Risk Management Strategy

2016 - 2017

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This is version 6 of the Risk Management Strategy and includes comments from discussions at the Board Development Workshop on 6 October, the Board of Directors on 12 October, Audit Committee on 18 October and Board of Directors 9 November 2016.

The strategy will be made available to all staff via the Sheffield Health and Social Care NHS Foundation Trust intranet and will be published on the internet.

This strategy replaces the previous Safety and Risk Strategy (issued March 2013) and Risk Management Policy Manual (version 3 issued February 2009)
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### Appendices

- **Appendix A (i)** Organisational Structure Chart
- **Appendix A (ii)** Committee / Group Structure Chart
- **Appendix B** Guidelines to Identify, Assess, Action and Monitor Risks (incorporating Risk Matrices)
- **Appendix C** Risk Register Protocol
  - **Appendix C1** – User guide for RiskWeb
  - **Appendix C2**: Risk Register Flowchart
- **Appendix D** Equality Impact Assessment
1. Statement of Intent

Sheffield Health and Social Care NHS Foundation Trust is committed to putting the safety of service users, carers, staff and the public first - at the heart of its business. A principle Trust objective is 'to provide high quality, safe and effective services.' A fundamental duty of all NHS staff is 'to do no harm.'

Trust staff will work collaboratively with service users and carers to provide safe services.

The Trust will develop further an open and fair culture. This means a culture that:
- is open to adopting new practices to improve the quality of care and treatment provided;
- learns from incidents, mistakes and near misses and is transparent

The Trust will minimise risks to service users and carers, staff and all its stakeholders through robust internal controls within a comprehensive and integrated system of risk identification, assessment and management. It will put steps in place to reduce avoidable harm.

This Strategy covers the 12 month period November 2016 – November 2017. The reason for a 12 month approach at this stage is to facilitate the embedding of the new Executive Management portfolios and to facilitate the joint working arrangements between the Corporate Governance Department and the Clinical Risk Department. The Strategy will be refreshed in September 2017 and it is proposed at that stage a three year strategy will be developed.

2. Introduction

This strategy promotes the absolute importance of safety by outlining the Trust’s safety and risk management culture. The strategy covers all aspects of safety and risk including clinical risk, staff related risk, environmental risk, corporate risk and financial risk. The principles and procedures described within this document are applicable for all types of risk.

Risk is defined by NHS England as 'the chance of something happening, or a hazard being realised, that will have an impact on objectives. It is measured in terms of consequence and likelihood.' Risk Management is the recognition and effective management of all threats and challenges to the Trust's objectives and values. This includes risk to people, assets and reputation that could impact upon or compromise the ability of the Trust to carry out its everyday activities of providing a high quality service to the right patient at the right time in the right place.

This strategy sets out staff roles and responsibilities in relation to risk management and describes the systems and processes for effective risk management. Service user safety and effective risk management is the responsibility of every member of staff within the Trust.

The Strategy refers to two key documents for managing risk at a strategic level these are:
- The Board Assurance Framework (BAF) – The BAF is a key mechanism to reinforce the strategic focus of the board and better manager risk. It is used to help the organisation capture, report and monitor key risks to the strategic
objectives, implement corrective action and report to Board on progress. It is
designed to provide assurance that that organisation is delivering on its objectives,
supporting the management of the potential and actual risks. The BAF also helps
the organisation to assess the controls it has in place to mitigate the risks and
review the assurances to check the controls are effective.

- The Corporate Risk Register – The Trust will use risk registers to record, rate and
monitor risks across the organisation. Details of this process can be found in other
sections of this document including Section 10 – Risk Register Process. Risks
which have a residual risk of 12 or above, or risks that impact on services or all
directorates, but do not meet the criteria for the BAF are considered for inclusion
onto the Corporate Risk Register. Those risks on the Corporate Risk Register
rated 12 or above will be presented to Executive Directors Group (EDG), Board
and its committees on a quarterly basis.

3. Risk Appetite

The Trust recognises that positive and managed risk-taking is essential for growth,
development and innovation. ‘Risk’ should never be set as a barrier to change and
improvement; instead risks should be recognised, considered and managed
effectively as part of the continual improvement process.

Risk appetite is defined as “the amount of risk at board level that an organisation is
willing to take on in order to meet strategic objectives” (2016: Institute of Risk
Management). It is the level at which the Trust Board determines whether an
individual risk, or a specific category of risks are considered acceptable or
unacceptable based upon the circumstances/situation facing the Trust.

The Trust’s approach is to minimise exposure to risk that impacts on patient safety
and the quality of our services. However, the Trust accepts and encourages an
increased degree of risk in our objectives around developing innovation so long as
the innovation is consistent with the achievement of patient safety and quality
improvements.

The table below details the risk scoring system operated by the Trust, the category of
the risk, definition and decision making framework.

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<tr>
<th>Risk Score</th>
<th>Residual Risk Category</th>
<th>Definition</th>
<th>Decision</th>
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<tr>
<td>1 – 4</td>
<td>Very Low</td>
<td>An acceptable level of risk which remains subject to review</td>
<td>TOLERATE</td>
</tr>
<tr>
<td>5 – 8</td>
<td>Low</td>
<td>An acceptable level of risk (if the likelihood is 2 or less) which is subject to possible action and remains subject to review</td>
<td>TOLERATE or TREAT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All risks assessed with likelihood score of 3 or above must be treated, any exceptions to this must be authorised by the Executive Directors Group (EDG)</td>
<td></td>
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<tr>
<td>9 - 12</td>
<td>Moderate</td>
<td>Requires action and review</td>
<td>TREAT or TRANSFER</td>
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<tr>
<td>15 - 25</td>
<td>High</td>
<td>Unacceptable level of risk. Requires urgent/immediate review and action. Risk is escalated to the EDG for moderation.</td>
<td>TREAT or TRANSFER or TERMINATE</td>
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The Trust is committed to assuring itself that it has effectively discharged its responsibilities for the performance of the Trust through effective arrangements for monitoring and continually improving the quality of healthcare provided to its service users, ensuring that best practice arrangements are in place for risk management and the Board Assurance Framework to support the Annual Governance Statement. The Trust is also committed to assuring itself that the necessary planning, performance management and risk management arrangements are in place to deliver its Annual Plan.

4. **Strategic Objectives**

Currently the Trust currently has 5 strategic objectives, these are:

- Developing Our Approach to Delivering Outstanding Quality Care & Support
- Involving Service Users In Designing and Delivering Care and Support
- Transforming the Services We Deliver
- Maintaining Our Financial Sustainability
- Workforce Engagement

The strategic objectives form part of the Trust’s Annual Business Plan and as such are reviewed annually through the Trust’s business planning cycle and processes and may change during the lifetime of this Strategy.

The Risk Management Strategy is a key strategy for the organisation and its objectives are to:

- provide a Strategy that assures Trust Board that the actions set out in its plan are being delivered;
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery (from ‘board to ward’) and
- support greater devolution of decision-making as close to the user of Trust services as possible;
- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust;
- promote a culture of performance monitoring and improvement, which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust’s plans and market position are identified and addressed;
- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints;
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection;
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, NHS Improvement compliance requirements and Trust’s licence.
4. **Risk Management Organisational Structure**

The Trust reviewed and revised its committee and governance structure in 2016/17. The organisational structure chart structure is attached at Appendix A (i).

The following Committees/Groups hold responsibility for risk management issues which are to be discussed, reviewed, actioned and escalated throughout the Trust as appropriate. A diagram of how these Committee/ Groups fit together is included at Appendix A (ii)

- Board of Directors
- Executive Directors Group
- Audit Committee
- Quality Assurance Committee
- Workforce and Organisation Development Committee
- Health and Safety Committee
- Finance and Investment Committee
- Service User Safety Group
- Information Governance Steering Group
- Mental Health Act Committee
- Safeguarding Vulnerable Adults Board
- Safeguarding Children Board
- Infection Prevention and Control Committee
- Medicines Management Committee
- Operational Directors Group (fed by directorate governance groups/committees)
- Individual Directorate Governance Groups/Committees

**Responsibility for Risk Management**

**Board of Directors**

The Board of Directors sets the strategic direction of the Trust. This includes setting strategic objectives and ensuring that service user and staff safety is prioritised and that effective and robust risk management systems are in place throughout the organisation.

Boards need to be able to provide evidence that they have systematically identified their objectives and managed the principal risks in achieving them. The Trust's Board Assurance Framework (BAF), with a hierarchy of reporting in place, enables the Board to fulfil this responsibility in an effective and focused way.

The Board of Directors develops, monitors and manages the Board Assurance Framework which records the potential risks to the Trust that inhibit the achievement of its strategic objectives. The Board Assurance Framework, in full, is reviewed quarterly by the Board of Directors.

The Trust's Corporate Risk Register will be managed by the Trust's Corporate Governance department. All risks rated 12 or above will be reported and reviewed monthly by the Board. Depending upon the nature of the risk both a public and confidential report is produced.
The Board of Directors also receives monthly performance indicator dashboards which highlight potential areas for concern in numerous areas, such as financial risks, risks to quality, service user experience, etc.

**Executive Directors Group**

The Executive Directors Group (EDG) is the lead operational group for the Trust, chaired by the Chief Executive and includes the Executive Directors, Associate Director of HR and Director of Corporate Governance.

The EDG monitors the Board Assurance Framework and the Corporate Risk Register, in its entirety, on a quarterly basis. All risks rated 12 or above will be reported and reviewed monthly by the EDG prior to presentation to the Board. Depending upon the nature of the risk both a public and confidential report is produced. EDG allocates responsibility and confirms authority for further assessment, management and monitoring of the risks reported on these documents. Nominated leads are responsible for providing progress and exception reports on the risks recorded and the action plans to control them.

A serious incident report is also reviewed monthly by the Executive Directors Group, together with exception reports as necessary for issues that require escalation.

A number of operational groups report to EDG. These groups regularly meet to discuss risks in their specific areas. The Service User Safety Group has a particular role in reviewing risks to the safety of service users and the public.

**Audit Committee**

The Audit Committee is a committee of the Board of Directors which ensures effective evidence and assurance of internal control, including Risk Management, is in place throughout the Trust. It provides the Board with independent and objective review and monitoring of:

- the effectiveness of the systems in place for the management of risk;
- quality, safety and effectiveness of services;
- delivery of the Board Assurance Framework.

The Committee is chaired by a Non-Executive Director. The Deputy Chief Executive/Executive Director of Operations, Executive Director of Nursing, Professions and Care Standards and Executive Director of Finance attend, together with Internal and External Audit and the Trust’s Local Counter Fraud Officer. Their reports together with regular updates from the Chairs of operational governance groups and key individuals support the review and monitoring process. This scrutiny of evidence provides independent assurance that effective systems are in place for the management of risk in the organisation.

The Audit Committee reviews the full Board Assurance Framework and those risks rated 12 or above on the Corporate Risk Register on a quarterly basis, prior to the report being presented to Board. This enables the Audit Committee to highlight any assurances or risks related to the BAF to the Board to facilitate a strategic discussion.
Quality Assurance Committee

The Quality Assurance Committee is a committee of the Board of Directors and is chaired by a Non-Executive Director. It provides assurance to the Board on the quality of care and treatment provided across the Trust by ensuring there are efficient and effective systems for quality assessment, improvement and assurance and that service user and carer perspectives are at the centre of the Trust’s quality assurance framework.

The Quality Assurance Committee reviews the relevant sections of the BAF and those risks of 12 or above on the Corporate Risk Register, which are relevant to it, on a quarterly basis.

Finance and Investment Committee

The Finance and Investment Committee is a committee of the Trust Board and is chaired by a Non-Executive Director. The Finance and Investment Committee provides the Trust Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust’s finance and investments in the context of delivering the Trust’s strategy, the underpinning Financial Plan and associated clinical activity data. The Committee has over-arching responsibility for financial risk on behalf of the Board.

The Finance and Investment Committee reviews the relevant sections of the BAF and those risks of 12 or above on the Corporate Risk Register, which are relevant to it, on a quarterly basis.

Workforce and Organisational Development Committee (WODC)

The Workforce and Organisational Development Committee is a committee of the Trust Board and is chaired by a Non-Executive Director. WODC provides the Board with assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services in support of getting the best outcomes and experience for patients and staff. It also provides assurance to the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of high quality, safe patient care. It also provides assurance that, where there are workforce or organisational development risks and issues that may jeopardise the Trust’s ability to deliver its objectives, that these are being managed in a controlled way.

The WODC reviews the relevant sections of the BAF and those risks of 12 or above on the Corporate Risk Register, which are relevant to it, on a quarterly basis.

6. Duties of Key Individuals and Groups

The **Chief Executive** is ultimately responsible and accountable for the Trust’s provision of safe services and for ensuring that the systems on which the Board of Directors relies to govern the organisation are effective. The Chief Executive is also responsible for signing the Annual Governance Statement, which declares that the Trust’s systems of governance and risk management are properly controlled within
the Trust. The Chief Executive is also the executive lead for corporate governance, complaints and litigation.

The **Deputy Chief Executive/Executive Director of Operations** is responsible for safe delivery of operational services across the Trust and overseeing clinical directorates. The Deputy Chief Executive is the Caldecott Guardian with a lead responsibility with regard to risk and safety issues relating to information, including service user confidential records. The Deputy Chief Executive is the executive lead for emergency planning and freedom to speak up. The Deputy Chief Executive is also the executive lead for social work and social care practice. They have responsibility for the overarching management of incidents and risks within their Directorates.

The **Executive Director of Nursing, Professions and Care Standards** is accountable for care standards (including compliance with the Care Quality Commission), implementation of the Mental Health Act, Mental Capacity Act and has lead responsibility for the professions; nursing, and allied health care as well as responsibility for infection prevention and control, safeguarding children and vulnerable adults. They have responsibility for the overarching management of incidents and risks within their Directorates.

The **Executive Medical Director** is responsible for clinical governance, clinical risk management and clinical effectiveness, together with service user experience and monitoring. They are also responsible for medical practice and for medical advice on risk and safety issues, progressing evidence-based practice, research and development and post graduate medical education/undergraduate medical. The Executive Medical Director also has executive responsibility for Medicines Management and the implementation of NICE guidelines. They have responsibility for the overarching management of incidents and risks within their Directorates.

The **Executive Director of Finance** is responsible for providing professional leadership and advice on financial strategy, financial risk and management and for the leadership and management of a range of key management and infrastructure functions. The Executive Director of Finance is currently also designated Senior Information Risk Officer and leads on the Trust performance management systems. They have responsibility for the overarching management of incidents and risks within their Directorates.

The **Associate Director of Human Resources** is responsible for health and safety within the Trust, staff experience, Prevent, recruitment and education and training development and any risks and risk management associated with these functions. They have responsibility for the overarching management of incidents and risks within their Directorate.

**Non-Executive Directors** of the Board of Directors are responsible for ensuring that the Trust provides safe services and that there are effective systems in place to assure the safety of service users, staff, carers and family members and the wider community. They are expected to act as champions for safety in the organisation, and to actively seek evidence that services are safe. They chair, or are members of,
the relevant committees of the Board of Directors in relation to quality, risk, finance, workforce and audit.

**Accountable Officer – Medicines Management** is responsible for ensuring the safe use of controlled drugs throughout the organisation, with a duty to report any breaches to lead commissioners. Currently, the Trust’s Chief Pharmacist fulfils this role. They have responsibility for the management of incidents and risks within their Department.

Each **Service and Clinical Director and Corporate Department Director** is operationally responsible for all risk management issues within their portfolios, including effective/positive risk management within their service/area of responsibility. They are responsible for making sure that:

- the Risk Register for their Directorate is an up-to-date and a ‘live’ working document
- incidents occurring within their Directorate are reported and investigated as required
- high level risks are escalated via the electronic risk register process
- lessons learned from when things go wrong are disseminated and any changes needed are implemented
- staff and premises within their sphere of responsibility meet the relevant health and safety guidelines and legislation
- they have systems in place to ensure that their staff are aware of and follow the Trust’s policies and procedures, including all those related to safety and risk management
- staff in their Directorate are enabled to take part in necessary training and development opportunities to maintain good practice in service user safety and risk management
- staff who carry out clinical risk assessments are trained and competent in clinical risk training and management

They have responsibility for the management of incidents and risks within their Department /Team.

Clinical and service directors should seek and respond to feedback from staff and service users and carers about safety issues. They will manage risk through their own **Directorate Governance Group**.

Directors may choose to allocate a lead role for safety and risk management to a senior member of staff in their directorate to deliver these requirements for the directorate.

The **Clinical Governance Department** is responsible for providing advice, support and guidance with regard to clinical risk management. The department currently integrates support for clinical risk management with corporate risk management and governance. They also provide risk management and data handling systems through the Ulysses Safeguard Risk Management System. The corporate element of this role will be reviewed in line with the new organisational management structures.

The Clinical Governance Department have a key role in enabling the sharing of lessons learned following serious incidents and ensuring the Trust learns from all incidents, including near misses.
The department is also responsible for overseeing the electronic risk register process in collaboration with the directorate risk register Nominated Links, and the Corporate Governance department, using the Ulysses Safeguard Risk Management System. They are responsible for providing advice, support, guidance and necessary training in relation to identifying and recording risk assessments, risk analysis, consistency checking and for ensuring action plans are carried out in a timely manner.

The Corporate Governance Directorate is responsible for providing, monitoring and updating the Corporate Risk Register and the Board Assurance Framework to the relevant Trust committees and Board in line with the monitoring frequency set out in this strategy.

The Health and Safety Risk Advisor is responsible for providing specialist support to managers and staff members, dealing proactively with health and safety matters, conducting regular internal health and safety audits and for the delivery of health and safety related training.

The Directorate Nominated Links are responsible for managing and updating their directorate risk registers in a timely manner.

All managers have the authority for and are responsible 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 low and very low reporting to their directors on completion.

They have responsibility for risk management and incidents within their department/team. 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 Managing Sickness/Capability 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 accidents)

All staff in the Trust, including those on temporary contracts, placements or secondments, and contractors must keep themselves and others safe. Staff have a duty of care to provide safe services and do no harm. They have a responsibility for managing incidents and risks within their area of responsibility.

This involves:
• working safely and within their area of competence
• receiving supervision and guidance on their work as required
• keeping up to date through learning and development agreed with their manager
• being alert to hazards and risks to safety, acting to manage them if safe and appropriate or notifying the relevant senior manager
• following Trust policies, procedures and guidelines so that they can deliver safe and effective services

All health and social care staff working directly with service users and carers are responsible for ensuring that their work is safe and that they use approved systematic clinical and corporate risk assessment and management processes in the delivery of care and treatment.

7. Authority within the Trust to act according to the level of risk

Not all risks can be avoided and there will be, inevitably, a level of identified risk in some areas that is agreed as acceptable. The decision to accept the level of risk will be based on any effect it may have on service provision, financial capacity and the extent to which it can be minimised. Ongoing review and monitoring using the Trust’s governing committee structure will ensure that risks and their management plans remain relevant. See Appendix B for details.

Very Low and Low Risks (Green/Yellow) - are dealt with by responsible managers at different levels within the services but are reported through the Trust governance structure. All managers have the authority for the effective management of risks within their teams, services or departments. They have the authority to assess and manage risks and directly manage risks graded low and very low reporting through their local electronic risk register and their line management structure to the Directorate Governance Group on completion.
**Moderate Risks (Amber)** - require approval of any remedial action by the Directorate Governance Groups. Clinical and service directors have the authority and are accountable for the implementation of remedial action. All risks rated 12 or above are reported to the Executive Directors Group, Board of Directors and Audit Committee. Other Board Committees receive a report of those risks rated 12 or above which are relevant to the work of that committee. Each Group / Board / Committee has the authority to challenge the effectiveness of the controls and/or remedial actions and to request further action from the directors.

**High Risks (Red)** – the Executive Directors Group has the authority to nominate a lead individual to manage each of these risks, reporting progress to them and the relevant Committee or Board on a quarterly basis. The Board of Directors has the ultimate authority for ensuring risks at this level are managed effectively and efficiently and that controls put in place are robust.

8. **Risk Management Tools**

The Trust has developed a number of tools to support staff in the identification, assessment, actions and monitoring arrangements. These are attached at Appendix B (Guidelines) and Appendix C (Risk Register Protocol). These tools are to be used for clinical and non-clinical risk management.

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

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.

The risk assessment and management document that is approved for use within the Trust is the Detailed Risk Assessment and Management plan (DRAM). Other risk assessment tools may be used as required to meet specific needs, e.g. falls risk assessment, suicide risk assessment, MUST (Malnutrition Universal Screening Tool, MRSA screening, prevalence screening, lifestyle assessment (physical health) etc.

The DRAM is available through Insight, the Trust’s service user administration system. They are also available for all staff through the Trust’s intranet.
9. Risk Assessment and Management Processes

Irrespective of the type of risk, whether it is strategic, clinical, financial or environmental, the same risk assessment and management processes apply. The Trust will use the three line of defence methodology in its management of risk (see diagram below).

![Diagram showing three lines of defence: 1st Line of Defence - Operational Management, Internal Controls; 2nd Line of Defence - Risk Management Processes, Compliance; 3rd Line of Defence - Internal Audit, Other External Assurance Providers]

Adapted from 3 Lines of Defence Model – Institute of Risk Management

Risk Assessment

Risk assessments identify the risks facing each part of the organisation and are used in all its activities, including patient care. They provide information on the potential for harm to arise in all areas of the Trust and the methods used to manage or control the risks. They also provide important information to improve the care and treatment of patients and support the future allocation of resources by helping to prioritise service developments.

It is important that the Trust understands its priority risk areas. To do this it is necessary to assess risks from all sources in a consistent manner. The Care Quality Commission’s Essential Standards for Safety and Quality, the Health & Safety Executive and the NHS Litigation Authority Risk Management Standards for Trusts all require a systematic approach to risk assessment.

Good governance, and risk management practice requires:

1. That a formalised risk assessment is carried out by a competent person to determine the significant risks associated with the provision of Trust services. Risk assessments should be completed before any activity commences.
2. Risks to employees, service users and others who may be affected by Trust activities must be considered, then remedial action taken to minimise risk. Special regard must be given to the health and safety of young persons and pregnant women/nursing mothers.

3. **ALL RISKS** must be re-assessed after any significant change occurs e.g. changes in the patient's condition/presentation, the environment, new employees commence, equipment/substances introduced, working practices change or following an incident.

4. Assessment of the possible exposure of service users, employees and the public to specific hazards need to be made under the various regulations including:
   - The Control of Substances Hazardous to Health Regulations 2002 (COSHH)
   - Construction (Design and Management) (Amendment) Regulations 2007
   - The Noise at Work Regulations 2005
   - Equality Act 2010
   - Regulatory Reform (Fire Safety) order 2005
   - Health and Safety (Display Screen Equipment)
   - The Provision and Use of Work Equipment
   - Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)
   - Use of Personal Protective Equipment at Work 2002
   - The Health and Safety (First Aid) Regulations 1981
   - NHS England

In order to rate risks systematically so that they can be classified and remedial action can be prioritised, it is necessary for all significant risks to be assessed and quantified using a standard methodology, by a competent person. Detailed guidance is provided within the Trust’s ‘Guidelines to Identify, Assess, Action and Monitor Risk, attached at Appendix B. The matrices incorporated within this, provide a simple way of assessing, scoring, and rating risk within the Trust. They are used to determine the classification of risk, applying a severity/consequences x likelihood measure which results in a residual risk score/rating being given to the risk, enabling it to be recorded on the appropriate risk register.

**Clinical Risk Assessments**

Clinical (patient, service user, client or resident) risk assessments form part of the effective management of care. The identification and elimination of avoidable risk is a pre-requisite to patient safety. Clinical risk assessments are carried out using the DRAM document. The care coordinator/lead professional/case manager is responsible for ensuring that there is an up to date risk assessment in the service users’ record, and for reviewing the risk assessment when there are changes to their circumstances or health. Risk assessments must be re-assessed after any significant change occurs in respect of the service user’s condition/presentation, or following an incident, e.g. violence and aggression, self-harm etc. Service user risk assessments are reviewed and revised in line with the Acute Care Pathway and Scheduled Care Pathway.
All risk assessments remain valid unless circumstances change, but should be reviewed at least annually.

Risk Assessment & Management Process

10. Risk Register Processes

Clinical risk assessments and their management plans are recorded within the service users’ notes and are updated and managed in accordance with the Scheduled Care Pathway and Acute Care Pathway.

All other identified risks, irrespective of their source, i.e. following a serious incident, litigation claim, external assessment, audits and surveys, financial, as well as direct reporting from teams/service, should be recorded on the appropriate electronic risk register.

All local, directorate and corporate risks are recorded and managed through the electronic Risk Register module (RiskWeb) of the Ulysses Safeguard Risk Management System, which is overseen by the Clinical Governance department but individually managed by departments and directorates. RiskWeb is a single electronic database with sub-sections for each Directorate. Within Directorates, individual teams or departments also have their own local risk registers.

The ‘Risk Register Protocol’ attached at Appendix C provides detailed guidance on the Trust’s Risk Register processes and the use of RiskWeb.
Local department/team/service Risk Registers

Individual teams, departments and services hold their own risk registers to evidence that consideration has been given to the day to day risks, particularly with regard to the generic health and safety risks such as lone working, manual handling, fire safety etc. They are responsible for the continual review and monitoring of their risk register.

Risks which are identified and are assessed as very low or low will be entered onto the local/team risk register and teams are responsible for implementing any required actions. Risks which are deemed high are recorded on the local/team risk registers and, or where there are insufficient controls in place must be escalated to the appropriate directorate risk register, for consideration and identification of further actions.

Directorate Risk Registers

Each directorate will be responsible for holding their own risk register, and the continual review and monitoring of that risk register and ensure their risk register is continuously reviewed and updated. Directorate risk registers are reviewed on a regular basis through the directorate’s local governance structure. They are also reviewed as part of the service review process undertaken with Executive Directors to ensure that they are live, effective, contemporaneous, and meet the NHS Litigation Authority requirements. Where a residual risk is assessed as or above, this will be escalated to the Corporate Risk Register, via the escalation process detailed in Appendix C.

Copies of individual directorate’s risk registers can be extracted from the Ulysses Safeguard Risk Management System, via RiskWeb by the directorates.

Corporate Risk Register

Risks which have a residual risk rating of 12 or above, or risks that impact on several or all directorates, but do not meet the criteria for the Board Assurance Framework, (i.e. they do not threaten the viability of the organisation or the delivery of its strategic objectives) are considered for inclusion onto the Corporate Risk Register, via the Trust’s Corporate Governance team. These risks are managed by the individual directorate(s) with accountable individuals responsible for review and are monitored through their appropriate operational governance group. The Executive Directors Group is responsible for reviewing these risks and allocating responsibility to the appropriate member of the group and the appropriate governance group.

The Corporate Risk Register is reviewed quarterly by the EDG and all Board committees. Any risks with a residual risk rating of 12 or above from the Corporate Risk Register are presented monthly to the Board of Directors meeting. This ensures the Board is fully aware of the risks rated 12 or above within the Trust and provides assurance on the robust processes/controls in place to manage them.
11. Training

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 which is defined in the Knowledge and Skills profile for their job.

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.

Clinical risk 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.

12. Implementation and Communication

Once ratified, this strategy will be launched across the Trust through email, team briefings, the Chief Executive’s letter, Risk Management Update, as well as being published on the Trust’s intranet and internet.

The processes and tools contained within this will be provided to staff through various training programmes, e.g. clinical risk management, health and safety for managers, corporate induction, as outlined in the Trust’s Mandatory Training Policy.

Implementation of this strategy will be monitored by the Director of Corporate Governance through the Quality Assurance Committee and the Audit Committee.

13. Monitoring Compliance and Review

Monitoring of risk and the effectiveness of the Risk Management Strategy is undertaken through:
- Review by Audit Committee every 6 months;
- review of the Strategy by Trust Board annually;
- scrutiny of Trust Board Committee minutes on a quarterly basis;
- internal and external audit activity;
- scrutiny of the assurance framework and risk register by Trust Board quarterly

14. Key Performance Indicators

The key performance indicators against which this strategy will be measured are:
- Numbers of Incidents and Serious incidents reported and trend analysis reviewed by directorates
- Action planning for all moderate and serious incidents occurs and are completed in a timely manner (within 3 months of the incident)
- Local risk registers are updated and reviewed as a minimum on a quarterly basis
- Directorate risk registers are updated and reviewed as a minimum on a quarterly basis
Corporate risk register is continually reviewed and outstanding actions are followed up by the Risk Register Coordinator on a monthly basis

Corporate risk register is reviewed by the Executive Directors Group, Quality Assurance Committee and the Audit Committee on a quarterly basis

Board Assurance Framework is reviewed by the Executive Directors Group and the Audit Committee on a quarterly basis, with the Board of Directors receiving it twice yearly

Training undertaken by staff is adequate for need

Compliance against the Care Quality Commission, NHS Improvement and NHS Litigation Authority standards

15. Links to Other Strategies & Policies

The Trust considers that a risk management approach is the foundation on which all policies are based, and as such, this Strategy links to all Trust policies. There is a strong link to a range of policies including the Incident Reporting Policy, the Complaints Policy.

All Trust policies are available via the Trust website (both intranet and internet). If you require assistance in accessing them, please contact the Corporate Governance Directorate.

16. References

The following are key documents referred to in this strategy:

- An organisation with a memory (Dept. of Health 2000)
- Safety First (Dept. of Health 2006)
- Seven Steps to Patient Safety (National Patient Safety Agency 2006)
- Seven Steps to Patient Safety – mental health version (National Patient Safety Agency 2008)
- High Quality Care for All (Dept. of Health 2008)
- Our Health, Our Care, Our Say (Dept. of Health 2006)
- Best Practice in Managing Risk (Dept. of Health 2007)
- NHS Litigation Authority Risk Management Standards for Acute, Community and Mental Health and Learning Disability Trusts (NHSLA 2012)
- The Care Quality Commission Essential Standards of Quality and Safety

17. Development and Consultation

The Risk Management Strategy was developed by the Head of Clinical Governance, reporting to the Deputy Chief Executive with support from colleagues across the Trust.

Consultation took place across the Trust via directorate structures, and specific consultation took place with the Executive Directors Group, the Operational Delivery Group, the Quality Assurance Committee, the Audit Committee and the Board of Directors.
GUIDELINES TO IDENTIFY, ASSESS, ACTION AND MONITOR RISKS

1. INTRODUCTION

Risk Management covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress. As outline in the Risk Management Strategy, the Trust has a single process for risk management.

In order for the Trust to manage and control the risks it faces, it needs to identify and assess them. This document is a comprehensive step-by-step guide to help staff undertake risk management systematically, and will ensure consistency of approach across the organisation.

For staff/managers that are very familiar with this process, as short version of the Trust’s Risk Rating Matrix is available on the Trust’s intranet page.

2. IDENTIFYING A RISK

There is no unique method for identifying risks. Risks can be identified in a number of ways and from a variety of sources. Risks identification can be both proactive and reactive in nature, and can come from both internal and external sources. The table set out below provides some examples of potential sources for the identification of risks.

<table>
<thead>
<tr>
<th>Reactive Risk Identification</th>
<th>Internal Risk Identification</th>
<th>External Risk Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious incidents</td>
<td>Safety checklists</td>
<td>Patient surveys</td>
</tr>
<tr>
<td>Incident themes</td>
<td>Ward refurbishment planning</td>
<td>Staff surveys</td>
</tr>
<tr>
<td>Near misses</td>
<td>Patient Environmental</td>
<td>External Audit reports</td>
</tr>
<tr>
<td>Complaints</td>
<td>Assessments</td>
<td>Monitor</td>
</tr>
<tr>
<td>Claims</td>
<td>(PLACE)</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Performance Reports</td>
<td>Internal Audit reports</td>
<td>MHA Commission</td>
</tr>
<tr>
<td>Sickness statistics</td>
<td>Staffing</td>
<td>HSE Inspection Reports</td>
</tr>
<tr>
<td>Stress Risk Assessments</td>
<td>Training</td>
<td>Networking and Benchmarking</td>
</tr>
<tr>
<td>Staff turnover/exit</td>
<td></td>
<td>Independent Inquiries</td>
</tr>
<tr>
<td>Interviews</td>
<td></td>
<td>Environmental Health Reports</td>
</tr>
<tr>
<td>Disciplinary/Grievance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. **DESCRIBING THE RISK**

Failure to properly describe the risk is a recognised problem in risk management. Common pitfalls include defining a risk as a statement, or defining the risk as an absence of controls. Consider describing the risk in terms of cause and effect. The table below provides an example of a good and bad risk description.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of staff sickness</td>
<td>x</td>
</tr>
<tr>
<td>Failure to deliver a high quality service due to inability to manage staff sickness effectively</td>
<td>✓</td>
</tr>
</tbody>
</table>

4. **CATEGORISING THE RISK**

All risks must be classified according to their nature. For the purpose of the Risk Register, the Trust has adopted the NPSA risk domains to use as its system of classification. These are:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>The risk has the potential to impact upon the safety of patients, staff or public. The harm may be physical or psychological.</td>
</tr>
<tr>
<td>Quality</td>
<td>The risk is delivering a poorer quality of service. The risk may manifest itself in increased complaints or poor audit results.</td>
</tr>
<tr>
<td>Workforce</td>
<td>Risks associated with human resources, organisational development, staffing issues or competence and training issues.</td>
</tr>
<tr>
<td>Statutory</td>
<td>Risk of non-compliance with a statutory duty or other regulatory/compliance frameworks or inspections, e.g. NHS Improvement, CQC, HSE, HM Coroner.</td>
</tr>
<tr>
<td>Reputational</td>
<td>Risks of damaging/adverse publicity that threatens the confidence of the general public in our services.</td>
</tr>
<tr>
<td>Business</td>
<td>Threats to our business or delivery of projects.</td>
</tr>
<tr>
<td>Finance</td>
<td>Risks to our financial stability including failure to make planned savings, reductions in income, excessive legal claims.</td>
</tr>
<tr>
<td>Environmental</td>
<td>Environmental risks that may result in service/business disruption (e.g. extreme weather, loss of water, loss of power) or threats to the environment from our activities (e.g. chemical spills, clinical waste)</td>
</tr>
</tbody>
</table>

When a risk has been identified as, for example, a ‘safety’ risk, this should be assessed against the safety domain in Table 1 Measures of consequence of the Trust Risk Rating Matrices.

Where a risk may impact on two or more domains, consideration should be given as to whether these should be assessed and recorded separately.
5. ASSESSING THE RISK

Assessing the risk allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

Ideally, risk assessment is an objective process and should be undertaken by someone competent in the risk assessment process, and should involve staff familiar with the activity being addressed.

Risks are assigned a risk rating/score based on a combination of the consequences if the risk is realised, and the likelihood of that risk being realised (to the identified consequences).

The Trust uses two risk score/ratings:

- **Initial Risk Score/Rating**: this is the risk rating/score from an assessment of the risk (consequences x likelihood) before considering any controls.

- **Residual Risk Score/Rating**: this is the risk rating/score from a re-assessment of the risk (consequences x likelihood) after controls have been identified and reviewed for their effectiveness.

- The Residual Risk Rating will determine if any actions are required to be taken.

### Effectiveness of controls

*Only to be taken into consideration when undertaking the residual risk assessment.*

Before establishing the Residual Risk Score/Rating, consideration must first be given to the controls that are already in place to mitigate the risk. The effectiveness of these controls must be recorded as follows:

- **Satisfactory**: Controls are strong, operating properly and providing a reasonable level of assurance that the risk is adequately controlled.

- **Some Weaknesses**: Some control weaknesses/inefficiencies have been identified. Although not considered to present a serious risk, improvements are required to provide reasonable assurance that the desired level of quality is attained.

- **Weak**: Controls do not meet an acceptable standard and do not provide assurance that the identified risk is adequately controlled.

### Scoring the consequences

Use *Table 1 Measures of consequence*, to score the consequence of the risk being realised.

Choose the most appropriate domain from the left hand column of the table, then using the descriptors as a guide, determine which level best describes the realistic consequence/s if the risk is realised.

i.e. 1 = Negligible; 2 = Minor; 3 = Moderate; 4 = Major; 5 = Catastrophic.
Table 1 – Measures of Consequences/Severity

Consequence Scoring – (severity levels) and examples of descriptors

<table>
<thead>
<tr>
<th>SAFETY</th>
<th>Impact on the safety of patients, staff or public (physical/psychological harm)</th>
<th>1 Negligible</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Minimal injury requiring no/minimal intervention or treatment.</td>
<td>• Minor injury or illness, requiring minor intervention</td>
<td>• Moderate injury requiring professional intervention</td>
<td>• Major injury leading to long-term incapacity/disability</td>
<td>• Incident leading to death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No time off work</td>
<td>• Requiring time off work for &gt;3 days</td>
<td>• Requiring time off work for 4-14 days</td>
<td>• Requiring time off work for &gt;14 days</td>
<td>• Multiple permanent injuries or irreversible health effects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Incorrect medication dispensed but not taken</td>
<td>• Increase in length of hospital stay by 1-3 days</td>
<td>• Increase in length of hospital stay by 4-15 days</td>
<td>• Increase in length of hospital stay by &gt;15 days</td>
<td>• An event which impacts on a large number of patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Incident resulting in a bruise/gaze</td>
<td>• Wrong drug or dosage administered, with no adverse effects</td>
<td>• RIDDOR/agency reportable incident</td>
<td>• Mismanagement of patient care with long-term effects</td>
<td>• Unexpected death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Delay in routine transport for patient</td>
<td>• Physical attack, such as pushing, shoving or pinching, causing minor injury</td>
<td>• An event which impacts on a small number of patients</td>
<td>• Wrong drug or dosage administered with adverse effects</td>
<td>• Suicide of a patient known to the service in the past 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expected death</td>
<td>• Self-harm resulting in minor injuries</td>
<td>• Physical attack causing moderate injury</td>
<td>• Physical attack resulting in serious injury</td>
<td>• Homicide (or suspected homicide) committed by a mental health patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing patient (low risk)</td>
<td>• Grade 1 pressure ulcer</td>
<td>• Self-harm requiring medical attention</td>
<td>• Grade 4 pressure ulcer</td>
<td>• Incident leading to paralysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Laceration, sprain, strain and anxiety requiring occupational health counselling (no time off work required)</td>
<td>• Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)</td>
<td>• Healthcare Acquired Infection (HCAI)</td>
<td>• Long-term HCAI</td>
<td>• Incident leading to long-term mental health problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing patient (medium risk)</td>
<td>• Incorrect or inadequate information/communication on transfer of care</td>
<td>• Incorrect or inadequate information/communication on transfer of care</td>
<td>• Slip/fall resulting in injury such as a sprain</td>
<td>• Rape/serious sexual assault</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vehicle carrying patient involved in a road traffic accident</td>
<td>• Vehicle carrying patient involved in a road traffic accident</td>
<td>• Missing patient (high risk)</td>
<td>• Loss of a limb</td>
<td></td>
</tr>
<tr>
<td>QUALITY</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>----</td>
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<td>----</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td><strong>Quality/Complaints/Audits</strong></td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
<td></td>
</tr>
<tr>
<td>• Peripheral element of treatment or service sub-optimal</td>
<td>• Overall treatment or service sub-optimal</td>
<td>• Treatment or service has significantly reduced effectiveness</td>
<td>• Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>• Incident leading to totally unacceptable level of quality of treatment/service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Informal complaint/inquiry</td>
<td>• Formal complaint</td>
<td>• Serious complaint</td>
<td>• Multiple complaints/independent review</td>
<td>• Gross failure of patient safety if findings no acted upon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local Resolution</td>
<td>• Single failure to meet internal standards</td>
<td>• Repeated failure to meet internal standards</td>
<td>• Low performance rating</td>
<td>• Inquest/Ombudsman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minor implications for patient safety if unresolved</td>
<td>• Reduced performance if unresolved</td>
<td>• Local resolution (with potential to go to independent review)</td>
<td>• Critical report</td>
<td>• Inquiry Gross failure to meet national standards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WORKFORCE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Resources/organisational development/staffing/competence</strong></td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
</tr>
<tr>
<td>• Short-term low staffing level that temporarily reduces service quality (&lt;1 day)</td>
<td>• Low staffing level that reduces the service quality</td>
<td>• Late delivery of key objective/service due to lack of staff</td>
<td>• Uncertain delivery of key objective/service due to lack of staff</td>
<td>• Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence</td>
<td></td>
</tr>
<tr>
<td>• Unsafely staffing level or competence (&gt;1 day)</td>
<td>• Unsafe staffing level or competence (&gt;5 days)</td>
<td>• Loss of key staff</td>
<td>• Loss of several key staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low staff morale</td>
<td>• Very low staff morale</td>
<td>• No staff attending mandatory/key training</td>
<td>• No staff attending mandatory training/key training on an ongoing basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STATUTORY</td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>-------</td>
<td>----------</td>
<td>-------</td>
<td>--------------</td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td>• No or minimal impact or breech of guidance/statutory duty</td>
<td>• No or minimal impact or breech of guidance/statutory duty</td>
<td>• Single breach in statutory duty</td>
<td>• Enforcement action</td>
<td>• Multiple breeches in statutory duty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Challenging external recommendations/improvement notice</td>
<td>• Multiple breeches in statutory duty</td>
<td>• Prosecution</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improvement notices</td>
<td>• Complete systems change required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Zero performance rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Severely critical report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPUTATIONAL</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse publicity/reputation</td>
<td>• Rumours</td>
<td>• Local media coverage</td>
<td>• Local media coverage</td>
<td>• National media coverage</td>
<td>• Multiple breeches in statutory duty</td>
</tr>
<tr>
<td></td>
<td>• Potential for public concern</td>
<td>• Short-term reduction in public confidence</td>
<td>• Long-term reduction in public confidence</td>
<td>with &lt;3 days service well below reasonable public expectation</td>
<td>Prosecution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Elements of public expectation not being met</td>
<td></td>
<td></td>
<td>Complete systems change required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Zero performance rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Severely critical report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BUSINESS</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Objectives/Projects</td>
<td>• Insignificant cost increases/schedule slippage</td>
<td>• &lt;5 per cent over project budget</td>
<td>• 5–10 per cent over project budget</td>
<td>• Non-compliance with national 10–25 per cent over project budget</td>
<td>• Incident leading &gt;25 per cent over project budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Schedule slippage</td>
<td>• Schedule slippage</td>
<td>• Schedule slippage</td>
<td>• Schedule slippage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Key objectives not met</td>
<td>Key objectives not met</td>
</tr>
<tr>
<td>FINANCE</td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Finance including claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Small loss</td>
<td>- Risk of claim remote</td>
<td>- Loss of 0.1-0.25% of budget</td>
<td>- Loss of 0.25-0.5% of budget</td>
<td>- Uncertain delivery of key objective/ loss of 0.5-1.0% of budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Claim less than £10,000</td>
<td>- Claims between £10,000 and £100,000</td>
<td>- Claim between 100,000 and £1 million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Vandalism/ theft &lt;£10k</td>
<td>- Vandalism/ theft £10-50k</td>
<td>- Purchasers failing to pay on time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Cosmetic damage to premises</td>
<td></td>
<td>- Vandalism/ theft £50-£100k</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIROMENTAL</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service/business interruption</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Loss/ interruption of &gt;1 hour</td>
<td>- Minimal or no impact on the environment</td>
<td>- Loss/ interruption &gt;8 hours</td>
<td>- Minor impact on environment</td>
<td>- Cosmetic damage to premises</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Major impact on environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Structural damage to premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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b) Scoring the likelihood

Using Table 2 – Likelihood, to score the likelihood of the assessed consequence/s. Use the descriptors as a guide to determine the likelihood score.

I.e. 1 = Rare; 2 = Unlikely; 3 = Possible; 4 = Likely; 5 = Almost
N.B. Remember you are scoring the likelihood of the consequence/s you have determined being realised

Table 2 Likelihood

<table>
<thead>
<tr>
<th>Score/Descriptor</th>
<th>Likelihood</th>
<th>Frequency</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rare</td>
<td>This will probably never happen recur</td>
<td>Not expected to recur for years</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>2 Unlikely</td>
<td>Do not expect it to happen recur but it is possible it may do so</td>
<td>Expected to occur at least annually</td>
<td>0.1 – 1.0%</td>
</tr>
<tr>
<td>3 Possible</td>
<td>Might happen or recur occasionally</td>
<td>Expected to occur at least monthly</td>
<td>1-10%</td>
</tr>
<tr>
<td>4 Likely</td>
<td>Will probably happen/recur possibly</td>
<td>Expected to occur at least weekly</td>
<td>10 – 50%</td>
</tr>
<tr>
<td>5 Almost certain</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
<td>Expected to occur at least daily</td>
<td>&gt;50%</td>
</tr>
</tbody>
</table>

c) Scoring/Rating the risk

Calculate the risk score by multiplying the consequence score by the likelihood to determine your risk rating score using Table 3 – Risk Rating.

It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the overall rating/score.

Table 3 Risk Score

<table>
<thead>
<tr>
<th>SEVERITY SCORE</th>
<th>LIKELIHOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Rare</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
</tr>
<tr>
<td>4 Major</td>
<td>4</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 4 Risk Rating below determines the overall Risk Rating given to the risk based on the scores from Table 3 Risk Score

Table 4 Risk Rating

<table>
<thead>
<tr>
<th>1-4</th>
<th>Very low</th>
<th>5-8</th>
<th>Low</th>
<th>9-12</th>
<th>Moderate</th>
<th>15-25</th>
<th>High</th>
</tr>
</thead>
</table>

**d) Risk Management Plan (Actions)**

Any risk management plan to control the residual risk must be devised and written down in an action plan format with SMART actions (Specific, Measurable, Achievable, Realistic, Timely), a named person and timescales should be allocated for each action.

It is essential that the plan to manage the risk is shared with everyone who needs to know about it, or is affected by it. With clinical risks, this will usually include service users and carers. A plan will not be effective if the people charged with implementing it do not know about it.

**5. RECORDING, MONITORING AND REVIEW**

All identified risks are recorded on the Trust’s electronic risk management module – Risk Web which can be accessed by appropriate individuals.

It is important that there is a system in place to regularly monitor and review these risks, therefore the table below sets out the response and frequency of review expected based on the Residual Risk Rating.

<table>
<thead>
<tr>
<th>RESIDUAL RISK:</th>
<th>RESPONSE REQUIRED</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score Rating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 Very Low</td>
<td>Remains on local risk register for monitoring</td>
<td>Bi-annually</td>
</tr>
<tr>
<td>5-8 Low</td>
<td>Remains on local risk register with local level actions identified where possible to reduce the risk as low as is reasonably practicable.</td>
<td>Bi-annually</td>
</tr>
<tr>
<td>9-12 Moderate</td>
<td>Actions must be identified and risk must be escalated to next level for consideration on to next level’s risk register. Escalated via usual weekly reports.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>15-25 High</td>
<td>Actions must be identified and risk must be immediately escalated to next level. Escalated via direct notifications to appropriate individuals.</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
**RISK REGISTER PROTOCOL**

**CONTENTS**

1. Introduction
2. Levels of Risk Register
3. RiskWeb
4. Escalating Risks
5. Duties, Roles and Responsibilities
6. Training
7. Appendices
   - Appendix 1 – User Guide for RiskWeb
   - Appendix 2 – Risk Register Escalation/De-escalation Flow Chart
1. **Introduction**

This protocol supports the implementation of the Trust’s Risk Management Strategy. It outlines how risks should be recorded and managed and clarifies roles and responsibilities at all levels in the organisation, and should be read in conjunction with the Risk Management Strategy.

The Trust Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk.

One element of this is through the risk register; a risk register is a log of all kinds of risks that can threaten the Trust’s success in achieving its aims and objectives. Risk registers should operate at all levels within the Trust at ward/department/team level, major projects and programmes, directorate level and corporate level. They are designed to be ‘live’ working documents which are populated through the Trust’s risk assessment and evaluation process.

Risks are managed through 4 key steps:
- Identification
- Assessment
- Action
- Monitoring

The Trust uses the electronic Ulysses Safeguard Risk Management System – RiskWeb, to collate and manage risk registers at all levels within the Trust.

2. **Levels of Risk Register**

Within the Trust there are 3 main levels of risk register:

- **Team Level**
  The Team Level Risk Register is made up of risks identified at local team/ward/department level and is reviewed and maintained through local team governance meetings.

  Risks requiring action outside of the remit of the local team are referred to the Nominated Directorate Link/s for consideration for the directorate risk register.

- **Directorate Level**
  These are risks identified at directorate level informed by both operational and governance related issues, and may include risks escalated from team level risk registers.

  It is reviewed on a quarterly basis at the relevant directorate governance meeting and a record kept.

  Risks requiring action outside of the remit of the directorate are referred to the Executive Director’s Group (via the Trust’s Risk Register Coordinator) for consideration to be included onto the corporate risk register.
**Corporate Level**

These are risks contained within the corporate risk register, rated 12 or above that may impact on several or all directorates or the Trust achieving its objectives, but do not meet the criteria for the Board Assurance Framework. They may include risks escalated from directorate level risk registers.

Each corporate level risk will have an allocated member of the Executive Director’s Group who will be responsible for the overall management. The Corporate Risk Register is reviewed on a quarterly basis by the Executive Director’s Group, the Quality & Assurance Committee, and the Audit Committee. The highest of these risks, i.e. all risks with a residual risk score/rating of 12 or above are reviewed by the Board of Directors on a monthly basis.

‘Figure 1 below shows an example of the hierarchy of risk registers

<table>
<thead>
<tr>
<th>Risk Register</th>
<th>Where reviewed</th>
<th>Frequency of review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate (12 or above)</td>
<td>Board of Directors</td>
<td>Monthly</td>
</tr>
<tr>
<td>Corporate (all)</td>
<td>Executive Directors Group Relevant Board Committees’</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Directorate</td>
<td>Directorate Governance</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Team</td>
<td>Team Governance</td>
<td>Bi-Annually</td>
</tr>
</tbody>
</table>
3. **RiskWeb**

Risks should be identified, assessed and managed in line with Appendix B of the Trust’s Risk Management Strategy – Guidelines to Identify, Assess, Action and Monitor Risks.

All risks will be recorded and managed via the Trust’s electronic risk management system – RiskWeb. Detailed guidance on the use of RiskWeb is attached at Appendix 1 of this protocol and is available on the Trust’s Intranet.

All risk registers will contain the following:

<table>
<thead>
<tr>
<th>Risk Number</th>
<th>A unique identifier auto generated by the RiskWeb system.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>When the risk was first identified/date of most recent significant change requiring new version.</td>
</tr>
<tr>
<td>Risk Level</td>
<td>This is the level the risk is currently being managed at.</td>
</tr>
<tr>
<td>Type of Risk</td>
<td>This is the classification of the risk</td>
</tr>
<tr>
<td>Risk Source</td>
<td>How/Where the risk has been identified – e.g. incident, claim, risk assessment.</td>
</tr>
<tr>
<td>Risk Description</td>
<td>A description of the cause and effect</td>
</tr>
<tr>
<td>Initial Risk</td>
<td>The risk score/rating given from an assessment of the risk (consequences x likelihood) before consideration of existing controls.</td>
</tr>
<tr>
<td>Score/Rating</td>
<td></td>
</tr>
<tr>
<td>Controls</td>
<td>What already exists and is in place to control the risk, e.g. training, policy. Only include controls already in place – a plan is not a control.</td>
</tr>
<tr>
<td>Residual Risk Score/Rating</td>
<td>The risk score/rating from a re-assessment of the risk (consequences x likelihood) after controls have been identified and reviewed for effectiveness.</td>
</tr>
<tr>
<td>Actions</td>
<td>Planned actions to further reduce or eliminate the risk. Once complete, actions may become controls.</td>
</tr>
<tr>
<td>Risk Assessor</td>
<td>The person who undertakes the assessment</td>
</tr>
<tr>
<td>Risk Owner</td>
<td>The person responsible for auctioning and managing the risk</td>
</tr>
<tr>
<td>Review Frequency</td>
<td>How often the risk will be reviewed</td>
</tr>
</tbody>
</table>
Reviewing and Updating Risks

In addition to the expected review frequency of the different levels of risk registers detailed above, all identified risks on team, directorate, and corporate risk registers must be regularly monitored, reviewed and updated via the RiskWeb system.

The table below sets out the expected frequency of review dependent upon the individual risk’s Residual Risk Score/Rating. All reviews, and their detail, should be recorded against each individual risk on the RiskWeb system.

<table>
<thead>
<tr>
<th>Residual Risk Score/Rating</th>
<th>Review Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low (1-4)</td>
<td>Bi-annually</td>
</tr>
<tr>
<td>Low (5-8)</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Moderate (9-12)</td>
<td>Monthly</td>
</tr>
<tr>
<td>High (15-25)</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

Where significant updates are required to be made to an individual risk, e.g. to the risk score/rating, the risk description - a new version of the risk must be created.

When significant changes are made, e.g. to an environment, the delivery of a service, this should trigger a review of the whole risk register for that area.

4. Escalating Risks

Risks can be escalated up to the next level within the Trust as and when it is deemed necessary. However, any risks with a residual risk score/rating of Moderate must be escalated (with rationale for the escalation) and be considered for inclusion onto the next level risk register.

Team Level to Directorate Level

Where a team risk has been escalated upwards to the directorate, rationale must be provided for the escalation and the escalated risk must be discussed at the relevant directorate governance meeting.

Example 1

A risk of a team receiving a financial fine may have a significant impact upon the team’s budget, and may be rated moderate or high. This is then escalated to the directorate Nominated Link and considered at directorate governance level.

It is agreed that as this is not considered to impact overall on the directorate budget, it will not be added to the directorate risk register.

Where it is agreed that the escalated risk should be included on the directorate’s risk register, the risk will not be transferred upwards, instead the directorate will record their own risk and undertake their own risk assessment.
Example 2

A significant ligature risk has been identified on a ward and escalated to the directorate Nominated Link for consideration at directorate governance level.

It is agreed that this risk is relevant to all wards and therefore added onto the directorate risk register.

If the risk (or a similar risk) is already recorded on the directorate’s risk register, a new version of that risk must be created to reflect the current status and assessed again.

Example 3

A risk relating to medical staff vacancies for Team 1 is already on the directorate’s risk register. A similar risk is escalated from Team 2 and from Team 3 for consideration at directorate governance level.

It is agreed that these risks are appropriate for the directorate risk register, and therefore a new version of that risk is created to incorporate Team 2 and Team 3, and re-assessed.

If the residual risk score/rating for the new directorate risk remains at Moderate or above (9+) the risk must be escalated again (i.e. to Corporate level)

Directorate Level to Corporate Level

Where a directorate risk has been escalated upwards to the corporate risk register it must be discussed at EDG. Where it is agreed that the risk should be included onto the corporate risk register, the risk will not be transferred upwards, instead a separate record of the risk and assessment will be entered onto RiskWeb.

The same risk may have a different risk score/rating at each level:

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Risk Description</th>
<th>Risk Score/Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team – Escalated</td>
<td>Team 1 inability to achieve cost improvement programme for 2016/17.</td>
<td>16 High</td>
</tr>
<tr>
<td>Directorate – Escalated</td>
<td>Team 1’s inability to achieve cost improvement programme will impact on directorate’s financial performance.</td>
<td>12 Moderate</td>
</tr>
<tr>
<td>Corporate</td>
<td>Potential for directorate 1 not achieving CIP may impact on overall Trust forecast.</td>
<td>8 Low</td>
</tr>
</tbody>
</table>

A flow chart detailing the escalation and de-escalation process for risks is attached at Appendix 2 of this protocol.
5. Duties, roles and responsibilities

All staff
The underpinning principle is that the management of risk is the business of everyone within the Trust. All staff must ensure that any identified risks that cannot be eliminated are reported to their immediate line manager for consideration of inclusion on the team’s risk register via Risk Web.

Managers
Managers are responsible for ensuring risks are recorded and managed effectively under their area of responsibility, and escalated where appropriate. They must maintain an up to date and live risk register on RiskWeb, so that they can demonstrate they have considered risks both reactively and proactively and that they have effective plans in place to control these. Managers should ensure the risk register is regularly reviewed at the relevant team governance meeting. Guidance for managers on recording and managing risks on Risk Web is attached at Appendix 1 of this protocol.

Nominated Directorate Link/s
The Nominated Directorate Link/s is the person identified within a directorate who will oversee the administrative process of managing risks on RiskWeb. They will have the necessary authority to ensure that risks in their directorate/area of responsibility are reviewed and updated regularly, processes for approving/rejecting escalated risks are followed, and where further escalation is necessary, this happens in a timely manner. Guidance for Nominated Directorate Links on recording and managing risks on RiskWeb is attached at Appendix 1 of this protocol.

Clinical Governance department
The Trust’s Clinical Governance department is responsible for the overall management and of the RiskWeb module. In conjunction with the Nominated Directorate Link/s and Managers, the Clinical Governance department ensures processes are followed and risks are kept updated.

They will provide support to the Corporate Governance department in relation to the management of the Corporate Risk Register.

They are also responsible for providing advice, support, and guidance in relation to risk registers, consistency checking and for ensuring action plans are carried out in a timely manner.

Corporate Governance department
The Corporate Governance department is responsible for providing the Corporate Risk Register and the Moderate and High level risks to the relevant Trust committees in line with the monitoring frequency set out in this protocol.
6. **Training**

Training for the use of RiskWeb will be provided to the Nominated Directorate Link/s from July 2016 and for Managers from August 2016, and will continue on an ad hoc basis as and when required.

The Clinical Governance department will continue to provide guidance and necessary training in relation to identifying and recording risk assessments, and risk analysis.
CONTENTS

1. Accessing RiskWeb
2. Viewing your risks
3. Adding a new risk
4. Action Plans
5. Risk reviews and updates
6. New versions
7. Notifications
8. Escalating and de-escalating risks
9. Closing a risk
10. Risk register reports
Accessing RiskWeb

Only authorised persons, i.e. persons responsible for managing/maintaining a risk register, are able to access RiskWeb.

To access Risk Web, double click on the link to E-Incident Login shown on your desktop.

Once you’ve signed in under your usual computer login, click on ‘Risk Register’ under ‘Quick
1. Viewing your risks

Risks that you are authorised to view/amend can be viewed in a number of different ways. There are 3 main filters:

- All Open Risks - shows all risks you have access to where the current status is ‘Open’
- All Closed Risks – shows all risks you have access to where the current status is ‘Closed’
- All Risks – shows all risks you have access to

Risks can then be grouped in different ways using the drop down under ‘Group’. The main groups are:

- Department (if you have access to more than one department)
- Directorate (if you have access to more than one directorate)
- Risk Level
- Risk Rate (this is the residual risk rate/score)
- Type of Risk
Clicking on the + allows you to drill down to an individual risk, which is displayed on the right hand side when selected/highlighted. You can then amend/update/review this risk as necessary.

2. Adding a new risk

To add a new risk click ‘Add’ and select the appropriate level and click ‘Open’.
- When adding a new team risk this should be ‘Team Level’
- When adding a new directorate risk this should be ‘Directorate Level’
The following risk form will open up:

**DETAILS OF THE RISK:**
- **Risk Number** - is generated automatically upon saving the risk.
- **Risk Level** – will show what you selected in the previous step.
- **Date identified** – will default to today’s date; this can be amended by clicking on the calendar.

**LOCATION OF THE RISK:**
- **Site/Department** – select the site and/or department that the risk relates to.
- **Directorate** – select the directorate your department belongs to.
**WHAT IS THE RISK ABOUT:**
This section is where the risk is categorised and described

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td>Reputational</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td>Statutory</td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
</tr>
</tbody>
</table>

- **Type of Risk:** Select from the drop down menu the most appropriate

- **Source:** Select from the drop down menu where/how the risk was identified

- **Risk Description:** Enter a description of the risk

Clicking on these ?Help buttons that appear throughout will open up additional guidance/help and link you to relevant

**- Risk Description:** Enter a description of the risk
- Assessor: This is the person who has undertaken the risk assessment

Type the surname then first name - the name will auto appear in a drop down for you to select

- Manager/Owner: This is the person responsible for managing and acting on the risk. This may be the same as the Assessor

**INITIAL RISK ASSESSMENT** (without considering existing controls)
Using the Trust’s Risk Rating Matrix double click on the appropriate severity x likelihood in the table

**SAVE**: The risk must now be saved before controls can be added. Simply click the ‘Save’ button at the top of the form.
**ADDING CONTROLS**
- Click ‘New’ to add a control. Each control should be added separately

A separate box will pop up. Enter the details of the control and click

The controls added will show as a list. To edit a control, double click on the control. Once all controls have been entered, select how effective the controls are from the drop down.

**RESIDUAL RISK ASSESSMENT** (considering existing controls)
Using the Trust’s Risk Rating Matrix double click on the appropriate severity x likelihood in the table, taking into account the existing controls you have listed above and their
4. Action plans

Actions must be identified for any risks with a residual risk score/rating of 9 Moderate and above

Click ‘New’ to add an

All actions already entered are shown as a list. To edit/update an action already listed select the relevant action and click ‘Edit’

Described the action to be taken

Select person responsible by entering surname then first name and selecting from the

Enter target date for completion

Click ‘Save’
To edit/update an action:

The action, responsible person, and target date for completion are shown here and can be edited.

All previous progress with date entered is shown here.

Enter any new progress.

If completed, enter date of completion.

Click ‘Save’.

5. Risk reviews and updates

When a new risk is added to RiskWeb, the frequency it will be reviewed must be selected in line with Trust’s Risk Register Protocol. A new review must be added each time the risk is updated or reviewed without change.

Click ‘New’ to add a new review.

When adding a risk, select the frequency of review from the drop down list here.

A list of previous reviews and the details are shown here as a...
Enter the date the risk was

Select person who undertook the review by entering surname then first name and selecting from the list

Enter the details of the review. This must include what changes (if any) have been made. E.g. Controls and actions reviewed at team governance—no change

6. New Versions

When significant changes are made to a risk e.g. to the risk score/rating or to the risk description, a new version of the risk must be created. This enables you to be able to look at changes in the risk over time by viewing previous versions.

N.B. The system will not allow you to alter the risk scores/ratings or the risk level without creating a new version of the risk.

To create a new version of the risk click

A pop up will appear asking you to confirm. Click ‘OK’

You can then continue to make the necessary changes, ensuring you update the review section and save the form once you’ve finished.
Clicking on the + allows you to view all previous versions of the risk.

7. Notifications

To notify another person of a risk, select ‘New’ or ‘Add Notify’. N.B. Each person must be notified separately.

Enter any text that you wish to be included in the email notification.

Select the person you wish to send the notification email to by entering surname then first name and selecting from the list.

Click ‘Save’ once finished to send the notification.
8. Escalating and de-escalating risks

Escalating

Any risks that are not able to be managed at the identified level can be escalated to the next level as appropriate. However, any risk with a residual risk rating/score of 9 Moderate or above, MUST be escalated to the next level.

To escalate a risk, select the appropriate ‘escalated’ level (i.e. the level you are escalating the risk from) from the drop down.

You will then be requested to enter a reason for the escalation

Select the relevant Assessor and Manager/Owner of the Risk by typing surname followed by first name and selecting from the drop down. This may remain the same as the previous.

De-escalating

When it considered that a risk should no longer be included within the next level’s risk register, that risk should be closed. The Risk Level of the original risk that was escalated should be amended to reflect that it is no longer an ‘escalated’ risk and rationale provided. This is done following the same process as above.
9. Closing a risk

When closing a risk, ensure the risk has been updated and reviews entered prior to closing.

To close a risk simply select ‘Closed’ from the current status drop

This will trigger two fields for completion as

DON’T FORGET TO ‘SAVE’ AT THE TOP

10. Reports

To access reports you can click on the ‘Menu’ in the top left hand corner of your screen OR use the ‘Quick Links’ on the homepage screen and select ‘Reports’
You will see a list of reports you are able to run from the Risk system.

Double click on the relevant report.

A pop up will appear, which describes the report. N.B. If you work across more than one directorate/department, you may be prompted to select from a drop down the relevant directorate/department’s report you wish.

Select ‘Report Output’ PDF. Also allows you to enter a password to protect the report if required.

Click ‘Next’.

A pop up will appear asking when you wish to schedule the report for.

To run the report straight away, click ‘Run Now’ followed by ‘Run Report’.
To schedule the report for the future and/or to repeat click ‘Schedule’ and completed the scheduling fields followed by ‘Run Report’

To email the report. Tick ‘Email?’ and enter email address, file name (name for report attachment), subject and any email message, followed by ‘Run Report’

The following pop up will appear. Click ‘OK’

The report will show as running here, and once completed you can double click on it and you will be asked if you wish to open or save the report.
RISK REGISTER: ESCALATION / DE-ESCALATION PROCESS

APPENDIX C2

Risk identified at Team Level

- Residual Risk Grading Score = 1-8 (Very Low; Low)
  - Risk to be managed, reviewed and monitored at local/team governance level
  - De-escalate back to Team level with rationale

- Residual Risk Grading Score = 9-25 (Moderate; High)
  - Escalate to Directorate Link for discussion at relevant Directorate Governance meeting

YES

Decision to add to directorate risk register

NO

Risk identified/added at Directorate Level

- Residual Risk Grading Score = 1-8 (Very Low; Low)
  - Risk to be managed, reviewed and monitored via directorate governance meeting
  - De-escalate back to Directorate level with rationale

- Residual Risk Grading Score = 9-25 (Moderate; High)
  - Escalate to Corporate Governance department for discussion at EDG

YES

Decision to add to corporate risk register

NO

Risk identified/added at Corporate Level

- All Risks on Corporate Risk Register monitored quarterly at EDG
- All Corporate Risks with a Moderate and High Residual Risk Rating added to Moderate and High level report and monitored monthly at EDG and Board
## Equality Impact Assessment Form

<table>
<thead>
<tr>
<th></th>
<th>Details</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>Do not know</td>
<td>reported by gender, age and ethnicity so that this question can be assessed</td>
</tr>
<tr>
<td>3</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td>But the strategy needs to be accessible to all service users and carers</td>
</tr>
<tr>
<td>5</td>
<td>If so can the impact be avoided?</td>
<td></td>
<td>A simplified user friendly pictorial version of the strategy will be developed so that it is more accessible to people with learning disabilities or literacy problems</td>
</tr>
<tr>
<td>6</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>None identified</td>
<td>Safety is a priority for the Trust. The strategy is a requirement of the NHSLA risk management standards</td>
</tr>
<tr>
<td>7</td>
<td>Can we reduce the impact by taking different action?</td>
<td></td>
<td>The strategy will also be disseminated via presentations which will strive to be as widely accessible as possible</td>
</tr>
</tbody>
</table>

There are no Human Rights Act implications for this Strategy which follows Department of Health policy guidance.