

BOARD OF DIRECTORS MEETING (Open)
Date: 13 March 2019
Item Ref:

4

TITLE OF PAPER	Risk Management Strategy Refresh
TO BE PRESENTED BY	Margaret Saunders, Director of Corporate Governance (Board Secretary)
ACTION REQUIRED	For ratification

OUTCOME	An agreed revised Risk Management Strategy.
TIMETABLE FOR DECISION	13 March 2019
BAF OBJECTIVE No AND TITLE	A401ii Effectiveness of Trust Governance Systems
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports on Risk Management Corporate Risk Register Board Assurance Framework Directorate Risk Registers
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES ETC	Board Assurance Framework (BAF) links to strategic aims and objectives, corporate (organisational) risk register, directorate risk registers. Plus the regulatory requirements of NHS Improvement.
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	The Trust is required to have an identified risk management strategy as part of its internal control system.
CONSIDERATION OF LEGAL ISSUES	Compliance with Governance requirements of NHS Improvement including Trust Provider Licence.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	February 2019

SUMMARY REPORT

Report to: Board of Directors

Date: 13th March 2019

Subject: Revised Risk Management Strategy

From: Margaret Saunders, Director of Corporate Governance (Board Secretary)

Prepared by: Sam Stoddart, Deputy Board Secretary

1. Purpose

For approval	For a collective decision	To report progress	To seek input from	For information	Other (please state below)
x					

To seek ratification from the Board of the revised risk management strategy.

2. Summary

In 2017 the Trust undertook a comprehensive review of its Risk Management Strategy (RMS) and chose to apply Oxford University Hospitals NHS Foundation Trust's strategy and tailor it to reflect its own requirements.

This revised strategy was approved by the Audit Committee in October 2017 with the requirement for the strategy to be revised in a year's time.

Since its implementation, the Trust received a limited opinion on its operational risk management (January 2018) specifically in relation to the use and oversight of risk registers, and a significant amount of work has taken place to address the actions identified in the audit report. This has included a whole scale review of the Trust's electronic risk management system known as Ulysses and the move from paper based risk registers to electronic ones. A large scale training programme has been in place to ensure that all key staff from team to senior manager level are trained in the use of Ulysses and are aware of the requirements of the Trust's RMS in terms of oversight of risk registers and risk escalation.

This work has driven a number of changes to the risk management strategy so that it reflects the practical application of risk management and use of the Ulysses risk management system.

Some of the key changes that have taken place are:

- Title change - the document is not only a strategy, but provides procedural and process information. Therefore its title has been amended to reflect this.

- Scope of risk - health and safety, training and clinical risk assessment need to be reinstated into the document from the Trust's previous strategy to ensure it encompasses all elements of risk.
- Escalation of risks – there is an addition regarding escalating risks from the Corporate Risk Register to the Board Assurance Framework and the same for programme risks.

However, for the ease of the Board, the attached strategy identifies amended and new information by highlighting in green and blue respectively and appendix 1 provides details of each amendment.

Revision of this strategy has taken place in consultation with the Head of Clinical Governance, Health & Safety Risk Advisor, Fire and Local Security Management Specialist and Associate Director of Patient Safety and Clinical Training leads.

The revised strategy was presented to the Audit Committee on 22 January 2019 following which further amendments were made to incorporate the Committee's comments. The Committee has approved the strategy and recommends it to Board for ratification.

In addition, the Board considered its level of risk appetite for 2019/20 at a Development Session held on 27 February 2019. It was agreed to consider revising the risk level descriptions and to finalise the risk appetite in March. These amendments will be incorporated into the strategy to be virtually approved by Audit Committee and for final presentation and ratification by the Board in April 2019.

3. Next Steps

Following ratification by the Board, the strategy will be uploaded to the Trust's intranet and circulated widely. The RMS handbook will also be revised to reflect changes made to the strategy.

4. Required Actions

The Board is asked to:

- Note the amendments to and strengthening of the risk management strategy;
- Note Audit Committee's approval of the strategy
- Ratify the strategy upon the recommendation of the Audit Committee.

5. Monitoring Arrangements

The strategy will be subject to review in 3 years' time. It will be the responsibility of the Audit Committee to be assured of the successful implementation of the strategy.

6. Contact Details

For further information, please contact:

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Amendments to Risk Management Strategy

Page	Paragraph	Amendment or Addition	Details
1	Title	Addition	Policy and Process added to title
1	Category	Addition	Policy & Procedure added
1	Summary	Amendment	Summary details amended to provide clearer information
1	Related Documents	Amendment & addition	Data policy title amended Health and safety policy added
2	Table of contents	Addition	New sections or expanded titles
3	1	Amendment	Reworded
3	4 and 5	Addition	Additional information detailing effective risk management and the Trust's view of it.
4	Policy Statement	Addition	New section
4	7	Addition	New paragraph
4	8	Addition	New paragraph
4	9-14	Amendment	Originally paragraphs in Risk Statement section. This has been changed to Policy statement.
4	Purpose and Aim	Addition	Title expanded
5	17 bullet point 4	Addition	Volunteers added
6	19 Trust's risk appetite	Addition	Previous version had an example of a risk appetite. This has been replaced by the Trust's risk appetite
6	19 Risk appetite description	Amendment	Definitions have been amended by the Board to identify improved outcomes and revised risk levels
8	29h	Amendment	Titles revised following clinical directorate restructure
8	30	Addition	Added to strengthen link with health and safety
9	31-35	Addition	Added to strengthen information relating to clinical risk
13	56	Amendment	Policy title amended
13	57	Addition	Care networks added to reflect new structure titles
14	61	Amendment	Terminology aligned
15	64	Addition	New structure title added
15	Department/ Team risk register	Amendment	Amended/expanded information
15	Directorate risk register	Addition	New structure title added and additional information
15	Corporate risk register	Addition	paragraph 1: new structure title added and frequency interval paragraph 2: amendments and new information added regarding the escalation of corporate risks

Page	Paragraph	Amendment or Addition	Details
			to the Board Assurance Framework paragraph 3: amendment to reporting timeframe
16	Risk Review 65	Addition	Review frequencies (which have changed)
17	68l.	Addition	Strengthens information within this section regarding need to have a process to identify programme risks which need to be escalated to the Corporate Risk Register or BAF.
19	73c	Amendment	Committee name amended
19	77a	Addition	Additional information to strengthen statement
19	77b	Addition	Additional information to strengthen details relating to process for risk escalation both onto the Corporate Risk Register and BAF.
20	72c	Addition	New risk table providing summary of types of risk, where they sit, their owner, how they are identified and their coverage. Information taken from HFMA good governance document.
21	83-85	Amendment	Updated to better reflect all training requirements including clinical risk.
22	88 final bullet point	Addition	Reference to new document
23	Statutory	Addition	additional information added
25	Annual Governance Statement	Addition	new information
25	Assurance	Amendment	description amended
25	Board Assurance Framework	Addition	new information
25	Clinical Risk	Addition	new information
25	Control(s)	Amendment	description amended
25	Corporate Risk Register	Addition	new information
25	Financial Business Risk	Addition	new information
25	Financial Impact	Addition	new information
25	Health & Safety	Addition	new information
26	Operational risks	Addition	new information
26	Organisation-al risks	Addition	new information
26	Principal risk	Addition	new information
29	Director/ Clinical Director etc	Amendment	new titles to reflect restructuring
32	Risk matrix	Amendment	terminology aligned
38	Environ-	Amendment	Descriptors amended to reflect align with the Fire

Page	Paragraph	Amendment or Addition	Details
	mental		Risk Assessment Risk Value Matrix provided from DoH Firecode
39	Board of Directors	Addition	New information clarifying the role and responsibilities of non-executive directors
39	FIPC	Amendment	Committee name amended



Sheffield Health
and Social Care
NHS Foundation Trust

Risk Management Strategy, Policy & Procedure

Category:	Strategy, Policy & Procedure
Summary:	<p>The overarching purpose of the risk management strategy is to describe the framework and processes within Sheffield Health & Social Care NHS Foundation Trust to:</p> <ul style="list-style-type: none">• Identify, manage, eliminate or reduce to an acceptable level, risks that threaten the delivery of high quality care and services.• Maintain a safe environment for individuals who are legitimately accessing Trust services.• Minimise financial loss to the organisation, and to• Demonstrate to the public, regulators, staff and commissioners that the Trust is a safe and efficient organisation
Valid From:	1 April 2019
Date of Next Review:	2022/23
Approval Date/ Via:	Audit Committee (22/01/19) Executive Directors Group (28/02/19) Trust Board (13/03/19) Trust Management Group
Distribution:	Trust-wide
Related Documents:	IMT 006 Data & Information Quality Management Health & Safety Policy
Executive Lead:	Chief Executive
Strategy Lead:	Director of Corporate Governance (Board Secretary)
Author(s):	Sam Stoddart, Deputy Board Secretary
Document Ref:	SHSC Risk Management Strategy 2018 version 1.0 With thanks to Oxford University Hospitals NHS Foundation Trust on whose Risk Management Strategy (2015) this document is based.
This document replaces:	Risk Management Strategy 2017 version 1.0

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Introduction

1. Sheffield Health and Social Care NHS Foundation Trust (the Trust) is committed to putting the safety of service users, carers, staff and the public at the heart of its business and as such is committed to ensuring effective risk management is a fundamental part of its management approach and underpins all activities. The Trust's approach to risk management is one of proactively identifying, mitigating, monitoring and reviewing risk.
2. Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.
3. This Board approved strategy for managing risk identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation based upon the Board's identified risk appetite (see paragraphs 18-24).
4. Effective risk management should protect and add value to the organisation and its stakeholders, and in turn robustly support the organisation's objectives by:
 - Providing a framework that enables future activity to take place in a consistent and controlled manner;
 - Improving decision making, planning and prioritisation by comprehensive and structured understanding of business activity, volatility and project opportunity/threat;
 - Contributing to the efficient use/allocation of capital and resources within the organisation;
 - Protecting individuals who come into contact with the organisation;
 - Protecting and enhancing assets and organisational reputation;
 - Developing and support people and the organisation's knowledge base;
 - Optimising operational efficiency.
5. The Trust recognises that health and social care is, by its very nature, a high risk activity. A positive risk management culture supports staff to make sound judgements and informed decisions concerning the management of risk and risk taking. In these circumstances, where staff have undertaken and document a risk assessment, identified appropriate action, monitored the implementation of such action and complied with Trust policies and procedures, they can be assured of the Trust's commitment and support for their actions.
6. Successful risk management involves:
 - Identifying and assessing risks;
 - Taking action to anticipate or manage risks;
 - Monitoring risks and reviewing progress in order to establish whether further action is necessary or not; and
 - Ensuring effective contingency plans are in place.

Policy Statement

7. The Trust Board is committed to delivering services to a high standard, and that any risks are minimised through organisation-wide robust risk management processes. The Trust's strategic objectives and associated strategies, policies and plans demonstrate a commitment to raise standards and continuously improve the quality of services through making risk management part of normal daily work practice.
8. In setting out processes which seek to effectively identify, analyse and control risk, this strategy is consistent with requirements of the International Organisation for Standardisation (ISO) 31000:2018 Risk Management – Guidelines. In addition, this strategy will support the Trust to demonstrate compliance with regulatory requirements.
9. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.
10. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.
11. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.
12. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.
13. **Senior management** will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.
14. **Line managers** will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

Purpose and Aim

15. The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:
 - that the Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected; and
 - the implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Trust Board.

Scope

16. The objective of the Risk Management Strategy is to promote an integrated and consistent approach across all parts of the organisation to managing risk.
17. At the Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:
 - All salaried employees;
 - Contractors, sub-contractors and External Consultants;
 - Agency staff, those seconded to the Trust from other organisations, those covered by a letter of authority / honorary contract, apprentices, trainees, **volunteers** and those on work experience; and
 - Board, Committee, sub-committee, Council of Governors and advisory group members (who may not be directly employed or engaged by the Trust).

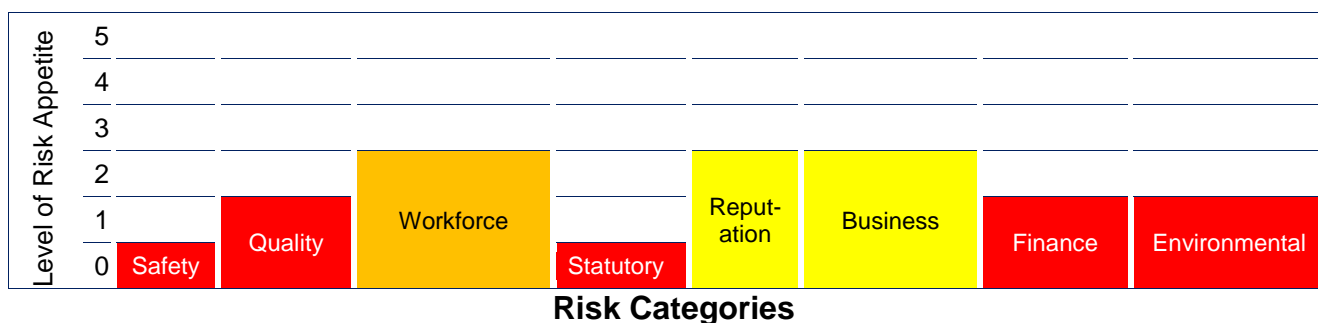
The strategy applies to all Trust staff, as referred to above. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

Risk Appetite

18. The risk appetite is the amount of the risk that the Trust is willing to seek or accept in the pursuit of its long term objectives. In practice, an organisation's risk appetite should address several dimensions:
 - a. The nature of the risks to be assumed;
 - b. The amount of risk to be taken on; and
 - c. The desired balance of risk versus reward.
19. On an annual basis the Trust will determine its risk appetite statement covering the overarching areas of:
 - d. Safety;
 - e. Quality;
 - f. Workforce
 - g. Statutory
 - h. Reputational;
 - i. Business;
 - j. Financial; and
 - k. Environmental risk.

These categories of risk are more fully explained in Appendix 1.

Trust's Risk Appetite



Risk Appetite	Description	Accepted Risk Target
0 = None	Avoid: the <i>avoidance</i> of risk and uncertainty is a key organisational objective.	None
1 = Low	Minimal: the preference for ultra-safe delivery options that have a <i>low</i> degree of inherent risk and only for limited potential for improved outcomes .	Low
2 = Moderate	Cautious: the preference for safe delivery options with a limited degree of inherent risk and may only have limited potential for improved outcomes .	Moderate
3 = High	Open: willing to consider all potential delivery options and choice while also providing an increased level of reward (and VfM) and improved outcomes .	High
4 = Significant	Seek: Eager to be innovative and to choose options offering potentially <i>higher</i> business rewards and improved outcomes. Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	Significant

20. The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.
21. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.
22. The Trust will review its appetite for, and attitude to, risk on an annual basis, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The review will consider:
 - l. Risk leadership;
 - m. People;
 - n. Risk policy and strategy;
 - o. Partnerships;
 - p. Risk management process;
 - q. Risk handling; and

r. Outcomes.

23. Risk tolerance can be measured as an acceptable/unacceptable range of variation relative to the achievement of a specific objective or to the aggregated risk appetite. Risk tolerance provides constraints around the level of risk, which may have upper boundaries (e.g., tolerate no more than) and lower boundaries (e.g., tolerate at a minimum or not tolerate a return less than x based on the risk assumed). It may be measured using the same units as the related objective. These risk tolerances may be accompanied by a risk target.

Risk appetite and tolerance both need to be considered in the context of risk capacity. This is the amount of risk the Trust can actually bear. The Trust's Board may have a high risk appetite but not have enough capacity to handle a risk's potential volatility or impact. Conversely, the risk capacity may be high but the Trust may decide based on strategy and objectives to adopt a lower risk appetite. An example of how this can be illustrated is shown below.

Risk Capacity	The maximum amount of risk the Trust is able to support within its available resources
Risk Appetite	How much and what type of risk the Trust is generally prepared to accept to achieve its strategic objectives.
Risk Tolerance	The maximum amount or type of risk the Trust is prepared to tolerate above risk appetite.

Appetite and tolerances for each management level of the risk management framework are defined for staff in the Risk Management Handbook.

24. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

Definitions of Risk and Risk Management

25. **A risk** is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.
26. **Risk Management** is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 2 for further definitions that relate to this strategy.

Principles of successful Risk Management

27. It is the role of the **Trust Board** to lead and support risk management across the

organisation. The principles of successful risk management are:

- a. to embrace an open, objective and supportive culture;
- b. to acknowledge that there are risks in all areas of work;
- c. for all staff to be actively involved in recognising and reducing risk;
- d. to communicate risks across the Trust through escalation and de-escalation processes; and
- e. to learn from mistakes.

Responsibilities and accountabilities for risk management

28. Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

29. Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks. To support the governance and escalation process. Appendix 3 sets out the specific risk management responsibilities of the following staff / staff groups:

- a. Chief Executive;
- b. Executive Director of Finance;
- c. Executive Medical Director;
- d. Executive Director of Nursing, Professions and Care Standards;
- e. Executive Directors and Associate Directors;
- f. Director of Corporate Governance (Board Secretary);
- g. Head of Clinical Governance;
- h. Director/Clinical Director of Operations & Transformation, Associate Directors, Associate Clinical Directors and Deputy Directors
- i. Senior Managers and Senior Staff;
- j. All staff; and
- k. Staff side representatives.

30. **All managers** are expected to make risk management a fundamental part of their approach to clinical and corporate governance and have the authority and responsibility for health and safety and the effective management of risks including the reporting and management of incidents and serious occurrences within their teams, services or departments. They have the authority to assess and manage risks and directly manage risks graded very low to moderate reporting to their directors on completion. Their specific duties include:

- maintaining an up-to-date and live service level risk register so that they can demonstrate they have considered risks both reactively and proactively and that they have effective plans in place to control these risks
- making sure all incidents occurring in their area or affecting service users in their care are reported and investigated appropriately, following the Trust's Incident Management Policy;
- making sure that lessons learnt from when things go wrong (whether through incidents, complaints or national reports) are disseminated and implemented within their teams, services or departments as appropriate
- making sure health and safety assessments are carried out and any problems found are put right quickly

- making sure all staff in their teams, services or departments are aware of and work to all Trust policies and procedures
- making sure all staff are aware of any risks with their work and what plans they need to follow to control these risks as much as possible (e.g. personal safety plans, managing violence and aggression guidance)
- making sure all staff in their teams, services or departments have annual personal development reviews which include consideration of risk and safety aspects of their roles
- making sure all new staff receive Trust and local induction – local induction to include risk and safety issues as described in the Trust Induction policy
- identifying any staff training and development needs with regard to risk and safety, including all statutory or mandatory training needs (e.g. First Aid, clinical risk assessment and management) and make sure staff are enabled to undertake the necessary training and development
- making sure all staff are fit and well and able to carry out their duties safely (in line with the Trust's Promoting Attendance and Managing Sickness Absence Policy)
- making sure all equipment and devices provided for the team or department's work is safe and fit for purpose (Medical Devices Policy)
- making sure the environment is safe for staff, service users, carers and members of the public (Health and Safety checklist, PLACE assessment and reporting of RIDDOR incidents)

Risk Assessment and Management Tools

31. The Trust has developed a number of tools to support staff in the identification, assessment, actions and monitoring arrangements. These tools are to be used for clinical and non-clinical risk management.
32. NHS England's Risk Management Policy and Process Guide, 2015 sets out an overarching strategic direction to manage risk. More specifically, the Department of Health published Best Practice in Managing Risk, guidance on risk assessment and management in mental health in 2007. This document sets a framework of principles to underpin best practice in mental health settings, and provides a list of tools for risk assessment and management. The philosophy underpinning this framework is one that balances care needs against risk needs and emphasises:
 - positive risk management
 - collaboration with the service user and others involved in their care
 - the importance of recognising and building on service users' strengths
 - the organisation's role in risk management alongside the individual practitioner
33. It stresses the importance of linking risk management with the Care Programme Approach and the Mental Health Act. Positive risk assessment, as part of a carefully constructed plan, is a required competency for all mental health practitioners.
34. The clinical/service user risk assessment and management document that is approved for use within the Trust is the Detailed Risk Assessment and Management plan (DRAM). Other risk screening/assessment tools may be used as required to meet specific needs, e.g. falls risk, suicide risk, MUST (Malnutrition Universal Screening Tool, MRSA screening, etc.
35. The DRAM is available through Insight, the Trust's service user administration system.

Risk Management Process

36. The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.
37. Risks are events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. Risk management also includes issues that 'have' happened and were not planned, but require management action.
38. Risks are clarified and managed in the following key stages:
 - a. Clarifying objectives;
 - b. Identifying risks that relate to objectives;
 - c. Defining and recording risks;
 - d. Completion of the risk register;
 - e. Identifying mitigating actions;
 - f. Recording the Likelihood and Consequence of risks; and
 - g. Escalation, de-escalation and archiving of risks as appropriate.

Stage 1: Clarifying objectives

39. Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.
40. In order to clarify:
 - a. Strategic (Corporate) Objectives - determine which Trust Strategic Objective(s) is relevant to the Directorate, Division or Service area.
 - b. Local Objectives – determine objectives that are only relevant to the Directorate, Division or Service area.

Stage 2: Identifying risks to objectives

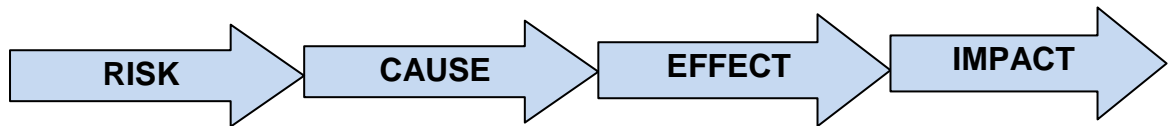
41. Once the objectives are clarified, risks are more easily identified.
42. Where appropriate, working collaboratively with colleagues, with consideration of the following suggested questions. This enables stakeholders to more accurately identify risk:
 - a. What are the risks which may prevent the delivery of your objectives?
 - b. What risks have an impact on the delivery of high quality, safe care?
 - c. What could happen or what could go wrong?
 - d. How and why could this happen?
 - e. What must we do to enable continued success in achieving objectives?
 - f. Who else might provide a different perspective on your risks?
 - g. Is it an operational risk or a risk to a strategic objective?

Stage 3: Describing Risk and Assigning Controls

43. Risks are described in a clear, concise and consistent manner to ensure common

understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

44. When wording the risk, it is helpful to think about it in four parts. For example:
“There is a risk that..... This is caused by and would result in.... leading to an impact upon”
45. The Trust’s standard for recording risks is to define risks in relation to:



- a. A **Risk** is described as something uncertain that may happen and could prevent us from meeting our objectives.
 - b. The **Cause** is the problem or issue that ‘could’ cause the risk to happen.
 - c. The **Effect** is the result of something that will happen if we do nothing about the risk
 - d. The **Impact** is the wider impact of the risk on the objectives if we do nothing.
46. An example of describing risk in the Trust standard is detailed in table 1 below:

Objective:	To ensure safe staffing levels
Risk:	Risk of failure to maintain safe staffing levels
Cause:	<ul style="list-style-type: none"> • High staff sickness rate • Difficulties in recruiting clinical staff
Effect:	Staff not receiving mandatory training in resuscitation or blood safety
Impact:	Increased safety risk to patient

47. **Key Controls** are identified and put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does. Where a gap in control has been identified you must ensure that actions to address this are identified. Each action must have an owner (i.e., a named individual, responsible for the action) and target completion date.
48. Key controls must describe the practical steps that are being taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.
49. Not all risks can be dealt with in the same way. The ‘5 T’s provide an easy list of options available to anyone considering how to manage risk:
- a. **Tolerate** – the likelihood and consequence of a particular risk happening is accepted;
 - b. **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
 - c. **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
 - d. **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity; or

- e. **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit.
50. In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:
- a. Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
 - b. When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.
51. Contingency Plans – if a risk has already occurred and cannot be prevented or if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the register. Good risk management is about being risk aware and able to handle the risk, not risk averse.
52. All risks and controls are to be described in accordance to the Trust standard and recorded in the risk register following assessment.

Stage 4: Completing the Risk Register

53. Trust Risk Registers are web based and stored electronically. It is a transparent system to enable users to share learning. All staff with permissions to access risk registers are able to see risks for the whole organisation but can update only those risks associated with their areas. Confidential risks are restricted to those staff with appropriate authority.
54. The process for completing risk registers
- Number (automatically assigned)
 - Assign risk level
 - Date identified
 - Directorate
 - Board Assurance Framework (BAF) Risk link
 - Risk type
 - Risk source
 - Risk description
 - Nominated executive lead
 - Assessor
 - Manager/owner of the risk
 - Initial risk assessment (rate the **likelihood** of the risk materialising against the **consequence** of the risk happening without controls in place)
 - Identify and list controls
 - Controls effectiveness
 - Residual risk rating (following the implementation of controls)
 - Actions (with responsible person and target date)
 - Review of risk frequency

- Reviews (when a review is undertaken and why – for audit purposes)

55. Headings in the register that need to be completed are:

- a. **Risk Manager/Owner** is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the Action Owner or the Assessor. High severity corporate risks, for example, will be owned by one Executive Director (nominated executive lead), but there may be many Action Owners. However, the system only allows for one action owner to be identified. This must therefore be the primary individual. The Risk Owner must know, or be informed, that they are the owner, and accept this.
- b. **Source** of how or where the risk was identified. This could include:
 - i. Business planning
 - ii. Audit (can be internal, external, clinical)
 - iii. Complaints
 - iv. External Review
 - v. Incident
 - vi. Legislation
 - vii. Litigation
 - viii. NICE guidance
 - ix. Regulatory standard
 - x. Risk Assessment
- c. **Initial Risk Rating** and **Residual Risk Rating** – when identifying a risk the initial risk rating should be stated (the severity and likelihood of the risk occurring without any controls in place) followed by the residual risk rating (the severity and likelihood of the risk occurring with controls in place). Each time the register is reviewed or the risk score is updated, this must be recorded in the review section. This is so the history and progress of a risk can be reviewed. The Trust's guidance on the matrix and advice on scoring is contained in Appendix 4.
- d. **Review Date** should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

56. It is crucial that attention is paid to the quality of information inputted onto the risk register. Staff must be mindful of the Trust's **Data & Information Quality Management Policy** and must ensure that information is complete, accurate, relevant, accessible and timely. In addition, it is equally important that information is up-to-date and reflects the current risk situation. In the event that information is found to be inaccurate, remedial action must be taken by the risk owner immediately.

Stage 5: Escalation and De-escalation of Risks

57. The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Team Risk Register to a Directorate/**Care Network** Risk Register, or from the Directorate/**Care Network** Risk Register to the Corporate Risk Register. The latter is reviewed by the Executive Director's Group, Audit Committee, Finance & Investment Committee, Quality Assurance Committee, Workforce & OD Committee, and finally the Board.

58. Risks will be escalated or de-escalated within the defined tolerances. Further guidance is contained in the Risk Management Handbook.

Escalating and De-escalating Risks



59. Wherever possible, the risk owner should discuss and seek approval from their manager before risk escalation to the next level. All risks that are rated 12 or above must be escalated for consideration onto the next level risk register.

60. An escalated risk will then be reviewed in the appropriate governance meeting and either accepted at the next level or rejected and returned to the management team to review and rescore, or for further action.

61. Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e. a risk rated 25 (red, or **high**) at Directorate level will be re-evaluated and may not be rated at 25 at Corporate level.

62. Once controls are in place and actions completed and the residual risk rating is revised below 12, it will be de-escalated for local management and oversight. Where a risk is de-escalated this must be communicated to the management level below,

and the risk monitored at the appropriate governance meeting to ensure that the risk continues to be contained and mitigated. In some instances it may be necessary to re-escalate the risk at a later date.

63. It is important that risks are reviewed regularly to ensure actions and controls reflect the current situation, to ensure actions are updated and timescales adhered to and to close a risk or action where necessary.
64. Risk registers at Directorate/Care Network level are reviewed by the Senior Management Team in the relevant Directorate Governance Meetings on a monthly basis to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. This will aid in identifying lower risk issues which may be common across many areas. Registers will also be reviewed to identify high impact but low frequency risks which may pose a threat.

Department/Team/Service Risk Registers

Individual teams, departments and services hold their own risk registers to evidence that consideration has been given to risks. In addition to a risk register, individual teams will complete generic risk assessments for risks such as lone working, manual handling, fire safety etc. Where risk cannot be managed by the application of local policies and standard operating procedures they should be entered on the risk register where teams are responsible for implementing any required actions to mitigate, control or remove the risk. Where risk ratings reach 12 or above, they must be escalated to the appropriate directorate/care network risk register, for consideration and identification of further actions. Local risk registers should be reviewed monthly in line with the Trust's governance framework.

Directorate/Care Network Risk Registers

Each directorate/care network will be responsible for holding their own risk register, and the continual review, monitoring and updating of that risk register through the directorate's local governance structure and Trust's agreed governance framework. They are also reviewed as part of the service review process undertaken with Executive Directors every six months to ensure that they are live, effective, contemporaneous, and meet the NHS Litigation Authority requirements. Where a residual risk is assessed as or above 12, this will be escalated for consideration onto the Corporate Risk Register, via the escalation process detailed in paragraphs 56-60 above.

Corporate Risk Register

Risks which have a residual risk rating of 12 or above, or risks that impact on several or all directorates/care networks are considered by the Executive Director's Group for inclusion onto the Corporate Risk Register on a monthly basis. This process is managed by the Director of Corporate Governance (Board Secretary). These risks are managed by the individual directorate(s)/care networks with accountable individuals responsible for their review. They are monitored through the appropriate operational governance group.

The Executive Directors Group is responsible for reviewing all corporate risks and allocating responsibility to an executive lead and the relevant Board Committee. EDG is also responsible for identifying when a corporate risk reaches a level that compromises any of the Trust's strategic objectives and should therefore be escalated

to the Board Assurance Framework.

The Corporate Risk Register is reviewed **quarterly** by Board and monthly by EDG. Board committees review their risks on a quarterly basis to ensure they are fully aware of the high level risks within the Trust and can provide assurance on the robust processes/controls in place to manage them.

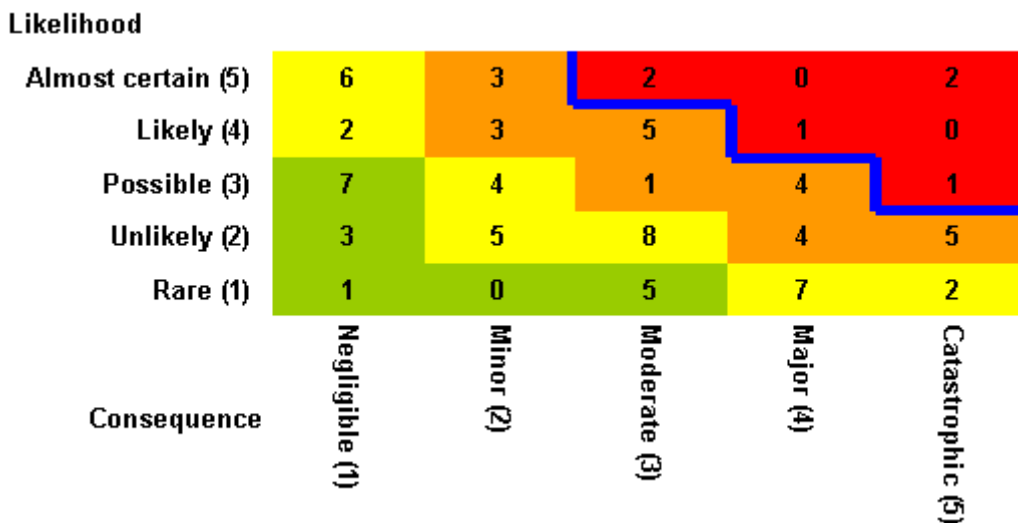
Risk Review

65. Individual risks should be reviewed in line with their residual risk rating. Those entering risks on the risk register are responsible for ensuring they attribute the correct risk review to their risk. This is not done automatically.

Score	Response Required	Frequency
1-6	Remains on local risk register for monitoring to the point where it has been sufficiently managed whereupon it should be removed	Six monthly
8-10	Remains on local risk register with local level actions identified to reduce the risk as low as is reasonably practicable.	Quarterly
12+	Actions must be identified and risks escalated for consideration onto the next level risk register.	Monthly

Risk Profile

66. A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing Risk Register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be considered. The risk profile can be shown (as below) according to residual risk rating or can be shown



according to risk type.

Example risk profile diagram

Project and Programme Risk

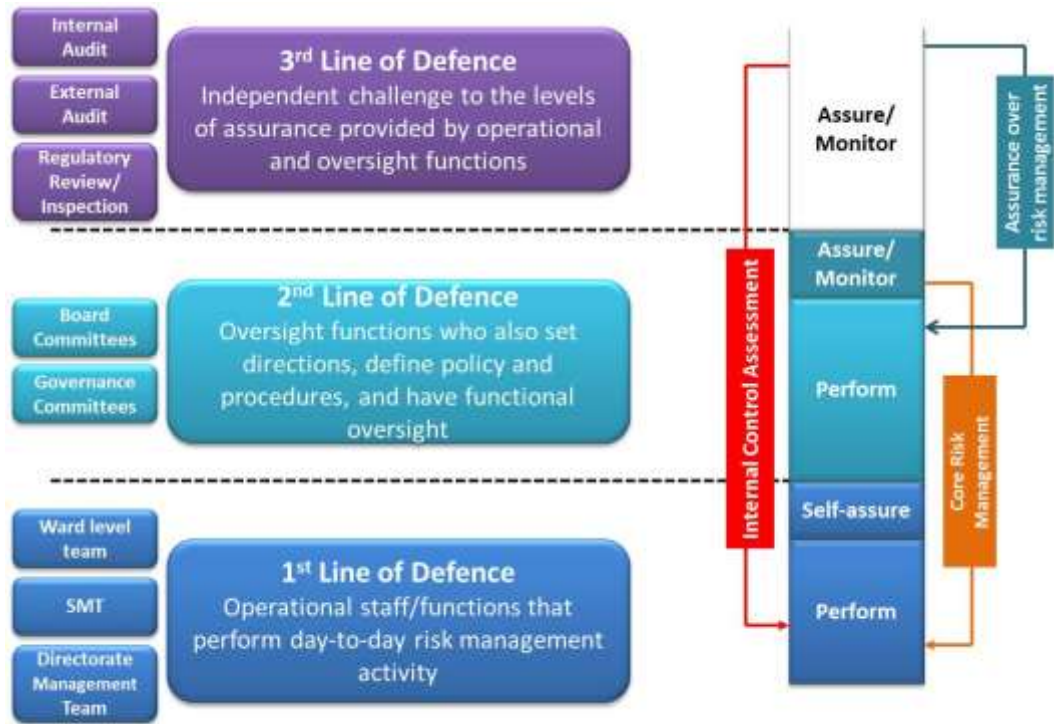
67. Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of project documentation.
68. Project and programme opportunities and threats are generally identified:
 - a. Through the escalation of risks from projects within the programme;
 - b. During project or programme start up;
 - c. By other projects or programmes with dependencies or interdependencies with this project or programme;
 - d. By operational areas affected by the project or programme.

Although a project or programme should adhere to the Trust Risk Management Strategy it should also have its own risk management guidelines, which should:

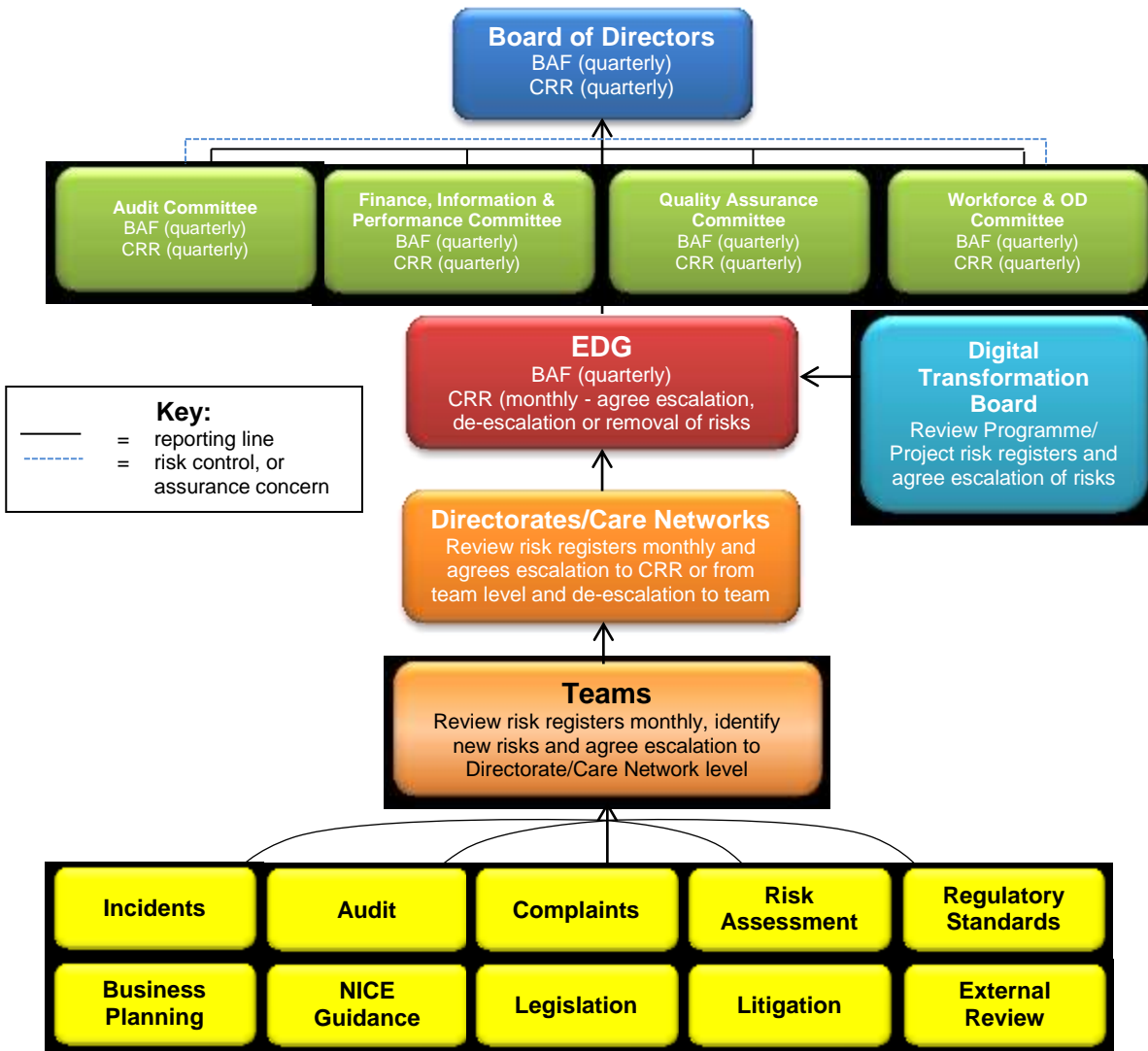
- e. Identify the owners of a programme and individual projects within the programme;
 - f. Identify any additional benefits of adopting risk management within this project or programme;
 - g. Identify the nature and level of risk acceptable within the programme and associated projects;
 - h. Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level;
 - i. Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects;
 - j. Identify how inter-project dependencies will be monitored and managed;
 - k. Clarify relationships with associated strategies, policies, and guidelines;
 - l. Have clear processes for escalating programme risks to the Corporate Risk Register or Board Assurance Framework**
69. Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.
 70. In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising. This should be recorded in the risk description column of the risk register as part of the impact description. The cost of mitigating the risk should also be recorded in the 'Key controls and Contingency Plans' column, if this can be determined. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

Risk Management and Assurance

71. Assurance is provided through transparent, timely and objective risk reporting. High quality and accurate risk management information helps to ensure that senior management is fully aware of material risks to which the organisation is exposed.
72. Appropriate internal control processes to manage risk can be demonstrated through the 3 lines of defence model.



Governance Structure



73. The Trust's governance structure identifies the relevant Committees and their relationship to the Board. Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by the following Committees and management groups (further detailed in Appendix 5):
- a. Board of Directors
 - b. Audit Committee
 - c. Finance, **Information & Performance** Committee (FIPC)
 - d. Quality Assurance Committee (QAC)
 - e. Workforce and Organisational Development Committee (WODC)
 - f. Executive Director's Group (EDG)
 - g. Digital Transformation Board (DTB)
 - h. Directorate Governance Committees
74. Additionally the Audit Committee and other Board Committees (FIPC, QAC and WODC) exist to provide assurance of the robustness of risk processes and to support the Board of Directors.
75. Each Directorate/Care Network and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.
76. Risks are correspondingly monitored at operational level (ward, team, service) through the appropriate governance team meetings.
77. Risk Management by the Board is underpinned by a number of interlocking systems of control: the Board reviews risk principally through the following three related mechanisms:
- a. The **Board Assurance Framework (BAF)** identifies risks in relation to each of the Trust's strategic objectives along with the controls in place and assurances available on their operation. **Board agendas are structured to ensure appropriate discussion and assurance that risks which may result in non-achievement of Trust objectives are appropriately mitigated. The BAF is reviewed by risk owners and quality assured by Executive Directors prior to presentation to Board and its committees on a quarterly basis. The BAF is also refreshed annually by the Board to reflect any risk to achieving operational priorities.**
 - b. The **Corporate Risk Register (CRR)** is a high level risk register (risks rated 12 and above **at directorate/care network level**) used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust. **The CRR is reviewed monthly by risk owners and quality assured by Executive Directors prior to a monthly presentation to the Executive Directors Group which includes risks escalated from clinical and corporate directorates to be considered for inclusion onto the CRR. It is at this stage that Executives will identify whether a risk has escalated to such a stage as to compromise strategic objectives and is therefore required to be included on the Board Assurance Framework. The CRR is presented quarterly to the Board and its committees for oversight and assurance purposes.**
 - c. The **Annual Governance Statement** is signed by the Chief Executive as the

Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

	Board Assurance Framework	Corporate Risk Register	Directorate/ Care Network Risk Registers	Team Risk Registers
Risk Type	Risks to the organisation's strategic objectives	High level risks in the context of operational objectives	Broad range of operational risks	Risks specific to teams/services
Risk Owner	Key focus: Board of Directors. Risks managed by the executive team.	Key focus: Executive Directors Group. Risks managed by executive/ senior management.	Key focus: senior management. Risks managed by heads of service/ department.	Key focus: Senior Operational Managers. Risks managed by team/service managers.
How risks are identified	Risks identified by the board and executives or escalated from the corporate risk register.	Risks identified through escalation from departmental risk registers and by senior management.	Risks identified through documented risk assessments and may be linked to incidents, audits, external assessments or other qualitative information.	Risks identified by team/service managers.
Coverage	Includes: Objectives, residual risk score, target risk score, controls (to mitigate the risk), gaps in control, assurances, gaps in assurances, action plan.	Includes: Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks deemed to impact upon the achievement of strategic objectives should be escalated to the assurance framework.	Includes: Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk strategy) should be escalated to the corporate risk register.	Includes: Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk strategy) should be escalated to the directorate/care network risk register.

Horizon Scanning

78. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the

business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

79. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.
80. The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:
 - i. Legislation;
 - ii. Government white papers;
 - iii. Government consultations;
 - iv. Socio-economic trends;
 - v. Trends in public attitude towards health;
 - vi. International developments;
 - vii. Department of Health and regulatory body publications;
 - viii. Local demographics; and
 - ix. Seeking stakeholder's views.
81. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.
82. Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

Training

83. Staff learning and development is critical to safety at work and safe working practices. All staff are expected to have a certain level of understanding of safety and risk management as determined by their job role.
84. Health and social care professionals will also be expected to meet core competencies with regard to service user safety, safe practice and risk assessment and management as part of their training and in their continuing professional development requirements.
85. Clinical risk assessment and management training, including familiarisation with the DRAM, is provided to staff in line with the Trust's Training Needs Analysis, incorporated within the Trust's Mandatory Training Policy. This training is required to be updated at least every three years (Best Practice in Managing Risk, DH 2007).

Monitoring Compliance

86. The Risk Management Strategy is subject to Annual Review prior to presentation to Board.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency of Monitoring	Group or Committee
Risk Management Strategy	Review	Director of Corporate Governance (Board Secretary)	Annual	EDG, Audit Committee & Board
Annual Governance Statement	Internal/ External Audit	Director of Corporate Governance (Board Secretary)	Annual	Audit Committee
Risk Management Process	Internal Audit	Director of Corporate Governance (Board Secretary) and Directorates	Annual	EDG and Audit Committee

Strategy Review

87. This strategy will be reviewed initially after 12 months then every three years or sooner if circumstances dictate thereafter.

References

88. The references relating to this strategy are:

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- NHS Audit Committee Handbook, Department of Health (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- **HFMA – NHS Governance 2017**

Equality Impact Assessment

89. As part of its development; this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

Appendix 1: Categories of Risks

Risk Domain	Description
Safety	<p>The risk has the potential to impact upon the safety of patients, staff or public. The harm may be physical or psychological.</p> <p>The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and carers and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in partnership with each other, patients and carers to minimise risk to the greatest extent possible and promote patient well-being.</p>
Quality	<p>The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.</p> <p>The risk is delivering a poorer quality of service. The risk may manifest itself in increased complaints or poor audit results.</p>
Workforce	<p>The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, operational, financial etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.</p> <p>Risks to workforce are associated with human resources, organisational development, staffing issues or competence and training issues.</p>
Statutory	<p>Risk of non-compliance with a statutory duty or other regulatory / compliance frameworks or inspections e.g. NHS Improvement, Care Quality Commission, Health and Safety Executive, HM Coroner, individual data and data protection.</p>
Reputational	<p>The Trust models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be</p>

Risk Domain	Description
	<p>attentive and responsive to change.</p> <p>Risks of damaging/adverse publicity that threatens the confidence of the general public in our services.</p>
Business	<p>The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Strategy and Strategic Planning Framework, whilst respecting and abiding by its statutory obligations.</p> <p>Risks in this domain relate to the threat to our business or delivery of projects.</p>
Finance	<p>Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wider range of risk areas to ensure safety and quality is maintained.</p> <p>Risk to our financial stability including failure to make planned savings, reductions in income or excessive legal claims.</p>
Environmental	<p>Environmental risks that may result in service / business disruption (e.g. extreme weather, loss of water, loss of power) or threat to the environment from our activities (e.g. chemical spills, clinical waste).</p>

Appendix 2: Definitions

Key term	Definition
Annual Governance Statement	Provides assurance that the Trust has a generally sound system of internal control that supports achievement of policies, aims and objectives and provides details of any significant internal control issues.
Assurance	Evidence that control measures are working effectively to manage risk. This can be internal (eg. workplace review, scrutiny by a committee or the board) or external (eg. Audit by external body). Assurance can be positive (providing evidence that controls are achieve the desired outcome) or negative (provide no such assurance and perhaps indicating the need for further action).
Board Assurance Framework (BAF)	A dynamic board-level summary identifying which of the Trust's strategic objectives are at risk because of inadequacies in the operation of controls or where the Trust has insufficient assurance that controls are effective. It also provides a summary of action being taken to address inadequate controls. It also records structured, positive assurances about where principal risks are being managed effectively and objectives are being delivered.
Clinical Risk	Any clinical activity which could have a direct effect on patient may include the lack of availability of services, supervision and competency of staff or adherence to Trust policies.
Control(s)	A measure in place to manage risk and assist in security the delivery of objectives. Controls are designed to make a risk less likely to happen or reduce its effect if it does happen. The controls recorded on the BAF should focus on the key strategic controls that help the Trust to manage principal risks and secure delivery of organisational objectives. The risk register may document additional controls in more detail, along with actions to address perceived gaps, as it serves as an action planning tool to manage risk, rather than a board level summary.
Corporate Risk Register (CRR)	A log of all high level risks that may threaten the achievement of the Trust's objectives. It is a dynamic document which is populated through the organisation's risk assessment and evaluation process. It enables risks to be quantified and ranked and provides a structure for collating information about risks.
Financial Business Risk	May include financial restraints, losses, irregularities or lost opportunities to deliver financial gain which may affect the Trust's ability to resource the services it provides.
Financial Impact	Where appropriate, risk should be assessed for their financial impact which is the cost the Trust accepts in order to achieve adequate management of the risk and should be considered alongside the maximum cost the Trust is willing to tolerate by way of losses if the risk were to materialise. It is acknowledged that not all risks are easily assessed in terms of their financial impact.
Health & Safety Risk	May include fire safety, security, buildings, plant and machinery, unsafe systems of work, failure to comply with health and safety legislation.

Key term	Definition
Internal Control	A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.
Inherent Risk	The level of risk before any control activities are applied.
Impact	The potential consequence if the adverse effect occurs as a result of the hazard.
Likelihood	The change or possibility of something happening.
Operational Risk	Results from day to day running of the Trust and includes a broad range of risks including clinical, financial, health and safety, information governance. These are usually managed by the service line in which they are identified.
Organisational Risk	Any activity which could have a detrimental effect on the day to day performance of the Trust and the services it provides. This may include the recruitment of staff, training and education, finance and information system, confidentiality and communication.
Principal Risk	Any risk that prevent the achievement of one or more of the Trust's strategic objectives as recorded in the BAF. Principal risks must be approved/removed by the Board. They may also be recorded on the CRR.
Residual Risk	The current risk "left over" after controls, actions or contingency plans have been put in place.
Risk	The change of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.
Risk Appetite	The level of risk the Trust is prepared to accept, tolerate or be exposed to at any point in time.
Risk Capacity	Maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in: <ul style="list-style-type: none"> identifying, assessing and judging risks; assigning ownership; taking actions to mitigate and anticipate them; and monitoring and reviewing progress.
Risk Owner	The individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation to risk (or a given level of the organisation).
Risk Rating	The total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.

Key term	Definition
Risk Tolerance	The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 3: Roles and Responsibilities

Title	Responsibilities
Chief Executive	The Chief Executive is the responsible officer for Sheffield Health and Social Care NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management.
Executive Director of Finance	The Executive Director of Finance has responsibility for financial governance and associated financial risk.
Executive Medical Director	The Executive Medical Director has responsibility for clinical governance and clinical risk, including incident management and quality.
Executive Director of Nursing, Professions and Care Standards	The Executive Director of Nursing, Professions and Care Standards has responsibility for patient safety and patient experience, and compliance with care standards.
Executive Directors and Associate Directors	The Executive and Associate Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates. Executive and Associate Directors also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.
Director of Corporate Governance (Board Secretary)	The Director of Corporate Governance (Board Secretary) is accountable to the Chief Executive for the overall performance of corporate governance functions, including the risk management framework, monitoring and assurance of the system of internal control; including the system and supporting processes for risk registers and maintenance of the Board Assurance Framework and its supporting processes.

Title	Responsibilities
Head of Clinical Governance	<p>The Head of Clinical Governance will support the Director of Corporate Governance (Board Secretary) to maintain and manage the risk register systems and processes.</p>
<p>Director/Clinical Director of Operations & Transformation, Directors, Associate Directors, Associate Clinical Directors, Deputy Directors</p>	<p>These senior staff are accountable for ensuring that appropriate and effective risk management processes are in place in their designated areas and that risks are identified, assessed and acted upon; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk registers; and ensuring that appropriate local and directorate governance groups review risk registers at least monthly as part of performance monitoring, to consider and plan actions being taken.</p> <p>They are accountable for ensuring that all staff are aware of the risks within their work environment, together with their personal responsibilities.</p> <p>They must ensure appropriate escalation of risks from team or service to Directorate level or from directorate to corporate level within the defined tolerances.</p> <p>They have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this strategy and related documentation.</p> <p>They are responsible for ensuring that staff receive the relevant elements of risk management training and that non-attendance is followed up.</p>
Senior Managers	<p>Senior Managers take the lead on risk management and set the example through visible leadership of their staff. They do this by:</p> <ul style="list-style-type: none"> • Taking personal responsibility for managing risk. • Sending a message to staff that they can be confident that escalated risks will be acted upon. • Ensuring risks are updated regularly and acted upon • Identifying and managing risks that cut across delivery areas. • Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risks faced; increasing the visibility of risk management

Title	Responsibilities
	<p>and moving towards an action focused approach.</p> <ul style="list-style-type: none"> • Communicating downwards the top risks. • Escalating risks from the front line. • Considering risks from a number of perspectives including financial, business continuity, environmental, strategy etc, not only from a service delivery perspective. • Ensuring staff are suitably trained in risk management. • Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve. • Ensuring that people are not blamed for identifying and escalating risks, and fostering a culture which encourages them to take responsibility in helping to manage them. • Ensuring that risk management is included in appraisals and development plans where appropriate. <p>Senior managers are expected to be aware of and adhere to the risk management best practice to:</p> <ul style="list-style-type: none"> • Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front line colleagues • Identify risk owners with the seniority to influence and be accountable should the risk materialise • Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do • Identify the actions needed to reduce the risk and assign action owners • Is there an opportunity to benefit from the risk or the work done to mitigate against the risk materialising? • Record risks on a risk register • Check frequently on action progress, especially for high severity risks • Apply healthy critical challenge • Implement a process to escalate the most severe risks, and use it
All staff	<p>All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow</p>

Title	Responsibilities
	the Speaking Up: Whistleblowing Policy incorporating guidance on both whistleblowing and raising concerns.
Staff side representatives	Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

Appendix 4: Risk matrix and risk scoring guidance

Calculate the consequence and likelihood rating using the scales below.

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

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

1-4	Very Low Risk
5-8	Low Risk
9-12	Moderate Risk
12+	High Risk

First, cross reference the likelihood and impact scores on the matrix above. For example, if you have a 'moderate' consequence and 'almost certain' likelihood then the overall risk rating would be:

$$\begin{aligned} \text{Consequence} \times \text{Likelihood} &= \text{Overall risk rating} \\ 3 \times 5 &= 15 \\ \text{Moderate} \times \text{Almost certain} &= \text{High Risk} \end{aligned}$$

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements and any relevant publication can be used to inform a judgement.

Likelihood – consider how likely it is that the risk will occur

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

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. In some cases it may be more appropriate to assess the probability of a risk occurring, especially for specific areas of risk which are time limited.

Consequence – consider how severe the impact, or consequence, or the risk would be if it did materialise.

Consequence is the term given to the resulting loss, injury, disadvantage, or gain if a risk materialises. Remember – there are likely to be a range of outcomes for this event.

Note - Evaluating risk is an iterative process. Once you calculate the risk rating, it could lead to the conclusion that, for example, a particular risk seems to have too high a risk rating. In such cases the rating may need to be reviewed, checking the likelihood and/or consequence ratings.

Consequence Table

Domains	CONSEQUENCE				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
<p>SAFETY Impact on the safety of patients, staff or public (physical/psychological harm)</p>	<ul style="list-style-type: none"> Minimal injury requiring no/minimal intervention or treatment. No time off work Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient Expected death Missing patient (low risk) 	<ul style="list-style-type: none"> Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days Wrong drug or dosage administered, with no adverse effects Physical attack, such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work) 	<ul style="list-style-type: none"> Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical 	<ul style="list-style-type: none"> Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Slip/fall resulting in injury such as dislocation/fracture / blow to the head Post-traumatic 	<ul style="list-style-type: none"> Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients Unexpected death Suicide of a patient known to the service in the past 12 months Homicide (or suspected homicide) committed by a mental health patient Incident leading to paralysis Incident leading to long-term mental health problem

	CONSEQUENCE				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
		required) • Missing patient (medium risk)	attention • Grade 2/3 pressure ulcer • Healthcare Acquired Infection (HCAI) • Incorrect or inadequate information/communication on transfer of care • Vehicle carrying patient involved in a road traffic accident • Slip/fall resulting in injury such as a sprain • Missing patient (high risk)	stress disorder	• Rape/serious sexual assault • Loss of a limb
QUALITY Quality/Complaints/ Audit	• Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• Overall treatment or service suboptimal • Formal complaint (stage 1) Local resolution • Single failure to meet internal standards	• Treatment or service has significantly reduced effectiveness • Formal complaint (stage 2) complaint • Local resolution	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/independent	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted upon • Inquest/

		CONSEQUENCE				
		1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic	
		<ul style="list-style-type: none"> Minor implications for patient safety if unresolved Reduced performance rating if unresolved 	(with potential to go to independent review) <ul style="list-style-type: none"> Repeated failure to meet internal standards Major patient safety implications if findings are not acted on 	review <ul style="list-style-type: none"> Low performance rating Critical report Major complaint / claim 	ombudsman inquiry <ul style="list-style-type: none"> Gross failure to meet national standards 	
WORKFORCE Human resources/ organisational development/staffing/ competence	<ul style="list-style-type: none"> Short-term low staffing level that temporarily reduces service quality (< 1 day) 	<ul style="list-style-type: none"> Low staffing level that reduces the service quality 	<ul style="list-style-type: none"> Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training 	<ul style="list-style-type: none"> Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training 	<ul style="list-style-type: none"> Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis 	
STATUTORY Statutory duty / inspections	<ul style="list-style-type: none"> No or minimal impact or breach of guidance/ statutory duty 	<ul style="list-style-type: none"> Breach of statutory legislation Reduced performance 	<ul style="list-style-type: none"> Single breach in statutory duty Challenging external recommendations 	<ul style="list-style-type: none"> Enforcement action Multiple breaches in statutory duty Improvement 	<ul style="list-style-type: none"> Multiple breaches in statutory duty Prosecution Complete systems change 	

	CONSEQUENCE				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
		rating if unresolved	/ improvement notice	notices Low performance rating Critical report	required <ul style="list-style-type: none"> Zero performance rating Severely critical report
REPUTATIONAL Adverse publicity/ reputation	<ul style="list-style-type: none"> Rumours Potential for public concern 	<ul style="list-style-type: none"> Local media coverage short-term reduction in public confidence Elements of public expectation not being met 	<ul style="list-style-type: none"> Local media coverage – long-term reduction in public confidence 	<ul style="list-style-type: none"> National media coverage with <3 days service well below reasonable public expectation 	<ul style="list-style-type: none"> National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS Business objectives/projects	<ul style="list-style-type: none"> Insignificant cost increase/ schedule slippage 	<ul style="list-style-type: none"> <5 per cent over project budget Schedule slippage 	<ul style="list-style-type: none"> 5–10 per cent over project budget Schedule slippage 	<ul style="list-style-type: none"> Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met 	<ul style="list-style-type: none"> Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
FINANCE Finance including claims	<ul style="list-style-type: none"> Small loss Risk of claim remote 	<ul style="list-style-type: none"> Loss of 0.1–0.25 per cent of budget Claim less than £10,000 Vandalism / theft <£10k 	<ul style="list-style-type: none"> Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 Vandalism / theft 	<ul style="list-style-type: none"> Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 	<ul style="list-style-type: none"> Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage

			CONSEQUENCE		
			3	4	5
Domains	1 Negligible	2 Minor	Moderate	Major	Catastrophic
		<ul style="list-style-type: none"> Cosmetic damage to premises 	£10-50k	million <ul style="list-style-type: none"> Purchasers failing to pay on time Vandalism / theft £50k - £100k 	<ul style="list-style-type: none"> Loss of contract / payment by results Claim(s) >£1 million Vandalism / theft over £100k
ENVIRONMENTAL Service/business interruption Environmental impact	<ul style="list-style-type: none"> Loss/interruption of >1 hour Minimal or no impact on the environment 	<ul style="list-style-type: none"> Loss/interruption >8 hours Minor impact on environment Cosmetic damage to premises 	<ul style="list-style-type: none"> Loss/interruption of >1 day Moderate impact on environment Structural damage to premises 	<ul style="list-style-type: none"> Loss/interruption of > 1 week Major impact on environment Permanent irreparable damages to premises/damage up to £100k 	<ul style="list-style-type: none"> Permanent loss of service or facility Catastrophic impact on the environment Serious fire Permanent/irreparable damage to premises/damage over £100k

Appendix 5: Committees and Governance Structures

Committee	Responsibilities
Board of Directors	<p>The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust.</p> <p>The Board will receive and scrutinise the Board Assurance Framework quarterly and the Corporate Risk Register bi-monthly.</p> <p>Non-Executive Directors: the role of Non-Executive Directors in the Board and as Chairs of Board Committees is that of oversight and challenge to ensure that internal systems of control and the process for management of risk is effective and fit for purpose.</p>
Audit Committee	<p>The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:</p> <ul style="list-style-type: none"> • To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. • To review the Trust corporate risk register on a quarterly basis. • To monitor and review the Board Assurance Framework, and ensure its presentation to the Trust Board at intervals that the Board determines. • To assess the overall effectiveness of risk management and the system of internal control. • To challenge on the effectiveness of controls, or approach to specific risks.
Finance, Information and Performance Committee	<p>The Finance, Information & Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues, and for providing assurance that these are being managed safely.</p>

Committee	Responsibilities
	<p>The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.</p>
Quality Assurance Committee	<p>The Quality Assurance Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care governance systems including risks for clinical, corporate, information and research & development issues; and regulatory standards of quality and safety.</p> <p>The committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.</p>
Workforce and Organisation Development Committee	<p>The Workforce and Organisation Development Committee is responsible for providing information and making recommendations to the Trust Board on workforce and organizational development issues, and for providing assurance that these are being managed safely.</p> <p>The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.</p>
Executive Directors Group	<p>The Executive Directors Groups (EDG) is in its role as the Executive decision making group of the Trust maintains oversight of strategic and operational risks. Risk is monitored through the Corporate Risk Register and Board Assurance Framework. EDG is also responsible for agreeing resourced risk treatment plans and ensuring their delivery.</p>
Digital Transformation Board	<p>The digital transformation board oversees three portfolios: clinical systems, business systems and infrastructure and the projects and programmes underneath them.</p> <p>The board attendance includes the executive medical and financial directors and the deputy chief executive. The group manages risks and issues that have been</p>

Committee	Responsibilities
	escalated from the strategy groups that report into them and makes strategic decisions regarding digital products
Directorate, Service, Clinical and Corporate Directors / Manager	<p>Directorate, Service, Clinical and Corporate Directors / Managers, are responsible for the risks to their services and for putting in place appropriate arrangements for the identification and management of risks. They will develop, populate and review their risks, drawing on risk processes within the services, to ensure that relevant Risk Registers are kept up to date through regular review.</p> <p>They and their management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.</p>