;
- Care Plan Policy;
- Care Programme Approach Policy;
- Central Alert System (CAS) policy
- Claims Management Policy;
- Clinical Risk Management Policy;
- Core Skills Training Policy;
- Governors handbook;
- Health and Safety Policy;
- Incident Reporting Policy;
- Infection Control Policy and Procedures;
- Information Governance Policy;
- Learning opportunities booklet (Training Calendar);
- Management of serious incidents policy;
- Medical Devices Policy;
- Medicines Management Policy;
- NICE Guidance Implementation Policy;
- Patient leave policy;
- Prevention and management of violence and aggression;
- Raising Concerns at Work Policy;
- Safeguarding Patient’s property policy;
- Search Policy;
- Security Policy;
- Self-Harm Guidelines;
14.0 AUDIT AND REVIEW

14.1 Compliance with the standards set out in the Risk Management Strategy will be assessed routinely by the Audit and Risk Committee and by the Foundation Trust Board. Divisional Managers and local management teams will also be responsible for reviewing compliance with this strategy within their management groups and via formal line management arrangements.

14.2 The robustness of the framework detailed within the Strategy will be contained within a risk management annual report and subject to scrutiny by internal audit. It will also be endorsed by a self-certification to NHSI which is signed off annually by the Board.

14.3 More detail regarding how the effectiveness of this strategy will be monitored is set out in a table in Appendix 14.

14.4 The strategy will be reviewed every 3 years but will be updated as necessary annually.

15.0 REFERENCES


4) NHSI’s Single Oversight Framework. September 2016


6) NHS Litigation Authority Risk Management Standards for Mental Health and Learning Disability Trusts. NHSLA 2013/14


10) NHS Counter Fraud Authority, Counter fraud standards.
GLOSSARY

**Acceptable Risk:** The maximum score associated with a specific risk that the Trust is willing to tolerate.

**Accident:** An unintended event or series of events that result in death, injury, loss or environmental damage.

**Adverse Event:** An undesired outcome that may or may not be the result of error.

**Board Assurance Framework:** A method for the effective and focused management of the principal risks that arise in meeting the Trust strategic objectives.

**Consequence:** Outcome or impact of an event.

**Control:** An existing process, policy, device, practice, barrier or other action or device that acts to minimise negative risk and enhance positive opportunities.

**Divisional Risk Register** A scored list of risks that affect the achievement of objectives and/or the particular local operation of the individual divisions, identified by the Chief Operating Officer and Divisional Management Groups.

**Hazard:** A source of potential harm.

**Incident:** An incident is any occurrence which gives rise to, (or, in the case of a near miss narrowly avoids giving rise to), unexpected or unwanted effects involving the safety or well-being of any person on Trust premises or employed by the Trust. It also refers to the loss of or damage to property, records or equipment that are on Trust premises or belong to the Trust. The term therefore includes accidents, clinical incidents, security and confidentiality breaches, violence, and any other category of event, which does or could result in harm. It also includes failures of medical or other equipment.

**Likelihood:** Used as a general description of probability or frequency.

**Probability:** The likelihood of a specified event or outcome occurring. This is measured by the ratio of specific events or outcomes to the total number of possible events or outcomes. Probability is expressed along a scale ranging from ‘rare’ to ‘almost certain’

**Residual Risk:** risk remaining after implementation of risk treatment.

**Risk:** The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood.

**Risk Analysis:** A systematic process to understand the nature of, and deduce the level of, risk.

**Risk Appetite:** The amount and type of risk that an organisation is prepared to seek, accept or tolerate.

**Risk Assessment:** The overall process of risk identification, risk analysis and risk evaluation.

**Risk Avoidance:** A decision not to become involved in, or to withdraw from, a risk situation.

**Risk Criteria:** Terms of reference by which the significance of risk is assessed.
**Risk Evaluation:** Process of comparing the level of risk against risk criteria.

**Risk Exposure:** The level of risk that an organisation or process or project is exposed to.

**Risk Identification:** This is the process of determining what, where, when, why and how something could happen.

**Risk Management:** The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects.

**Risk Management Process:** The systematic application of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.

**Risk Reduction:** Actions taken to lessen the likelihood, negative consequences or both associated with risk.

**Risk Treatment:** Process of selection and implementation of measures to modify risk (avoiding, modifying, sharing and retaining).

**Service User:** A person who is using services provided by the Trust.

**Stakeholders:** Those people and organisations who may affect, be affected by, or perceive themselves to be affected by a decision, activity or risk.

**Target Risk:** Highest acceptable (tolerated) level of risk

**The Trust:** Camden and Islington NHS Foundation Trust.

**Trust Risk Register:** A list of risks to the organisation scoring at or above the threshold of 15, identified from any Trust operational risk register, by the Executive Directors, by sub-committees of the Board or by processes of assurance. Controls and assurances in relation to these risks are also set out in the Trust Risk Register.
Guidance for Rating Risks  

APPENDIX 2


**STEP ONE: Severity** - How severe are the consequences?

### Table 1: Severity / Impact Categories

<table>
<thead>
<tr>
<th>Consequence score (severity levels) and examples of descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Impact on the safety of patients, staff or public (physical/psychological harm)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Quality/complaints/audit</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Human resources/organisational development/staffing/competence</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Statutory duty/inspections</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
STEP 2: Likelihood – How likely is it that the risk event will occur / reoccur?

Likelihood may need to be assessed in a different manner depending on the nature of risk. For example, the likelihood that a particular incident will occur in a particular team is best suited to a likelihood measure that is based on ‘frequency’ (Table 2). If, however, we look at the risks associated with visiting a service user at home, it is sensible to focus on the ‘probability’ that the risk will be actualised given existing controls that are in place (Table 3). It is for this reason that the measure of likelihood has been split into two tables, either of which may be used as appropriate. The Trust has decided to follow examples of good practice by using the two scales as below.

Table 2: Likelihood / Frequency Scale

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>Not expected to occur for years.</td>
<td>Expected to occur at least annually.</td>
<td>Expected to occur at least monthly.</td>
<td>Expected to occur at least weekly</td>
<td>Expected to occur at least daily</td>
</tr>
</tbody>
</table>
Table 3: Likelihood / Probability Scale

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>This will probably never happen/recur</td>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
<td>Will probably happen/recur but it is not a persisting issue</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
</tbody>
</table>

STEP 3: The Risk Matrix (Likelihood x Consequence) - In order to calculate the risk score, the ‘likelihood’ is multiplied by the ‘severity/impact’ using the matrix in Table 4.

Table 4: The Risk Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Unlikely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Likely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Almost certain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

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

STEP 5: Risk Treatment – Decide on a course of action which is relative to the level of risk.

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Degree of Risk</th>
<th>Action required to reduce the risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1-3)</td>
<td>Low</td>
<td>A risk at this level may be acceptable. If not acceptable, existing controls should be monitored or adjusted. No further action or additional controls are required.</td>
</tr>
<tr>
<td>(4-6)</td>
<td>Moderate</td>
<td>Not normally acceptable. Efforts should be made to reduce the risk, provided this is not disproportionate. Establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.</td>
</tr>
<tr>
<td>(8-12)</td>
<td>Significant</td>
<td>Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be taken.</td>
</tr>
<tr>
<td>(15 - 25)</td>
<td>High</td>
<td>Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.</td>
</tr>
</tbody>
</table>
Datix Risk Register – User Guide

Adding a New Risk

1. Click on **Add a new risk**

2. Complete the following details on the Risk Details page:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref.</td>
<td>Datix automatically generates a unique ID for each new risk but if you have a reference number from a legacy system you want to retain you can record it here. If not leave this field blank.</td>
</tr>
<tr>
<td>Description</td>
<td>Describe your risk in concise, plain English, without the use of technical language, identifying the consequence if the risk is realised e.g. “if cause then consequence”</td>
</tr>
<tr>
<td>Short reference description</td>
<td>This is a short description of your risk using key words. It is important that this description is meaningful as this is the field that will appear in some tables and reports on the system.</td>
</tr>
<tr>
<td>Risk Lead</td>
<td>This is the person with direct responsibility and oversight of activities to manage the risk (Action Plan Manager). Usually Service Manager level or above.</td>
</tr>
<tr>
<td>Risk Owner</td>
<td>This is the Senior Manager who is accountable for ensuring the risk is</td>
</tr>
</tbody>
</table>
managed appropriately. The Risk Owner should appoint a suitable Risk Lead to co-ordinate the action plan to mitigate the risk. Usually Associate Director level or above.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Lead Director</td>
<td>This is the Director who is ultimately accountable for ensuring the risk is managed appropriately.</td>
</tr>
<tr>
<td>Opened</td>
<td>This is the date the Risk was first identified.</td>
</tr>
<tr>
<td>Last Review Date</td>
<td>This date indicates how up to date the details recorded against the risk are. Update this date every time you review the risk, even if you don’t make any changes or updates.</td>
</tr>
<tr>
<td>Division</td>
<td>If the risk is specific to a particular division it should be indicated here. If the risk is relevant to more than one division leave this field blank.</td>
</tr>
<tr>
<td>Team</td>
<td>If the risk is specific to a particular team it should be indicated here. If the risk is relevant to more than one team leave this field blank.</td>
</tr>
<tr>
<td>Risk Register</td>
<td>Indicate here which Risk Register the risk belongs to.</td>
</tr>
<tr>
<td>Risk Subtype</td>
<td>Choose the most appropriate category for the risk here.</td>
</tr>
<tr>
<td>Responsible Committee</td>
<td>Indicate which Board level committee will have oversight of this risk.</td>
</tr>
<tr>
<td>Responsible Sub Group(s)</td>
<td>Indicate all the groups with responsibility for monitoring this risk.</td>
</tr>
<tr>
<td>Current Risk Score</td>
<td>Current level of risk, taking into consideration existing controls and assurances and identified gaps in controls and assurances.</td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>Risk remaining after completion of the risk action plan to address the gaps in control and assurance.</td>
</tr>
<tr>
<td>Target Risk Score</td>
<td>Highest acceptable (tolerated) level of risk.</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>Risk appetite can be defined as the amount of risk the organisation is willing to pursue or retain in order to meet their strategic objectives.</td>
</tr>
<tr>
<td>Risk Register Notepad</td>
<td>Keep relevant notes here e.g. if the score has been changed make a note here of why the scores has gone up or down.</td>
</tr>
</tbody>
</table>

3. Select the appropriate approval status.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Risk, awaiting</td>
<td>Select this level of approval if the Risk Owner needs to review the risk before it is sent to the Risk Manager for approved.</td>
</tr>
</tbody>
</table>
4. Click **Save** – Save can be found at the bottom of each page or on the floating bar which always hovers on the bottom left of the screen.

5. Select the Assurances & Actions and fill in the following details on this page:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
</table>
| Controls and Assurances| *Controls*: these are the systems already in place to support delivery of objectives and to minimise the risk.  
*Assurances*: this is the evidence that the controls are effective. What evidence is there that objectives are being delivered? |
| Blockages to progress  | These are external blockers outside the control and/or parameters of the system that are preventing the risk from being reduced. |

6. Click **Save**.
Adding the Risk Action Plan

1. Click on **Create a new action**

![Image of Risk Action Plan form]

2. Complete the following details on the Risk Action Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap in control or assurance</td>
<td>These are the things that cause the risk to remain a threat, despite the existing controls and positive assurances in place.</td>
</tr>
<tr>
<td>Action plan to address gaps in control or assurance</td>
<td>What action needs to take place to close the identified gap in control or assurance?</td>
</tr>
<tr>
<td>Start Date</td>
<td>This is the date the action was started</td>
</tr>
<tr>
<td>Due Date</td>
<td>This is the deadline by which the action must be complete</td>
</tr>
<tr>
<td>Action Owner (Responsibility to)</td>
<td>The person with direct responsibility for ensuring the action is complete to the deadline specified. The Action Owner is accountable to the Risk Lead.</td>
</tr>
<tr>
<td>Action Status</td>
<td>The is tells you if your actions are within deadline, overdue or complete. An action can be superseded if it is no longer relevant to mitigating the risk.</td>
</tr>
</tbody>
</table>
3. Click on **Save**.

4. Repeat steps 1 – 3 above to add further actions to your action plan.

**Updating Risks and Risk Action Plans**

There are a number of ways to access risks and action plans in order to review and update them

**Access Risks and Action Plans from the Risk Register Home Page**

1. Click on any of the individual status levels to see which risks are held there

2. Click on the risk you wish to open.

3. Update the risk and action plan and save the details.

**Access Risks and Action Plans from My Reports**

1. Click on **My Reports** from the risk register home page.
2. Select a report.

3. From within the report click on the risk you wish to review to open it.

4. Update the risk and action plan and save the details.

**Access Action Plans from My Reports**

1. Click on the **Actions** module from the main menu

2. Click on **My Reports** from the Actions home page.

3. Select a report.
4. From within the report click on the action you wish to review to open it.

5. Update the action plan and save the details.

6. To access the Risk details from the Actions module click on *Links*. 
STANDING COMMITTEES OF THE BOARD AND THEIR SUB-COMMITTEES (tier 1 and tier 2 committees)

*The Exec Team Meeting is not a sub-committee of the Board but is shown here for information and completeness.
*** The People and Culture Committee is a new Board Committee which is in the process of being set up.
*** The Council of Governors and its sub-committees and working groups are not a sub-committee of the Board but is shown here for information and completeness.
## Trust Risk Register Fields

The fields in the Trust Risk Register are as follows:

<table>
<thead>
<tr>
<th>Field</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk ID</td>
<td>Unique identification number given to a risk.</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Description of the risk</td>
</tr>
<tr>
<td>Date opened</td>
<td>Dated risk added to the risk register.</td>
</tr>
<tr>
<td>Last Reviewed</td>
<td>Date the risk was last reviewed.</td>
</tr>
<tr>
<td>Responsible Committee</td>
<td>Committee with oversight and responsibility for the work area/function</td>
</tr>
<tr>
<td></td>
<td>affected by the risk</td>
</tr>
<tr>
<td>Responsible Sub-Group</td>
<td>Sub-group/s with oversight and responsibility of the work area/function</td>
</tr>
<tr>
<td></td>
<td>affected by the risk</td>
</tr>
<tr>
<td>Primary Risk Grouping</td>
<td>Categorises risks into a ‘risk type’ (e.g. financial, quality, operational)</td>
</tr>
<tr>
<td>Lead Director</td>
<td>Director who is ultimately accountable for ensuring the risk is managed</td>
</tr>
<tr>
<td></td>
<td>appropriately.</td>
</tr>
<tr>
<td>Risk Owner</td>
<td>Senior Manager who is accountable for ensuring the risk is managed</td>
</tr>
<tr>
<td></td>
<td>appropriately. The Risk Owner should appoint a suitable Risk Lead to</td>
</tr>
<tr>
<td></td>
<td>coordinate the action plan to mitigate the risk.</td>
</tr>
<tr>
<td>Risk Lead</td>
<td>Person with direct responsibility and oversight of activities to manage</td>
</tr>
<tr>
<td></td>
<td>the risk (Action Plan Manager).</td>
</tr>
<tr>
<td>Controls and Assurances in place</td>
<td>What controls/systems have we got in place to assist securing the delivery of our objective. Where can we gain evidence relating to the effectiveness of the controls/systems on which we are relying? Is there evidence (internal or external) that shows we are reasonably managing our risks and objectives are being delivered.</td>
</tr>
<tr>
<td>Current Likelihood</td>
<td>Likelihood that the risk will be actualised given existing controls.</td>
</tr>
<tr>
<td>Current Consequence</td>
<td>Impact if the risk was actualised given existing controls.</td>
</tr>
<tr>
<td>Current Risk Score</td>
<td>Current likelihood x current impact as per the risk assessment 5x5.</td>
</tr>
<tr>
<td></td>
<td>Represents the current level of risk, taking into consideration existing</td>
</tr>
<tr>
<td></td>
<td>controls and assurance and identified gaps in control and assurance</td>
</tr>
<tr>
<td>Direction of Risk Score (since previous quarter)</td>
<td>Has the risk scored increased, decreased or remained the same since the previous quarter?</td>
</tr>
<tr>
<td>Gaps in Control or Assurance</td>
<td>Where are we failing to put controls/systems in place (planned improvement)?</td>
</tr>
<tr>
<td>Action Plan to Address Gaps</td>
<td>Actions developed to address gaps in controls and/or assurances. A timeframe must be stated for every action.</td>
</tr>
<tr>
<td>Action Plan Update</td>
<td>Self-explanatory. Where items are overdue a reason and revised deadline</td>
</tr>
<tr>
<td></td>
<td>should be noted.</td>
</tr>
<tr>
<td>Blockages To Progress</td>
<td>Anything that may be hindering attempts to reach the desired objective.</td>
</tr>
<tr>
<td>Residual Likelihood</td>
<td>Likelihood that the risk will be actualised after action plan has been</td>
</tr>
<tr>
<td></td>
<td>implemented.</td>
</tr>
<tr>
<td>Residual Consequence</td>
<td>Impact if the risk was actualised after action plan has been</td>
</tr>
<tr>
<td></td>
<td>implemented.</td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>Residual likelihood x residual impact as per the risk assessment 5x5.</td>
</tr>
<tr>
<td></td>
<td>Represents the level to which the risk is expected to be reduced by the</td>
</tr>
<tr>
<td></td>
<td>action plan</td>
</tr>
<tr>
<td>Target Likelihood</td>
<td>Lowest acceptable (tolerated) likelihood that the risk will be actualised</td>
</tr>
<tr>
<td>Target Consequence</td>
<td>Lowest acceptable (tolerated) impact if the risk was actualised</td>
</tr>
<tr>
<td>Target Risk Score</td>
<td>Target likelihood x target impact as per the risk assessment 5x5.</td>
</tr>
<tr>
<td></td>
<td>Represents the highest acceptable (tolerated) level of risk</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>The amount and type of risk that the organisation is prepared to seek,</td>
</tr>
<tr>
<td></td>
<td>accept or tolerate.</td>
</tr>
</tbody>
</table>
**Risk Register Process Flowchart**

**OBJECTIVE**

**PRINCIPAL RISK**
Threat to the achievement of the objective

**KEY CONTROLS**
What is already in place that will mitigate this risk? e.g. a group/committee/post, a written policy, a formal process etc

**CURRENT RISK SCORE**
Assessed using the 5x5

**GAP IN CONTROL**

**RISK MANAGEMENT ACTION PLAN**
Identify control needed

**RESIDUAL RISK SCORE**
What effect will the control have?

**CURRENT RISK SCORE**

**ASSURANCES ON CONTROLS**

**GAP IN ASSURANCE**

**RISK MANAGEMENT ACTION PLAN**
Identify how assurance can be gained e.g. commission external review, conduct internal review, introduce management check.

**CURRENT RISK SCORE**

**RISK MANAGEMENT ACTION PLAN**
Cross reference to existing plan

**POSITIVE ASSURANCE**

**OBJECTIVE**

**PRINCIPAL RISK**
Threat to the achievement of the objective

**KEY CONTROLS**
What is already in place that will mitigate this risk? e.g. a group/committee/post, a written policy, a formal process etc

**CURRENT RISK SCORE**
Assessed using the 5x5

**GAP IN CONTROL**

**RISK MANAGEMENT ACTION PLAN**
Identify control needed

**RESIDUAL RISK SCORE**
What effect will the control have?

**CURRENT RISK SCORE**

**ASSURANCES ON CONTROLS**

**GAP IN ASSURANCE**

**RISK MANAGEMENT ACTION PLAN**
Identify how assurance can be gained e.g. commission external review, conduct internal review, introduce management check.

**CURRENT RISK SCORE**

**RISK MANAGEMENT ACTION PLAN**
Cross reference to existing plan

**POSITIVE ASSURANCE**
BUSINESS PLANNING AND RISK MANAGEMENT FRAMEWORK

Trust Strategy

5 Year Strategic Plan

Identification of Strategic Risks to Principal Objectives

Director's Objectives

Divisional Annual Plans

Team Annual Plans

Trust Risk Register

Quarterly monitoring and reporting

Risks identified through Divisional and Departmental Risk Registers

Risks identified by Directors against objectives

Risks identified by committees

Audit and Risk Committee (Reviews assurance on significant risks)
**Staff with Specialist Responsibilities for Risk Management**

The groups or individuals shown below carry out the operational work supporting risk management responsibilities. Responsibilities that sit with staff within Shared Services are managed through the relevant Service Level Agreement.

Key:

<table>
<thead>
<tr>
<th>Key</th>
<th>Lead Group</th>
<th>Key</th>
<th>Lead Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARC</td>
<td>Audit and Risk Committee</td>
<td>DSPB</td>
<td>Digital Strategy Programme Board</td>
</tr>
<tr>
<td>QSC</td>
<td>Quality &amp; Safety Committee</td>
<td>DTC</td>
<td>Drugs and Therapeutics Committee</td>
</tr>
<tr>
<td>PCPB</td>
<td>People and Culture Programme Board</td>
<td>SEG</td>
<td>Safer Environments Group</td>
</tr>
<tr>
<td>RC</td>
<td>Resource Committee</td>
<td>EPSR</td>
<td>Emergency Planning Strategic Review Group</td>
</tr>
<tr>
<td>ICC</td>
<td>Infection Control Committee</td>
<td>PHNG</td>
<td>Physical Health &amp; Nutrition Group</td>
</tr>
<tr>
<td>HSFC</td>
<td>Health &amp; Safety and Fire Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Area</th>
<th>Officer responsible for co-ordination and advice</th>
<th>Responsible for identification of risks</th>
<th>Responsible for Analysis</th>
<th>Responsible for Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Incident Reporting &amp; Analysis, Risk Registers.</td>
<td>Risk &amp; Patient Safety Manager/s</td>
<td>Individual Services Risk &amp; Patient Safety Manager/s</td>
<td>All teams / services Governance and Quality Assurance Department Business and Performance Managers</td>
<td>ARC / QSC</td>
</tr>
<tr>
<td>Board Assurance Framework (BAF)</td>
<td>Trust Company Secretary</td>
<td>Board Trust Company Secretary</td>
<td>Trust Executive</td>
<td>ARC</td>
</tr>
<tr>
<td>Clinical and Non-Clinical Claims</td>
<td>Complaints &amp; Legal Service Manger</td>
<td>Complaints &amp; Legal Service Manger</td>
<td>Complaints &amp; Legal Service Manger</td>
<td>QSC</td>
</tr>
<tr>
<td>Complaints</td>
<td>Complaints &amp; Legal Service Manger</td>
<td>Individual Services Incidents and Complaints Manager</td>
<td>All teams / services Governance and Quality Assurance Department</td>
<td>QSC</td>
</tr>
<tr>
<td>Serious Incident Investigations</td>
<td>Risk &amp; Patient Safety Manager/s</td>
<td>Individual Services Risk &amp; Patient Safety Manager/s</td>
<td>All teams / services Governance and Quality Assurance Department</td>
<td>QSC</td>
</tr>
<tr>
<td>Building, Land, Plant, Non-Medical Equipment</td>
<td>AD Estates and Facilities</td>
<td>All teams / services AD Estates and Facilities</td>
<td>AD Estates and Facilities</td>
<td>RC</td>
</tr>
<tr>
<td>Catering &amp; Food Hygiene</td>
<td>AD Estates and Facilities</td>
<td>All teams / services AD Estates and Facilities</td>
<td>AD Estates and Facilities</td>
<td>RC</td>
</tr>
<tr>
<td>Risk Area</td>
<td>Officer responsible for coordination and advice</td>
<td>Responsible for identification of risks</td>
<td>Responsible for Analysis</td>
<td>Responsible for Control</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>Head of Emergency Planning Response &amp; Resilience Chief Operating Officer</td>
<td>All services</td>
<td>Head of Emergency Planning Response &amp; Resilience Chief Operating Officer</td>
<td>EPSR</td>
</tr>
<tr>
<td>Environmental Management</td>
<td>AD Estates and Facilities</td>
<td>All teams / services AD Estates and Facilities</td>
<td>AD Estates and Facilities</td>
<td>RC/SEG</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Health and Safety Manager</td>
<td>All teams / services Health and Safety Manager AD Estates and Facilities</td>
<td>Health and Safety Manager AD Estates and Facilities</td>
<td>HSFC / RC</td>
</tr>
<tr>
<td>Health &amp; Safety Management</td>
<td>Health and Safety Manager</td>
<td>All services</td>
<td>Health and Safety Manager</td>
<td>HSFC</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Associate Director of HR/OD</td>
<td>Associate Director HR/OD</td>
<td>Associate Director HR/OD</td>
<td>PCPB</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Senior Nurse – Infection Prevention &amp; Control</td>
<td>Infection Control Team</td>
<td>Infection Control Team</td>
<td>CC</td>
</tr>
<tr>
<td>ICT</td>
<td>Associate Director ICT</td>
<td>Associate Director ICT</td>
<td>Associate Director IT</td>
<td>DSPB</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Head of Information Governance</td>
<td>Head of Information Governance</td>
<td>Head of Information Governance</td>
<td>DSPB</td>
</tr>
<tr>
<td>Learning &amp; Development</td>
<td>Associate Director of HR/OD</td>
<td>Associate Director HR/OD</td>
<td>Associate Director HR/OD</td>
<td>PCPB</td>
</tr>
<tr>
<td>Medical Devices</td>
<td>Medical Device Lead</td>
<td>Medical Device Lead Deputy Director of Nursing</td>
<td>Medical Device Lead Deputy Director of Nursing</td>
<td>SEG / PHNG</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Chief Pharmacist</td>
<td>Chief Pharmacist</td>
<td>DTC</td>
<td>QSC</td>
</tr>
<tr>
<td>Fleet &amp; Transport Management</td>
<td>AD Estates and Facilities</td>
<td>All teams / services AD Estates and Facilities</td>
<td>AD Estates and Facilities</td>
<td>QSC</td>
</tr>
<tr>
<td>Audit and Local Counter Fraud Service.</td>
<td>Deputy Director of Finance Local Counter Fraud Specialist</td>
<td>Deputy Director of Finance Local Counter Fraud Specialist</td>
<td>Deputy Director of Finance</td>
<td>ARC</td>
</tr>
<tr>
<td>Waste Management</td>
<td>AD Estates and Facilities</td>
<td>All teams / services AD Estates and Facilities</td>
<td>AD Estates and Facilities</td>
<td>HSFC / SEG</td>
</tr>
</tbody>
</table>
Risk Guidance for Committees / Sub-Committees

Risk Guidance for Committees and Sub-Committees

This guidance refers to Board committees and their sub-committees/working groups as outlined in Appendix 4.

COMMITTEES

- Audit and Risk Committee
- Quality & Safety Committee
- Resource Committee
- Strategic Development Committee
- People & Culture Committee
- Board Remuneration & Nominations Committee
- Emergency Preparedness Strategic Review Group
- Trust Charity Advisory Group
- Exec Team Meeting (this is not a sub-committee of the Board but is shown here for completeness)

SUB-COMMITTEES

Each of the committees has a number of sub-committees/working groups reporting into them. These are depicted on the Board Council Committee Structure (Oct 2020) See Appendix 4.

A. RESPONSIBILITIES OF COMMITTEES AND SUB-COMMITTEES:

Process for Risk Management within Committees and Sub-committees

Committee meeting agenda should routinely cover the following three items relating to risk;
- Current Committee Risks Scored 12+
- Consideration of Risks Referred by Sub-committees
- New Risks Identified at the Meeting

Sub-committee agenda should routinely cover the following two items relating to risk;
- Current Sub-committee Risks Scored 12+
- New Risks Identified at the Meeting

Reviewing Current Risks

All Trust committees are accountable for overseeing the management of risks which fall within their remit, and these risks should be monitored routinely. Committees may choose to review all their risks, but it is recommended that as a minimum, risk scored 12+ are reviewed at every meeting. Where responsibility for a risk has been devolved to a sub-committee, both the committee and sub-committee should apply this process.
The Committee Secretary is responsible for obtaining an up to date extract of committee risks from the centrally database, prior to each meeting, which should be submitted as part of the Committee Papers.

The committee or sub-committee should review the risks to provide assurance on the progress of mitigating actions.

**Guidance on reviewing current risks** – Regular review of current risks should inform agenda planning for the committees and sub-committees. Risks need only be noted by the committee or sub-committee and discussed by exception. If a risk is covered by a separate item on the agenda there is no need to spend additional time discussing it under the risk section.

The focus of the committee or sub-committee should be on gaining assurance that the action plan to mitigate the risk is sufficient to reduce the risks, and is progressing to target.

Risks are reviewed in depth and updated during the quarterly risk monitoring rounds, so there is no need for committees or sub-committees to spend time discussing the details of every risk at every meeting. It is the responsibility of the risk owners to ensure the risks details are kept up to date.

**Risks Referred by Sub-committees**

Risks identified by sub-committees are referred on to the appropriate ‘parent committee’ by way of their minutes. Risks that require consideration for inclusion on the Trust Risk Register are escalated upwards via the committee structure and reviewed by the Executive Risk Scrutiny Group during the quarterly risk scrutiny exercise.

The Committee Secretary, when putting together the papers for the meeting, should highlight all new risks scored 12+ identified by sub-committees through their minutes.

The committee should consider the risk, including whether the sub-committee has scored the risk appropriately.

Following the meeting the Committee Secretary should refer all risks agreed to be scored 12+ to the Executive Risk Scrutiny Group (via the Risk & Patient Safety Manager). If a risk is not agreed for escalation the Chair of the originating committee should be informed by the Committee Secretary. The originating committee will be charged with managing this risk.

**Guidance on risks referred by sub-committees** – Committees and sub-committees should be aware that identifying an issue as a risk and scoring it at 12 or above does not escalate it outside the responsibility of the group. Escalating a risk through the committee structure is simply a way of flagging high level risks, so they can be monitored at the appropriate level to ensure senior level scrutiny of mitigating actions. However, the committee or sub-committee remains accountable for the oversight and management of this risk.
**New Risks Identified at the Meeting**

Each committee and sub-committee has responsibility for identifying new risks from the material submitted directly to the meeting. Risks should be identified from the direct business of the committee, rather than from indirect sources.

To support committees and sub-committees in keeping track of new risks the following table should be included as standard in minute template. Actions identified in the last column can be picked up and monitored via the matters arising schedule.

<table>
<thead>
<tr>
<th>New Risks Identified</th>
<th>Likelihood score</th>
<th>Consequence score</th>
<th>Risk Score</th>
<th>Responsible Director &amp; Risk Lead</th>
<th>Action to be taken by the Committee/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description</strong></td>
<td><strong>Use the risk matrix to determine the likelihood of the risk being realised.</strong></td>
<td><strong>Use the risk matrix to determine the consequence of the risk being realised.</strong></td>
<td><strong>Use the risk matrix to determine the risk score.</strong> (LxC =RS)</td>
<td><strong>Identify the individuals with overall responsibility for the management of this risk.</strong></td>
<td><strong>What action will the Committee/group take to ensure this risk is being managed? This may be to refer the risk onto another group or individual for action.</strong></td>
</tr>
<tr>
<td>Describe the risk here</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risks should be scored in the meeting and recorded in the minutes. Risks identified by sub-committees are referred on to the appropriate ‘parent committee’ by way of their minutes. The Committee Secretary refers risks scored 12 and above to the Executive Risk Scrutiny Group (via the Risk & Patient Safety Manager).

To facilitate committees and sub-committees scoring risks at the meeting it is recommended that the following risk scoring matrix be included as standard on the agenda template under the item called “New Risks Identified at the Meeting”

<table>
<thead>
<tr>
<th>The Risk Matrix</th>
<th>Likelihood score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequence score</td>
<td>1 Rare</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
</tr>
<tr>
<td>4 Major</td>
<td>4</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
</tr>
</tbody>
</table>

**Guidance on identifying new risks** – Committee Chairs must allow time for scoring risks at the meeting but if this is not possible the Committee Secretary should follow up and confirm the risk score, as a priority following the meeting. This should not be left until the Chair approves the draft minutes of the meeting as this can often be a number of weeks after the meeting.

Risks identified at meetings are issues which have been revealed from the material submitted to the meeting. Irrespective of the risk score allocated to them, risks should
be managed in the same way by the committee or sub-committee as any other issue highlighted; for example; by making recommendations or assigning an action to them, and monitoring this through the minutes and matters arising schedule. There is no requirement for committees and sub-committees to maintain a separate log of risks.

B. RESPONSIBILITY OF THE EXECUTIVE RISK SCRUTINY GROUP

The Executive Risk Scrutiny Group undertakes a risk scrutiny exercise on a quarterly basis. As part of this exercise, the Group will:

▪ Receive all risks from Committees (and their Sub-Committees) with a score of 12 and above.
▪ Consider and may wish to re-score risks that have been referred to it.
▪ Decide which risks are appropriate for recording on the risk register.

Any risk that has been approved for inclusion in the risk register will be allocated to an Executive Director. The Executive Director will be responsible for co-ordinating action on the particular risk.
## Risk Appetite for NHS Organisations

A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

### Risk levels

<table>
<thead>
<tr>
<th>Appetite</th>
<th>NONE</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>SIGNIFICANT</th>
</tr>
</thead>
</table>

### Key elements

**Financial/VFM**
- Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern.

- Only prepared to accept the possibility of very limited financial loss if essential. VFM is the primary concern.

- Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints.

- Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM).

- Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return - Investment capital type approach.

- Consistently focused on the best possible return for stakeholders. Resources allocated in 'special capital' with confidence that process is a return in itself.

**Compliance/regulatory**
- Play safe, avoid anything which could be challenged, even unsuccessfully.

- Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance.

- Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.

- Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.

- Changes of losing any challenge are real and consequences would be significant. A win would be a great coup.

- Consistently pushing back on regulatory burden. Front foot approach informs better regulation.

**Innovation/Quality/Outcomes**
- Defensive approach to objectives - aim to maintain or protect, rather than to create or innovate. Prioritize for light management controls and oversight with limited evolved decision taking authority.

- General avoidance of systems/technology developments.

- Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology developments to protect current operations.

- Tendency to stick to the status quo. Innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to improvements to protect current operations.

- Innovation supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.

- Innovation pursued – desire to ‘break the mould’ and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than light control.

- Innovation the priority – consistently ‘breaking the mould’ and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than light control is standard practice.

**Reputation**
- No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.

- Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.

- Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.

- Appetite to take decisions that are likely to bring scrutiny of the organisation and additional scrutiny/interest. Prospective management of organisation’s reputation.

- Willingness to take decisions that are likely to bring scrutiny of the organisation and additional scrutiny of interest. Prospective management of organisation’s reputation.

- Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
Monitoring of the Strategy

The effectiveness of this strategy will be monitored as set out in the table below:

<table>
<thead>
<tr>
<th>Element to be monitored (NHSLA minimum requirements)</th>
<th>Lead</th>
<th>How Trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendation and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational risk management structure detailing all those committees / sub-committees/groups which have some responsibility for risk.</td>
<td>Risk &amp; Patient Safety Manager and Trust Company secretary</td>
<td>Review of performance of risk management structure to be contained within Trust’s Risk Management Annual Report.</td>
<td>Annually</td>
<td>Audit and Risk Committee / Board</td>
<td>Required actions will be identified at the Audit and Risk Committee and completed in a specified timeframe.</td>
<td>Required changes to practice will be identified at the Audit and Risk Committee and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
<tr>
<td>Process for Board or high-level committee review of the organisation-wide risk register</td>
<td>Risk &amp; Patient Safety Manager</td>
<td>TRR will be reviewed quarterly at the Executive Risk Scrutiny Group and quarterly by the Audit and Risk Committee. The Audit and Risk Committee will view and monitor all risks rated 15 and over on a quarterly basis and all risks on an annual basis.</td>
<td>Quarterly</td>
<td>Audit and Risk Committee / Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process for the management of risk locally, which reflects the organisation-wide risk management strategy</td>
<td>Chief Operating Officer</td>
<td>Operational risk registers will be monitored regularly at Divisional Management Groups /Monthly Performance Meetings. Operational risk registers will be reviewed quarterly at the SLT Risk Scrutiny Group and annually by the Audit and Risk Committee. The Executive Risk Scrutiny Group will view and monitor all risks rated 15 and over from the operational risk registers on a quarterly basis.</td>
<td>Quarterly / Annually</td>
<td>Audit and Risk Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duties of the key individual(s) for risk management activities</td>
<td>Risk &amp; Patient Safety Manager</td>
<td>Review of performance of key individuals against assigned risk management duties to be contained within Trust’s Risk Management Annual Report.</td>
<td>Annually</td>
<td>Audit and Risk Committee / Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process for assessing all types of risk</td>
<td>Trust Company Secretary</td>
<td>The BAF risks will be identified and agreed at the Annual Board Risk Seminar. The Trust Board will view and monitor the BAF on a quarterly basis</td>
<td>Annually</td>
<td>Audit and Risk Committee / Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk &amp; Patient Safety Manager</td>
<td>The risks on the Trust Risk Register, risks to director’s objectives, risks identified and referred by committees and fast tracked risks) will be monitored and reviewed quarterly by lead directors. The TRR will then be monitored quarterly at the Executive Risk Scrutiny Group and at the Audit and Risk Committee. The Audit and Risk Committee will view and monitor all risks rated 15 and over on a quarterly basis and all risks on an annual basis.</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process for ensuring a consistent approach to risk assessment</td>
<td>Internal Auditors / Risk &amp; Patient Safety Manager</td>
<td>The internal auditors will consider the risk management process on an annual basis and will review the process periodically as part of their audit programme. The Risk Management Annual report will also review the risk management process.</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authority levels for managing different levels of risk within the organisation</td>
<td>Risk &amp; Patient Safety Manager</td>
<td>Review of performance of key individuals against assigned risk management duties to be contained within Trust’s Risk Management Annual Report.</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How risks are escalated through the organisation</td>
<td>Risk &amp; Patient Safety Manager</td>
<td>The risks on the TRR are identified via: • Operational risks registers (all risks scored 15+) • Risks to Director’s objectives • Risks identified and referred by committees Risks will be monitored and reviewed quarterly by lead directors. The TRR will then be monitored quarterly at the Executive Risk Scrutiny Group and at the Audit and Risk Committee. The Audit and Risk Committee will view and monitor all risks rated 15 and over on a quarterly basis and all risks annually.</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Equality Impact Assessment Tool

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>2. Is there any evidence that some groups are affected differently?</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>4. Is the impact of the policy/guidance likely to be negative?</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>5. If so can the impact be avoided?</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>6. What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>7. Can we reduce the impact by taking different action?</strong></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>