RUH

Royal United Hospital Bath NHS
NHS Trust

Strategic Framework for Risk Management

Reference Number:	210
Author & Title:	Alexandra Lucas Head of Risk and Assurance
Responsible Director:	Director of Nursing
Review Date:	February 2014
Ratified by:	Trust Board
Date Ratified:	February 2014
Version:	6.2

Related Policies	• Incident Reporting and Management Policy and Procedure; including the management of Serious Untoward Incidents • Major Incident Policy • Control of Infection Strategy • Information Management Policy • Complaints Policy and Procedure • Policy and Procedure for the Management of Claims • Health and Safety Policy • Raising Serious Concerns (Whistleblowing) Policy & Procedure

Index:

Summary diagram *4*

The Risk Management Strategy *6*

1. Introduction *6*

2. Objectives for Managing Risk *6*

3. Definitions *7*

3.1 Risk **7**

3.2 Risk Management **7**

3.3 The Trust-wide Risk Register **8**

3.4 The Board Assurance Framework **8**

3.5 Acceptable risk **8**

3.6 Tolerable risk **9**

3.7 Significant risk **9**

3.8 Extreme risk **9**

3.9 Residual risk **9**

3.10 Fair blame **9**

4. Risk Appetite *10*

5. The Board Assurance Framework *10*

6. Requirements *11*

6.1 Legislation **11**

6.2 Care Quality Commission **12**

6.3 NHS Litigation Authority **12**

6.4 Her Majesty's Treasury **12**

6.5 Health & Safety Executive **12**

6.6 Statutory Statement on Internal Control **12**

7. Monitoring through External Standards *13*

8. Monitoring compliance *13*

9. References *13*

10. Bibliography *14*

Risk Management Policy *15*

11. Policy Statement *15*

12. Roles and Responsibilities *15*

12.1 Role responsibilities **15**

12.2 Committee Responsibilities **20**

13. Education and Training 25
14. The Risk Management Process 27
14.1 Assessment 27
14.2 Managing the risk 28
14.3 Monitoring, review and updating 28
14.4 Completion 29
15. Acceptable Levels of Authority for Resolving Risks 30
16. Risk Management and the Trust Planning Process 31
17. Projects and Strategic Policy Decisions 32
Appendix 1: Consultation Schedule 34
Appendix 2: Governance Framework 35
Appendix 3: Risk assessment matrix 36
Appendix 4: Easy steps to the risk assessment process 40
Document Control Information 45
Ratification Assurance Statement 45
Equality Impact: (A) Assessment Screening 46

Amendment History

Issue	Status	Date	Reason for Change	Authorised
5	Approved	October 2011	Planned Review	Trust Board
6	Approved	20 December 2012	Planned Review	Francesca Thompson Director of Nursing

Summary diagram

What?	Who?	How?
Risk identification	All	• Observation • Incident reporting • Business planning • Project planning • External assessment/recommendation
▼		
Risk assessment	Line manager or nominated individual/lead	Using guidance in Appendix 4 and scoring with the use of the matrix in Appendix 3
▼		
Action plan development	Line manager	Using guidance in Appendix 4 and scoring with the use of the matrix in Appendix 3
▼		
Approval of the risk assessment and action plan	Line manager/Project Board (risk score 1-4) Specialty/Service Management Group (risk score 5-9) Divisional Board / Project Board (risk score ≥ 10) Management Board (risk score ≥ 16)	Documented review and agreement of the risk assessment & proposed action plan. Any amendment to be communicated to the risk 'owner'.
▼		
Inclusion on the Trust-wide Risk Register (Datix)	Risk 'owner'/manager/Project Board lead	Following completion of a risk assessment with an action plan, or equivalent information
▼		
Approval of risk entry on The Risk Register	Head of Risk & Assurance/Directorate Manager/Director	In Datix, following confirmation of Divisional/Directorate/Specialty approval (dependent upon score)
▼		
Risk Assessment and action plan Organisational monitoring	Ward/Department (risk score 1-4) Specialty manager (risk score 5-9) Divisional Board (risk score 10 -15) Management Board (risk score ≥ 16)	Review and updating of the Risk Register entry in datix
▼		
Assessment of appropriate action for significant risks	Trust Board	Following review of the relevant entries on The Risk Register
▼		
Agreeing closure of Risk Register entry	Ward/Department Manager (initial risk score 1-4) Divisional/Directorate management Board (initial risk score 10-15) Management Board (risk score ≥16)	Direct to The Risk Register in Datix, following review of the identified risk & **confirmed completion of the action plan.**

▼

Communication back to risk owner	Divisional/Directorate/Specialty Manager	Agreed internal communication process.

▼

Updating of The Risk Register	risk 'owner/'Head of Risk & Assurance	Direct to The Risk Register on Datix, following formal notification from the relevant management meeting

The Risk Management Strategy

1. Introduction

The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing the Board with assurance on the framework for clinical, non-clinical and corporate governance.

Failure to implement effective risk management processes could severely impact on the Trust's reputation and services, resulting in serious financial consequences.

The Trust Board recognises that complete risk control/avoidance is impossible, but that risks can be minimised by making sound judgements from a range of fully identified options.

This document and related policies clearly set out the processes by which all risks are identified and controlled, including the roles and responsibilities from the individual employee up to Trust Board.

2. Objectives for Managing Risk

The Risk Management Strategy aims to deliver a pragmatic and effective multidisciplinary approach to Risk Management, which is underpinned by a clear accountability structure from Board to Practitioner level. It recognises the need for robust systems and processes to support continuous programmes of Risk Management, enabling staff to integrate Risk Management into their daily activities, wherever possible and support better decision making through a good understanding of risks and their likely impact.

The primary objective of the strategy is to identify and manage the risks that may prevent the achievement of Trust objectives.

The key objectives of the risk management strategy are:

- Develop a culture where risk management is integrated into all Trust business;
- Ensure appropriate structures are in place to manage risks with clear escalation levels and processes;
- Create a system which is user friendly and allows the prompt assessment and mitigation of risk;
- Clearly describe the risk appetite of the organisation;

- Reduce risks to patients, carers, staff, sub contractors, members of the public, visitors, etc., to an acceptable level;
- Maximise resources available for patient services and care;
- Minimise financial liability;
- Prioritise risk management action plans;
- Embed risk management throughout the Trust, in support of integrated governance;
- Provide a system which integrates into the planning and performance management frameworks to minimise duplication whilst adding value.

Effective risk management requires the organisation to understand the risks to which it is exposed and make decisions on their management in an informed and proactive manner.

Risk Management is the job of management and is not different from or separate to the job of management. Effective risk management requires the organisation to understand the risks to which it is exposed and make decisions on their management in an informed, proactive manner.

Effective risk management supports better planning and enables the Trust and its senior managers to take risks with increasing confidence. With the result that:

- Adverse (damaging) events are less likely;
- Capital and resources are utilised more efficiently and Adverse (damaging) events are less likely;
- Costly re-work and fire-fighting is reduced;
- Achievement of objectives is more likely;
- Quality of service is improved.

3. Definitions

3.1 Risk

Risk is defined as an uncertain event or set of events which, should it occur, will have an effect on the achievement of objectives.

3.2 Risk Management

Risk Management the term applied to a logical and systematic application of principles for identifying, analysing, evaluating, reducing and/or controlling the risks associated within an activity, function or process. The risk management process should be a key approach to improving the quality and safety of care for patients, clients and others affected by the activities of the Trust, offering a practical means of

enhancing the safety of services, reducing the potential for systems failing and minimising the effects of risk when things go wrong.

3.3 The Trust-wide Risk Register

The Risk Register can be described as “a log of all the risks that may threaten the success of the Trust in achieving its declared aims and objectives”. It will operate at both a local and organisational level and will include Board Assurance Framework managed risks.

The Risk Register is the principle tool that the Trust will use for managing its risk assessment systems and processes will be the organisations risk register.

3.4 The Board Assurance Framework

The Board Assurance Framework is a high level management assessment process and record of the primary risks relating to the delivery of strategic objectives and the strength of internal control to prevent risks occurring. It identifies sources of control and assurance and evaluates them for suitability. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be confirmed or modified.

3.5 Acceptable risk

The term describes the likelihood of an event whose probability of occurrence is small, whose consequences are so slight, or whose benefits (perceived or real) are so great, that individuals or groups in society are willing to take or be subjected to the risk that the event might occur.

The Trust classifies risks according to a risk classification matrix (Appendix 3), which allocates a colour to indicate the level of risk associated with a hazard (green = very low, yellow = low, orange = medium, red = high or extreme). Risks are considered in relation to all staff, patients and public.

The Trust considers a risk to be acceptable when there are adequate control measures in place and the risk has been managed as far as is considered reasonably practicable.

Risks falling in the green ‘insignificant’ risk category are considered ‘acceptable’, although the Trust will still need to take action on these risks where the assessment has identified that risks can be easily minimised.

3.6 Tolerable risk

Tolerable risks are those from activities that people are prepared to live with, in order to secure benefits and in the confidence that the risk is being properly controlled.

The Trust regards tolerable risks as those falling within the yellow 'low' and orange 'medium' risk categories (Appendix 3).

3.7 Significant risk

A significant risk is one that requires action in the short to mid term to reduce the likelihood of harm.

The Trust regards risks that fall into the red 'high' category as significant and actions to control the risk must be taken, as identified in Appendix 3.

All significant risks must be notified to the Head of Risk & Assurance immediately.

3.8 Extreme risk

The Trust regards risks that fall into the red, 'extreme' category as unacceptable. Therefore, the identified activity must be stopped immediately until mitigating action is taken to reduce the risk.

All extreme risks must be notified to the Head of Risk & Assurance immediately.

3.9 Residual risk

The risk remaining following treatment.

3.10 Fair blame

Fair Blame is a term often used in conjunction with reporting of adverse events. The organisation can learn many important lessons through an open approach, which would not otherwise be learned where blame is apportioned or staff feel under threat through incident reporting or the identification of risk. The Trust promotes a just, fair and responsible culture that fosters learning and improvement, whilst encouraging accountability. It is the intention of the Trust that all staff must feel able to raise issues of concern.

Where there is an individual or corporate responsibility, there is necessarily an associated expectation for the responsible person, clinician or manager to be held to account for the delivery or non-delivery of that responsibility. While the organisation understands the day to day pressures of operational management, the Board supports

the identification of risks and it is essential that line managers are aware of the need to highlight identified risks and the required mitigating actions up through the organisational chain of accountability.

4. Risk Appetite

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

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

The Trust has defined that an acceptable risk is one which falls in the green 'insignificant' risk category. This statement, in conjunction with the matrix in Appendix 3, defines the risk appetite for the Trust. Risk appetite covers all areas of business and is easier to quantify in financial terms. Therefore based on the information in Appendix 3 the Risk Appetite for the Trust can be quantified as:

> 'The Trust is willing to risk the collective loss of budget of up to 0.25% of the total annual budget to achieve the Trust's Objectives. This equates to approximately £525,000.'

Risk appetite can also be described in less quantifiable terms, for example in relation to reputation and publicity. The Trust's appetite in relation to reputation is to minimise the possibility of any negative publicity to a level which only has a local, short duration impact.

5. The Board Assurance Framework

All NHS Trust are required to create and maintain a Board Assurance Framework (BAF). The Board Assurance Framework:

- Is a high level management assessment process and record of the primary risks relating to the delivery of strategic objectives and the strength of internal control to prevent risks occurring;
- Identifies sources of control and assurance and evaluates them for suitability. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be confirmed or modified.

The Assurance Framework must remain focused on upon strategic objectives and risks. The Board Assurance Framework will undergo a quarterly review at Board level and will be updated on a six-monthly cycle.

The BAF provides direct evidence to support the Chief Executive's annual Statement on Internal Control.

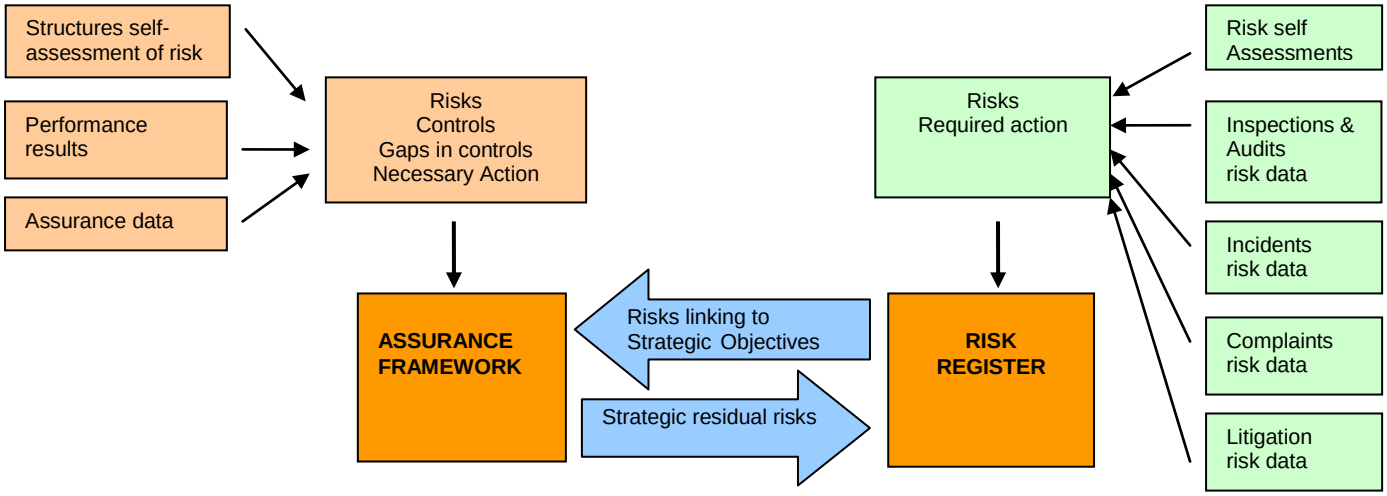


Figure 1. Information flows between the risk register & the assurance framework

6. Requirements

6.1 Legislation

The Trust has a statutory responsibility under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to 'evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment'. This statutory requirement extends to patients, visitors, volunteers and others and is discharged through current Trust approved policies.

Under the Management of Health and Safety at Work Regulations 1992 (Amended 1999), supplementary to the Health and Safety at Work etc Act 1974, employers are required to implement systems with which to identify, assess and minimise risks within the workplace and to provide employees with "comprehensible and relevant information on the risks they face and the preventative and protective measures that control those risks" and to "have effective arrangements in place for planning, organising, controlling, monitoring and reviewing preventative and protective measures".

Sections 2 and 3 of the Health and Safety at Work etc. Act 1974 place the responsibility for ensuring the health and safety of workers and for reducing risks to others affected by work activities (e.g. patients and other members of the public) upon employers, who are required to prepare and to make sure staff know about a written statement of all

relevant health and safety policy and the arrangements in place to put it into effect.

6.2 Care Quality Commission

From compliance with the outcome measures of the Essential Standards for Quality & Safety, it is expected that patient safety is enhanced through health care processes, working practices and systematic activities, based on evidence-based practice, that prevent or reduce the risk of harm to patients and that are continuously and systematically reviewed through the requirement to implement a cycle of continuous quality improvement, to improve all aspects of activities that directly affect patient safety. It is a requirement that health care organisations undertake systematic risk assessment and risk management.

6.3 NHS Litigation Authority

The NHS Litigation Authority (NHSLA) requires Board level accountability for risk management to be clearly defined, with clear lines of accountability for managing risk throughout the organisation, leading to the Trust Board.

6.4 Her Majesty's Treasury

HM Treasury requires of the organisation an ongoing process designed to identify and prioritise the risks to the achievement of departmental policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

6.5 Health & Safety Executive

The Health and Safety Executive are the enforcing body for health and safety and can inspect the trust at any reasonable time. The Health and Safety Executive require the Trust to have robust systems in place to identify hazards and associated controls and from this, evaluate the level of risk and to control all health and safety hazards to the lowest level reasonably practicable.

6.6 Statutory Statement on Internal Control

The Department of Health requires organisations to produce an annual Statement on Internal Control which is assured by an effective risk management system.

This statement is produced as part of the Trust's annual report and must be signed by the Chief Executive. It aims to demonstrate that the organisation is doing its "reasonable best" to manage its affairs

efficiently and effectively through the implementation of internal controls to manage risk, (H*SC 2001/005. Governance in the new NHS: Controls Assurance Statements 2000/2001*).

7. Monitoring through External Standards

All governance committee papers are submitted with an accompanying summary sheet, which highlights to the committee membership the purpose of the report/document, the related CQC standard and any identified risks either currently identified on The Risk Register, or those that require recording. Authors highlighting risks are required to ensure the appropriate Divisional/Directorate Management team or are aware of the need to enter the risk on to the Trust-wide Risk Register.

8. Monitoring compliance

Monitoring compliance of this Strategy will be through the annual Internal Audit of the Assurance Framework/risk management/risk maturity, undertaken to assess the Risk Maturity of the organisation, which is based upon the review of the design, adequacy and effectiveness of the organisation's Assurance Framework and Risk Management processes.

The audit report and any resulting action plan to address recommendations is submitted to the Audit Committee and relevant Assurance Committee for approval, and also to the Management Board and informs the statement on internal control, which is contained within the Trust's annual financial statements.

The Management Board will facilitate completion of the Risk Management audit report action plan until completion.

The Audit Committee will review progress against identified elements of the audit report action plan until completion.

9. References

Successful Health and Safety Management HSG65 HSE Books, 1997

Australian and New Zealand Risk Management Standard (AS/NZ 4360:2004)

National Patient Safety Agency A risk matrix for risk managers, January 2007

Management of Health and Safety at Work Regulations, 1999

‘Assurance: the Board Agenda’, July 2002

10. Bibliography

Integrated Governance Handbook, Department of Health, 2006

A risk matrix for risk managers, the National Patient Safety Agency, 2008

The Risk Management Process, Federation of European Risk Management Associations (FERMA), 2005

Risk Management Model (HSG65), Successful Health & Safety Management, HSE Books, 1997

Five steps to risk assessment, Health & Safety Executive, 2006

Seven Steps to Patient Safety, the National Patient Safety Agency, 2005

Taking it on Trust. Audit Commission, 2009

11. Policy Statement

The management of risks is a key factor in achieving the provision of the highest quality care to our patients. Of equal importance is the legal duty of the Trust to control any potential risk to staff and the general public, as well as safeguarding the assets of the Trust. It is the responsibility of all staff to be involved in the identification and reduction of risks.

All staff are responsible for the health and safety of staff, patients, visitors and others who attend our premises and this is the main component of much health and safety legislation, as identified within the Health and Safety Policy. The purpose of this Policy and associated Procedure (section 14) is to assist staff in implementing the Trust Strategic Framework for Risk Management.

12. Roles and Responsibilities

The Trust recognises that the Board and individual employees carry responsibility for ensuring the successful implementation and application of a risk management framework.

12.1 Role responsibilities

12.1.1 The Chief Executive has the overall and final responsibility for all risk, health and safety issues and for providing the Trust with the necessary organisation and resources to produce, implement and manage effective policy/action to realistically minimise risk to the lowest level possible within resources.

12.1.2 The Director of Nursing is the designated director with responsibility for the implementation of governance frameworks and risk management. This post holder is responsible for ensuring that the Trust's overall duty for risk management is discharged appropriately and for ensuring that effective operational arrangements are in place throughout the Trust. Achievement of this will be through the Management Board.

This post has responsibility for ensuring that the necessary systems and resources are in place to help the organisation assess and control risk. The Director of Nursing is a member of

the Trust Board, The Management Board and the Clinical Governance Committee.

12.1.3 The Director of Finance has delegated responsibility and accountability for financial risk. The Finance Director is a member of the Trust Board and the Management Board and also attends the Audit Committee.

12.1.4 The Director of Human Resources is the designated director with responsibility for ensuring that there is a framework in place for the management of non-clinical risk across the organisation. The Director of Human Resources is a member of the Trust Board, the Management Board and the Non-clinical Governance Committee.

12.1.5 The Chief Operating Officer, as Senior Information Risk Officer (SIRO) is the designated director with responsibility for ensuring that there is a framework in place for the management of information governance risk across the organisation. The Chief Operating Officer is a member of the Trust Board, the Management Board and the Non-Clinical Governance Committee.

12.1.6 Director of Estates and Facilities

The Director of Estates & Facilities is the Director responsible for health and Safety and is responsible for ensuring effective physical and human precautions are in place to control health and safety risks.

12.1.7 The Medical Director is nominated to support the corporate clinical risk management function by acting as the Medical Risk Lead for the Trust in supporting the Head of Risk & Assurance in matters requiring medical staff collaboration and/or advice and perspective. The post has responsibility for ensuring that clinical risk is pursued as part of the clinical governance agenda at specialty level. The Medical Director is a member of the Trust Board, the Management Board and the Clinical Governance Committee.

12.1.8 Trust Board Secretary

The Trust Board Secretary is responsible for organising the Trust Board's Annual Cycle, making provision for the discussion of all new significant risks entered on to The Risk Register and that the Trust Board undertakes at least one annual review and discussion of all risks. The Trust Board Secretary should make sure, through the Chairman, that the Board give due consideration to risk when considering the business on their agenda. The Trust Board Secretary is a member of the Management Board, the Clinical Governance Committee and the Non-Clinical Governance Committee.

12.1.9 The Head of Risk & Assurance

The Head of Risk & Assurance is responsible for the overview of risk activity in the Trust, for the purpose of providing the Board with assurance.

The Head of Risk & Assurance has responsibility for:

- advising on and co-ordinating risk management activities at all levels of the organisation;
- maintaining and updating the risk management tools and systems for assessing risk, reporting and investigating incidents;
- maintaining the risk management database used for collating and analysing incident information and risks;
- raising awareness of the risk management responsibilities to line managers, by providing information, advice and support with risk management activities;
- updating The Risk Register upon receipt of related information;
- reviewing the content of The Risk Register to identify themes and trends in risk reporting amongst Specialties/Directorates;
- checking that risk scoring is consistently applied across the Trust by risk 'owners', by ensuring the application of the guidance for determining the consequence/severity and likelihood of risks;
- ensuring that the duplication of risks on the Trust-wide risk register is minimised;

The Head of Risk & Assurance is a member of the Operational Governance Committee, and attends the Clinical Governance Committee. The Head of Risk & Assurance will also attend any other corporate committee or Board meetings at the request of the Director of Nursing.

12.1.10 The Head of Health & Safety

The Head of Health & Safety has responsibility for advising and co-ordinating non-clinical risk management activities at all levels of the organisation. The Head of Health & Safety is responsible for:

- Assisting with the assessment of areas of non-clinical risk, in partnership with identified experts, both internal and external; reporting and investigating non-clinical incidents;

- Ensuring line managers are aware of their responsibilities and are supported in risk management activities by providing them with information and advice or training;
- Advising the Head of Risk and Assurance of any risk assessment scored at 16 or above;
- Reporting and investigating non-clinical incidents, providing information to external stakeholders where appropriate.

The Head of Health & Safety is a member of the Health & Safety Committee and will attend any other corporate committee or Board meetings at the request of the Director of Estates & Facilities.

12.1.11 Executive and Non-Executive Directors (all) are ultimately accountable for the Trust's achievement of integrated risk and governance.

12.1.12 All Senior/Divisional Managers/Heads of Division must understand and implement the Trust's risk management strategy and underlying policies.

They are responsible for:

- Ensuring they have adequate knowledge and/or access to all legislation relevant to their areas and, as advised by appropriate experts, ensuring that compliance to this legislation is maintained;
- Ensuring the guidance about governance and risk management is implemented in their specialties/departments and that all staff are alert to the risks within their work environment and of their individual responsibilities;
- Ensuring that all staff have access to the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations including agency staff, contractors, members of the public and visitors;
- Ensuring all employees attend mandatory training, as identified in the Training Matrix, and that appropriate mandatory updates are maintained;
- Ensuring adequate resources are available and procedures are in place to identify clinical and health and safety risks to our patients and staff and that risk assessments are carried out within their respective are of responsibility;

- The on-going maintenance and review of their risks recorded on The Risk Register in Datix. Where significant risks have been identified and where local control mechanisms are considered to be inadequate they are responsible for ensuring that these issues are raised at the appropriate Divisional/Directorate governance groups, in accordance with the risk escalation pathway;
- Ensuring that risk identified through local/divisional/directorate risk assessments are considered as sources for service improvement/development and fed into the Local Development Plan (LDP) process;
- Ensuring financial probity and accountable use of resources within their remit area(s) and reporting risks to financial balance to their line manager;
- The Divisional management team are responsible for supporting the governance of risk as a core function in each department. Guidance for the responsibilities of these groups is attached at **Appendix 2.**
- Communicate the outcomes of Management Board discussions to the relevant risk 'owner'.

12.1.13 **All Employees** are required to:

- Report incidents or events, using the Trust's approved incident reporting mechanism (Datix), as required by the Management of Health and Safety at Work Regulations 1999. The Trust has point of reporting for all types of incident; whether clinical, non-clinical (including health and safety), financial, corporate or information incidents. This information will inform the nominated leads of related risks;
- Provide safe clinical practice in diagnosis and treatment, by not delivering any service activity that is beyond their established competence;
- To read, understand and implement all policies relevant to their professional role on the rationale that policy is the cumulative knowledge or memory of an organisation, and usually arises from or is informed by past errors and is aimed at the minimisation of identified risks. The ignorance of policy is not an excuse for breeching any policy;
- Attend all mandatory training, as identified in the Mandatory Training Matrix, and not undertake any service

requiring established competency, until training and competency has been achieved;

- Be aware that they have a duty under the Health and safety at Work Act 1974 and subordinate legislation to take reasonable care for their own safety and the safety of others who may be affected by their acts or omissions;
- When requested, assist managers to undertake risk assessments;
- Be familiar with the Trust risk management policies and local health and safety and clinical procedures/guidelines and comply with these.

12.2 Committee Responsibilities

The governance committee structure is attached at Appendix 2. The High Level Risk Committees are defined as the Management Board and Assurance Committees.

12.2.1 The Trust Board

The Trust Board has ultimate responsibility and accountability for the quality and safety of services provided by the Trust. Risk management in the overarching framework of governance is therefore the principle role of the Board, as reiterated by Department of Health documents such as 'An Organisation with a Memory (2000)' and 'Safety First'.

The Trust Board reviews the top operational risks scoring 16-25 on a quarterly basis, to review any impact upon the Board Assurance Framework.

12.2.2 Assurance Committees

The three Assurance Committees have responsibility for assuring the Board that safe and effective healthcare is being delivered and that the Trust is meeting its statutory duties, including the assessment of the Trust's compliance with the Essential Standards of Quality and Safety. The Assurance committees are:

- **Clinical Governance Committee**
- **Non-Clinical Governance Committee**
- **Audit Committee**

As identified in the committee terms of reference, each Assurance committee is chaired by a Non-Executive Director, who will provide a written report to the Trust Board, at least quarterly, on the key issues being addressed by the committee.

Cross membership between committees will ensure that there is a corporate view of clinical and non-clinical issues, together with meeting strategic objectives. The Board Assurance Framework is a standing agenda item of the three committees.

The Audit Committee is delegated authority by the Trust Board to oversee the Risk Management systems and process and seek assurance on behalf of the Board that the system is robust and is functioning effectively.

To obtain assurance on the effectiveness of the Trust's risk management strategy, the Audit Committee will review progress against the recommendations and corresponding action plan from the annual audit of risk management process and risk maturity.

As part of the assurance process, the Audit committee will review all Risk Register entries that remain unapproved after three months.

12.2.3 The Management Board

The Management Board is accountable to the Trust Board for the operational management of the Trust and the delivery of objectives set by the Trust Board. The Management Board is the key decision taking sub-committee of the Trust Board in the Trust and has responsibility for the operational success of the Trust. The Management Board meets monthly and meetings will be conducted in line with their Terms of Reference.

As such, it is responsible for:

- the management of the key risks to the organisation;
- monitoring the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Trust Board;
- the monthly review of all current risks on The Risk Register scoring ≥ 16, monitoring progress against the action plan agreed to mitigate the risk, or identifying actions necessary to achieve completion of the action plan;
- the monthly review of all Risk Register entries that remain unapproved after three months;
- monitoring all risk related disclosure statements, in particular the annual Governance Statement and declarations of compliance with the Care Quality Commission Essential standards for quality and safety, prior to approval by the Board;

- Ensuring all actions identified in the annual audit of Risk Management are completed to achieve the achievement of the Strategic Framework for Risk management.

As the committee responsible for managing and balancing all operational issues including, finance, performance and managing risk, the Management Board will approve all business cases with a financial cost.

12.2.4 The Divisional/Directorate (Management) Boards

The Divisional/Directorate Boards underpin the Management Board, in being responsible for the day to day delivery of health care and related services. The Standing Orders and Standing Financial Instructions, increase the autonomy and decision taking powers of the Divisions by reducing bureaucracy and increasing self management. The development of service line reporting allows the Management Board to focus on performance, risk management, corporate operational issues and strategic developments. The meetings take place monthly and meetings will be conducted in line with their Terms of Reference.

The Divisional Boards are responsible for:

- ensuring systematic risk assessment and effective risk management takes place across the areas within their sphere of responsibility;
- ensuring that risks are brought to their attention and either managed with the allocation of appropriate resources, or escalated where appropriate to the Management Board, for the identification of resources or acceptance of the risk;
- monitoring progress against the action plan agreed to mitigate the identified risk(s);
- arranging for the updating The Risk Register as appropriate.

12.2.5 Programme and Project Boards

The Trust also creates programme and project boards to oversee a specific programme or project, for example Application to become a Foundation Trust. These groups are required to manage the risks associated with the defined project and ensure they are assessed and appropriate action plans developed. They are required to maintain an independent risk register which links to the Trust-Wide Risk register, through a single overarching risk which covers the whole programme or project.

12.2.6 Specialty/Service Management meetings

The Local Specialty/Service management team oversee the delivery of specific services, reporting to the Divisional/Directorate Management team through existing line management structures.

The Local Specialty/Service management team is responsible for:

- Proactively predicting and undertaking resolution planning of risk;
- Reviewing and updating their Divisional Board on progress against action plans for mitigating identified service risk(s).

12.2.7 The Divisional Governance Groups

In recognition of the large operational clinical governance agenda to be delivered within the clinical Divisions, each Divisional Board has delegated responsibility and authority for clinical governance to a Divisional Clinical Governance Group. The Divisional Clinical Governance group deals with clinical governance and associated risk issues on behalf of the Divisional Board. The Divisional Clinical Governance group is chaired by either the Divisional Board Chair or a nominated Governance lead. There is a substantial shared membership between the Divisional Board and the Divisional Governance groups. Meetings will be at least quarterly and meetings will be conducted in line with their Terms of Reference.

Each Divisional Governance group has responsibility for:

- Ensuring each speciality/department within their remit holds local governance/risk meetings;
- Reviewing incidents, claims and complaints data, in order to identify themes and trends, key risks to the organisation and implement actions to learn, reduce and prevent reoccurrence;
- Ensuring every Specialty/Department is involved in a local Governance/risk meeting;
- Proactively predict and undertake resolution planning of clinical risks;
- Escalate clinical risks to the Divisional/Directorate Board (see Appendix 2);
- Review and update the Divisional/Directorate Board on progress against action plans for mitigating identified risk(s).

As identified in their Terms of Reference, the Divisional Governance Groups will formally report to the Operational Governance Committee on a quarterly basis, identifying

progress against the identified objectives for achieving effective clinical governance, including risk management.

12.2.8 The Specialty Governance groups

Smaller specialties or departments may decide to participate in a larger overarching governance groups within their Division/Directorate.

The departmental governance/risk meeting chair must ensure the minutes of these meetings are submitted to the relevant Divisional/Directorate Governance Group.

The Local Specialty Governance Team is responsible for:

- ensuring that incident trends are monitored to identify themes, trends and risks to patient safety and delivery of the service, escalating these to the Risk Register where the risks are not amenable to local resolution;
- Proactively predict and undertake resolution planning of clinical risks;
- Review and update the Divisional Board on progress against action plans for mitigating identified risk(s).

12.2.9 Ward/department management meetings

Ward and Department Managers

- ensuring that risk assessments are completed locally, recorded and shared with the Risk Management or Health and safety Departments, where necessary;
- ensuring that identified risks are incorporated into the Trust-Wide Risk Register in Datix and through the Division/Directorate, where the risks are not amenable to local resolution;
- ensuring that incident trends are monitored to identify local themes and trends and risks to patient safety and delivery of the service, escalating these to the Risk Register where the risks are not amenable to local resolution;
- Review and update the Divisional Board on progress against action plans for mitigating identified risk(s).

12.2.10 The Operational Governance Committee (OGC) acts as the operational Committee for supporting the management of clinical risk issues. The OGC facilitates the resolution of Trust-wide clinical risk issues amenable to control by policy and procedural change at a corporate-wide level and recommends action to the Management Board, where there is a financial implication for the resolution of the risk.

12.2.11 **The Health & Safety Committee** acts as the operational committee for supporting the management of health and safety risks. The Health & Safety Committee facilitates the resolution of Trust-wide non-clinical (health and safety) risk issues amenable to control by policy and procedural change at a corporate-wide level and recommends action to the Non-Clinical Governance Committee and thence to the Board, where there is a financial implication for the resolution of the risk.

Strategic risks identified outside the remit of these committees/groups will be entered onto The Risk Register upon the decision of the relevant Executive Director.

13. Education and Training

The Trust will continue to develop training that will ensure all staff are alert to potential risk areas and are aware of the systems, processes and resources to assess and manage risks appropriately.

Senior managers who are members of the Trust Board and Management Board will receive risk awareness training as identified in the Board development plan and the Management Board work plan.

The Trust's Learning Management System (LMS), managed by the Workforce Development Department, is available for staff to maintain an up to date log of their training, both formally and informally. This will facilitate staff access to the mandatory training matrix, which includes risk management courses.

All staff, including Executives and Non-Executives must refer to the Mandatory Training Matrix, available on the intranet at http://webserver.ruh-bath.swest.nhs.uk/development/mandatory/documents/matrix_roles.xls, to identify what training in relation to risk management is relevant for their role. The Mandatory Training Matrix identifies when training needs to be undertaken, the method of delivery and frequency of the training.

The Mandatory Training policy identifies how training non-attendance will be followed up and managed and is available on the intranet at http://webserver.ruh-bath.swest.nhs.uk/staff_resources/governance/policies/documents/non_clinical_policies/black_hr/HR_148_Mandatory_training_policy.pdf

Attendance at the Trust Board and Management Board development sessions are managed by the Trust Board secretary and are recorded on the training sign in sheet. Senior managers unable to attend the identified session, must review the relevant information and documents supplied by the Trust Board Secretary and provide evidence of their understanding of the information.

Attendance at development sessions will be reported in the annual Governance Statement.

14. The Risk Management Process

14.1 Assessment

Risk may be identified through a variety of external and internal sources:

The requirement and timescales for the assessment of specifically identified areas of risk (i.e. health & safety, security, stress, hazardous substances, violence abuse and harassment etc.) are clearly identified within the dedicated procedural documents.

Risk will be assessed and prioritised using a risk assessment matrix (Appendix 3), which enables the organisation to assess the level of risk based upon measurement of the likelihood and consequence of the occurrence. This prioritisation tool is based upon the National Patient Safety Agency guidance and the Australian and New Zealand Risk Management Standard (AS/NZ 4360:2004). This matrix will be used to evaluate the level of risk and determine the risk category (i.e. severity and likelihood scores) for each risk identified. Risk assessment guidance can be found at Appendix 4.

14.1.1 Other Delivery Groups

The Trust has also developed a number of operational delivery groups which oversee a specific area of Trust business, for example, Health & Safety, Policy Approval and Capital Prioritisation. These groups will identify risks as part of their ongoing programme of work and it is their responsibility to highlight these risks and refer them to the appropriate operational management group for assessment and development of an appropriate action plan.

14.2 Managing the risk

Once a risk has been assessed at a local level, or directly on to the Risk register database (Datix); if all the actions for resolution can be achieved at a local level progress against these will remain the remit of the specialty/service/ward/department. If not all of the actions for resolution can be achieved, the risks must be escalated to the Divisional/Directorate Board for agreement on treatment or acceptance of the identified risk(s). The group agreement on the decision to treat or accept the risk(s) must be clearly documented in the minutes of the meeting.

The Divisions/Directorates will maintain a register of risks, comprised of all the risks identified but unresolved at ward/department/specialty level, as well as those identified Division/Directorate wide. This Divisional/Directorate risk register will be part of the Trust-Wide Risk Register, maintained in the Datix database.

Where mitigation of the risk(s) is not achievable through development of new systems, division wide policy/procedure changes, financial allocation etc., the meeting minutes must record the inability to resolve the risk at Divisional/Directorate level.

If not all of the actions for resolution can be achieved within the Division/Directorate, the risk must be escalated to the Management Board for agreement on treatment or acceptance of the identified risk(s). The Management Board decision to treat or accept a risk must be clearly documented in the minutes of the meeting.

The risk 'owner' is required to place the risk onto The Risk Register, following agreement from the Divisional Manager/Director.

14.3 Monitoring, review and updating

The Division/Directorate is responsible for monitoring progress against the identified actions to reduce the risks scoring ≥ 5 identified within their areas of responsibility and updating The Risk Register, following every review. The frequency of monitoring of progress against the actions identified to reduce the risk will depend upon the anticipated duration of the action plan, but should be undertaken, as a minimum, every three months. The risk 'owner' is required to update the Risk Register, following any review and assessment of progress.

The Management Board is presented with all new risks scoring ≥ 16 entered on to The Risk Register since their previous meeting, in order to approve the scoring and validity of the proposed action plan to mitigate the risk. The Management Board decision to treat or accept a risk must be clearly documented in the minutes of the meeting.

At each meeting, the Management Board will be presented with a summary report detailing significant Trust-wide risks on The Risk Register scoring ≥12, in order to monitor and review progress against the agreed action plans and challenge, if necessary, progress against the agreed action plan deadlines.

All decisions to 'accept' risk(s) not amenable to resolution in the existing financial climate, will be reviewed by the Trust Board on an annual basis, to confirm the decision, or review the treatment plan.

14.4 Completion

The Management Board decision to accept or close a risk will be clearly documented in the minutes of the meeting. This decision will be communicated to the risk owner, via the Director/Divisional Manager. The Head of Risk & Assurance is also notified of such decisions, in order to ensure The Risk Register remains accurate.

The Trust Board will review the top operational risks on an annual basis, to monitor progress on resolution, recommend action, or formally minute acceptance of the risk at its current level.

Significant or extreme risks are those that are potentially damaging to the organisation's objectives and it is these that will be addressed by the Trust Board. The Trust Board has ultimate responsibility and accountability for decisions regarding actions to be taken on extreme risks. The Trust Board may choose to:

- return the risk to local, divisional or executive team level for further clarification or resolution;
- accept the risk as adequately, whilst not optimally, controlled, by existing risk reductions measures.;
- Accept the risk as not amenable to resolution in the existing financial climate;
- Transfer the risk in full or in part to another organisation;
- Adopt actions to reduce the likelihood only;
- Adopt actions to reduce the consequences only;
- Adopt actions to reduce the likelihood and consequences;
- Avoid the risk by eliminating the service.

The Trust Board decisions to treat or accept the risk(s) will be clearly documented in the minutes of the meeting and communicated to the Head of Risks & Assurance by the Trust Board Secretary, in order to update The Risk Register.

All decisions to 'accept' a risk not amenable to resolution in the existing financial climate will be reviewed by the Management Board on an annual basis, to confirm the decision, or review the treatment plan.

Any decision to treat the risk(s) must be clearly documented in the minutes of the meeting and communicated to the risk owner by the nominated Director.

A summary of this process is available at Appendix 2.

15. Acceptable Levels of Authority for Resolving Risks

The responsibility invested in local wards/departments/specialties for resolving risks is defined by what they can do locally to create safer systems of work and by the risk ranking which has been arrived at for the particular risk assessed. Risks that have been given a green or yellow ranking (Appendix 3) can usually be resolved locally, through ward or department actions.

Once a risk extends beyond the parameters of department service provision OR if it has been assessed and given an 'orange' or 'red' or ranking, it will need to be discussed at the relevant Divisional/Directorate (Management) Board, to identify the appropriate action plan to treat or accept the identified risk(s).

Risk extending beyond the sphere of responsibility of one Division/Directorate OR if it has been assessed and given a 'red' or ranking will need to be discussed at the Management Board, to identify the appropriate action plan to treat or accept the identified risk(s) or identify multidivisional actions.

If the Management Board is unable to resolve the issue, the risk will be escalated to the Trust Board for a decision to achieve resolution or other disposal as described in **section 3**. The Trust Board will look at all the potential consequences of carrying the risk and decide whether investing in a solution is justified or alternatively accepting the risk. This is shown diagrammatically in figure 2.

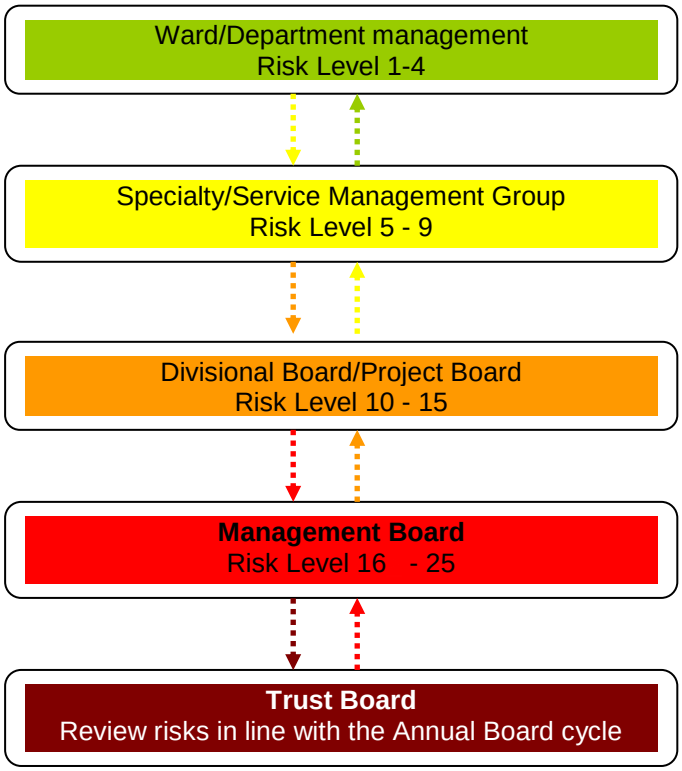


Figure 2. Acceptable levels of authority for resolving risks

If the Trust Board decides the risk is externally driven or its resolution limited by available funding, there may be reason to take the discussion to the Trust partners e.g. Clinical Commissioning Group (CCG) or Trust Development Authority (TDA) (SHA).

16. Risk Management and the Trust Planning Process

The development of the Trust strategic plan, the Local Delivery Plan and any business plans must include an assessment of the risks to the Trust.

The risk management approaches adopted by the Trust are equally applicable in all areas and are built into all future planning and development. In particular, the methodologies for identifying, assessing and prioritising risk will be used by the relevant Directors, or their nominated deputy, to undertake risk assessments in the following areas:

- Capital planning, and in particular the National Development Plan;
- Procurement;
- Service Planning;
- Re-organisation and re-structuring.

The planning process and integral risk assessment must include an awareness of our stakeholders, with regard to the way in which their behaviour affects the

organisation and the way in which the behaviour of the Trust affects them. 'Stakeholders' include patients, local health community partners, public interests, and service user interests.

The Trust Board is required to sign a statement, as part of the annual report, which states that they have confidence in the system within the Trust for managing risk. This statement reflects the risks flowing from the LDP and the Chief Executive's objectives.

The Standards for Quality and Safety, upon which the Trust Board signs off their assurance are concerned with the management/minimisation of risks and the Board, will therefore provide adequate resources to Risk Governance and the achievement of regulatory compliance.

The Trust is resolved to subscribe to the National Health Service Litigation Authority, in order to meet its insurance cover against clinical and non-clinical claims.

17. Projects and Strategic Policy Decisions

17.1 Programme or Project Risk(s)

These relate to risk(s) relating to a Programme or Project which may impact on the delivery of the project.

A project may be defined as the process of carrying out work to achieve a clear objective, usually bringing about a change. A project will normally have a set of characteristics:

- Agreed, well defined documented set of objectives and end products;
- A start point and an endpoint which brings about change;
- A definition which sets out what is included and excluded from the project;
- A plan which takes account of timescales, costs and quality;
- A defined set of tasks – which will often be inter-related and can be grouped into phases or work areas;
- An agreed set of staff & resources – who should have an agreed dedicated level of time to carry out the tasks;
- Access to a wider community of interested parties;
- A well defined plan, with constraints issues and risks communicated and managed;
- A prescribed set of benefits and outcomes which can be measured – before and after the project, leading to a successful conclusion on time to budget and meeting expectations.

All discrete/significant projects or strategic policy decisions within the Trust must be risk assessed using the agreed risk assessment process. Each Project Manager within the Trust must undertake risk assessments of their designated projects at the beginning of the project.

All risks must be subjected to the same risk assessment process, using the agreed process (Appendices 4 - 5), to ensure consistency. Each project is required to have a separate risk register. The Project Manager will review the risks at regular intervals and maintain an active project register of risk.

The management of the project's risk register must be a standing agenda item at all Project Board (or equivalent) meetings, where risks must be reviewed and updated where necessary. Any changes identified and agreed by the project team must then be reported to the overarching Committee with responsibility for reviewing the project. One overarching risk should then be added to the Trust-Wide Risk Register which covers the whole programme or project. The identified reporting process will report significant risks to the Management Board via the Trust-wide Risk Register.

Where the Trust is involved in projects which are managed through third parties with contractual commitments to utilise a different project methodology, a clear protocol will be established which identifies how risks held in the project format or system will be escalated to The Risk Register.

There may be projects that require formal project methodology which is fully documented within a Project Initiation Document, detailing all project risks which are known and are included in any associated Business Case. A formal project approach using or based upon a recognised project methodology will reduce the associated risks within a project.

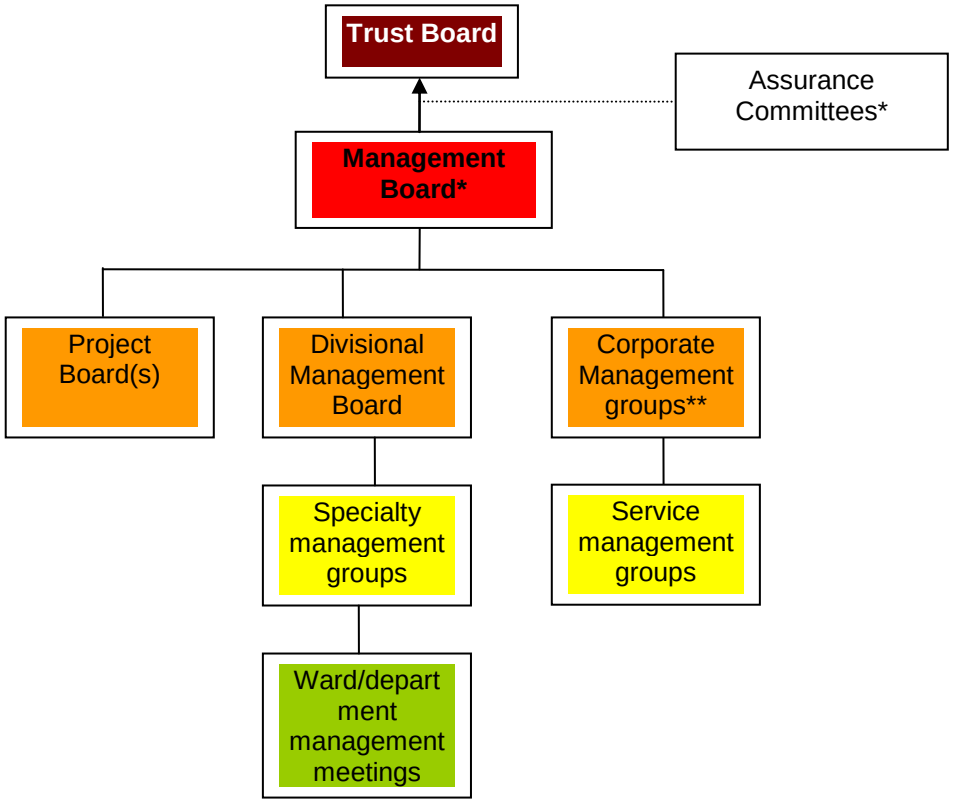
17.2 Partnership Risk(s)

A risk relating to joint working arrangements with other NHS and Non-NHS organisations may be identified as part of the planning process. Elements of these risks maybe outside of the control of the Trust and therefore appropriate assurances should be identified from the partner organisation.

Appendix 1: Consultation Schedule

Committee name	Date reviewed
Management Board	
Trust Board	

Appendix 2: Governance Framework



Please note: This is a representation of the Governance Structure of the Trust. For an accurate picture please refer to the Governance Structure published on the intranet at www.ruh.nhs.uk

Legend

Insignificant risk (1 -4): Low risk (5 – 9): Medium risk (10 – 15):

High risk (16 – 24): Extreme risk (25):

* High Level Risk Committees

** Includes: Risk Management, Trust Board Secretary, Claims & Litigation, Information Technology, Business Intelligence Unit, Business Planning

Appendix 3: Risk assessment matrix

Acceptable Risk
Risk is tolerable as long as it is well managed and controlled. In addition to identified hazards, all incidents claims and complaints will be risk assessed according to the following process and investigated according to the severity or the consequence and likelihood of (re)occurrence.

All Risk Assessments within the Trust will identify:

I. The hazards within the Task/ area being assessed inherent in the work undertaken
II. who and how many people would be affected
III. how often specific events are likely to happen (may be based on frequency of previous occurrence):
IV. how severe the effect or consequence would be
V. how controllable the hazards are.

Acceptable risk will be determined using the following traffic light system:

Severity/consequence

Given the (in)adequacy of the control measures, how serious the consequences are likely to be for the group, patient or Trust if the risk does occur (using the matrix).

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating

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

Likelihood

Given the (in)adequacy of the control measures for each risk, decide how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for very likely.

Score	Descriptor	Description
1	**Rare**	Extremely unlikely to happen/recur – may occur only in exceptional circumstances – has never happened before and don't think it will happen (again)
2	**Unlikely**	Unlikely to occur/reoccur but possible. Rarely occurred before, less than once per year. Could happen at some time
3	**Possible**	May occur/reoccur. But not definitely. Happened before but only occasionally - once or twice a year
4	**Likely**	Will probably occur/reoccur. Has happened before but not regularly – several times a month. Will occur at some time.
5	**Very Likely**	Continuous exposure to risk. Has happened before regularly and frequently – is expected to happen in most circumstances. Occurs on a daily basis

Risk Score is determined by Severity x Likelihood

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

Tolerance Level

Action to be taken following identification of risk score

1 – 4 ***Insignificant***	*5 – 9* ***Low***	*10 – 15* ***Medium risk***	*16 – 24* ***High***	**25** ***Extreme***
Action may be long term. **Risks subject to aggregate review, use for trend analysis**	**The majority of control measures are in place.** **Risk subject to regular review should be reduced as part of directorate long term goals**	**There is moderate probability of major harm of high probability of minor harm, if control measures are not implemented.** **Prioritised action plan required with timescales. To be monitored and reviewed annually**	**Significant probability that major harm will occur if control measures are not implemented. Urgent action is required. Consider stopping procedures. Actions to be audited until in control. Review three monthly**	**Where appropriate and in discussion with the lead clinician/manager stop all action IMMEDIATELY. Controls to be implemented immediately and audited until risk score reduced. Review weekly**

Appendix 4: Easy steps to the risk assessment process

A risk assessment is a systematic and measured examination of any **risk** identified, i.e. what, in your work, could cause harm to:

- **people** - including yourself, patients and their friends or relatives, carers, staff (both permanent, temporary and independently contracted), visitors, etc.

  or

- **the organisation** – including day to day tasks, operations, our environment, services, etc.

It will assist you to decide whether or not you have taken enough precautions to prevent harm or loss or should do more.

The following words will assist in clearly stating the risk:

As a result of…

There is a risk that…

Which may result in…

Please refer to a copy of the Trust Risk Assessment Form (Appendix 4), this is available on the intranet.

N.B. This form should not be used to carry out specialist risk assessments such as COSHH, Patient Handling, DSE, etc.

Remember, a Risk Assessment should provide a means of communicating the hazards or threats identified and control measures available to minimise risks. The risk assessment should be explicit, enabling anyone who doesn't yet know of the issue, to understand it. Abbreviations should not be used, only facts (not opinion) and staff titles/roles (not names).

Follow the steps below in order to complete a Risk Assessment.

Step 1 **Identify the Department** – including the Responsible Manager, Assessor and Date of Assessment.

Step 2 **Hazard/Threat:** Describe the hazard or threat, so that anyone will understand the issue.

Step 3 **Associated Risks:** Describe the risks associated with the Hazard/Threat, who might be injured, what might happen to that person (including, patients, relatives, carers, staff, visitors, etc.), property or project and why/how.

Step 4 **Existing Control Measures:** – assess the measures currently in place to control the hazard and thereby reduce the risk (there may or may not be measures already in place to minimise the risk). If there are no Current Control Measures in place, simply record this fact.

Remember, the Trust is committed to an open and fair culture, recognising that many important lessons are learnt through an open and transparent approach, which would not otherwise be learned where blame is apportioned, or staff feel under threat through risk assessment. The Trust promotes a just, fair and responsible culture that fosters learning and improvement, whilst encouraging accountability.

Step 5 **Current Risk Score:** – identify the Risk Score with existing Current Control Measures in place; this will help you to:

- understand the value of your Current Control Measures in place (sometimes, Current Control Measures in place actually increase risk).
- recognise the risk level potential if any of your Control Measures fail.

Use the Risk Scoring Matrix (**Appendix 3**) to assess the Risk Score as follows:

1. Select the most appropriate ***severity/consequence*** of the Hazard/Threat and subsequent risk occurring
(e.g. Negligible, Minor, Moderate, Major or Catastrophic)

and

2. Select the most appropriate ***Likelihood*** of the Hazard/Threat and subsequent risk occurring
(e.g. Rare, Unlikely, Possible, Likely or very likely)

then

3. Cross-reference the chosen *severity scores* and *Likelihood score* to produce a Risk Score, e.g. if you decide that the Impact is 'Major' (4) and the Likelihood of the risk occurring is 'Unlikely' (2), then the Risk Score is Moderate (8).

N.B. Use the statements around potential impact on people and the organisation on the Risk Scoring Matrix as a guide, but remember, Risk Scoring is subjective not exact. It is designed only to assist in thinking systematically around an identified risk.

Remember, you should try to consider the Risk Score in terms of the **organisation as a whole**; for example:

1. An isolated issue such as a lack of available shelving within a room resulting in items being stored inappropriately on the floor and damaged, may feel as though it has a Risk Score of 20 to the room

user, but in the context of all other risks faced across the organisation as a whole, it is more realistically a 'Negligible' *Impact* (1) x a 'Certain' *Likelihood* (5), producing a Risk Score that is Low (5).

2. A non-slip floor that could cause a patient or other person to fall, resulting in semi-permanent harm, reflected as a 'Moderate' *Impact* (3) x a 'Possible' *Likelihood* (3), producing a Risk Score that is Moderate (9).

N.B. If the **current risk score is 16 or above**, please discuss with your department manager immediately on completion of the risk assessment; they may adjust your score or confirm your assessment and notify the Head of Risk & Assurance or Head of Health & Safety.

Step 6 **Identify the Control Measures Required** (best case scenario)**:** - consider whether the Current Control Measures in place (if any) tackle the root cause of the problem, or just the symptoms of the problem. Decide upon the best case scenario course of action and describe the Control Measures Required to minimise the risks as far as possible. Identify the Control Measures/actions required to be taken in order of priority.

Control Measures fit into a '**Hierarchy of Controls**', as follows:

1. Elimination:
Always the first choice

- By substitution with a less dangerous alternative, e.g., using a safer substance, or a safer machine
- Avoiding certain processes, e.g., buying in from a sub-contractor
- Redesigning to eliminate the risk altogether

2. Engineering Controls

- Engineering controls, e.g., maintenance, lagging pipes
- Isolate the hazard, e.g., guard the dangerous parts of a machine
- Machinery to reduce risks, e.g., 4 section profiling bed, riser/recliner chair

3. Procedural Controls

- Segregate staff from the hazard, e.g. stand behind a barrier whilst an x-ray is taken
- Safe working procedures, e.g. correct methods of handling toxic waste, permit to work systems
- Time exposure, e.g. reduce time exposed to a chemical
- Warning systems, e.g., using signs to warn of a slippery floor

4. Behavioral Controls
Always the last choice

- Information, Training, Instruction and Supervision, e.g., providing manual handling training relevant to the job
- Personal Protective Equipment (PPE), e.g., use of gloves, visors, safety shoes, etc.

This should be the **LAST RESORT**, as human behavior is not failsafe - for use only where the above measures do not control the risk!

This list indicates an 'order of priority' for Control Measures in any hazardous/threatening situation. The hierarchy reflects the fact that eliminating and controlling risk using engineering and procedural controls is more reliable than relying solely on people changing their behavior, which can never be failsafe, because people will always be prone to error, i.e. through lapses in concentration, distraction, differences in perception and experience. It is a well-documented fact that adverse incidents occurring are usually the result of unanticipated failures within system and process design.

The measures at the top of the Hierarchy of Controls seek to create a safe workplace whilst the measures at the lower end of the Hierarchy attempt to make people safe in a hazardous environment. If you have more than one Required Control Measure, list and number these in order of priority as you record them.

The line Manager should make every effort to implement required Control Measures identified by the Risk Assessment and should ensure that all new and Current Control Measures are made known to their staff and are working.

Step 7 **Target Risk Score** (best case scenario)**:** Identify the **Risk Score** anticipated with the **Required Control Measures** in place. Usually, **Required Control Measures** will reduce the **Risk Score** substantially (although not always, e.g. some risks are occupational, such as lone-working in the community, and although minimised through **Control Measures**, will always exist to some extent).

Adding this **Risk Score** will help you to compare the value of the **Current** risk score (Step 5) and doing nothing to minimise the risk, with the risk once the **Required Control Measures** (Step 7) are in place.

Step 8 Identify the **Target (Completion) Date,** the **Cost** of the **Actions/Control Measures Required** and the **Manager Responsible** (Risk 'owner').

Step 9 Present the completed risk assessment to your line Manager for discussion. Your line Manager will review the assessment and may make adjustments, e.g. to the risk score, because of their over-arching perspective on the score, or to the actions/control measures required, suggesting other solutions.

Your line Manager will arrange for the risk assessment to be entered onto The Trust-wide Risk Register (Datix), for regular review and monitoring by the specialty/department; being used to inform departmental business planning through allocation of resources in order to minimise the risks identified therein.

Your line manager may not have the resources, authority or means to action all control measures identified by the risk assessment, e.g. purchase of equipment, change to strategy or premises, but is now formally informed of

the Hazard/Threat and risk, in order to work towards the required control measures.

Step 10 depending upon the initial score, your line manager will arrange for the risk a to be reviewed by the Specialty/Divisional/Directorate Management Board, for either regular monitoring of progress against the action plan, or agreement on the decision for the appropriate course of action in managing the risk.

Document Control Information

Ratification Assurance Statement

Dear James

Please review the following information to support the ratification of the below named document.

Name of document: Strategic Framework for Risk Management

Name of author: Alexandra Lucas

Job Title: Head of Risk and Assurance

I, the above named author confirm that:

- The procedural document presented for ratification meets all legislative, best practice and other guidance issued and known to me at the time of development of the document;
- I am not aware of any omissions to the document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known;
- The procedural document meets the requirements as outlined in the document entitled Trust-wide Policy for the Development and Management of Policies;
- I have undertaken appropriate consultation on this document;
- I will send the document and signed ratification checklist to the Policy Co-ordinator, for publication at my earliest opportunity following ratification;
- I will keep this document under review and ensure that it is reviewed prior to the review date

Signature of Author: _____ **Date:** _____

Name of Person Ratifying this policy: _____

Job Title: _____

Signature: _____ **Date:** _____

To the person approving this policy:

Please ensure this page has been completed correctly, then print, sign and **post this page only** to: The Policy Coordinator, John Apley Building.

The **whole policy** must be sent electronically to: ruh-tr.policies@nhs.net

Equality Impact: (A) Assessment Screening

To be completed when submitted to the appropriate Executive Director for consideration and approval.

Person responsible for the assessment:	
Name:	Alexandra Lucas
Job Title:	Head of Risk and Assurance

Does the document/guidance affect one group less or more favourably than another on the basis of:	**Yes/No**	**Comments**
Race	☐ Yes ☒ No	
Ethnic origins (including gypsies and travellers)	☐ Yes ☒ No	
Nationality	☐ Yes ☒ No	
Gender (including gender reassignment)	☐ Yes ☒ No	
Culture	☐ Yes ☒ No	
Religion or belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Age	☐ Yes ☒ No	
Disability (learning disabilities, physical disability, sensory impairment and mental health problems)	☐ Yes ☒ No	
Is there any evidence that some groups are affected differently?	☐ Yes ☒ No	
If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?	☐ Yes ☐ No	N/A
Is the impact of the document/guidance likely to be negative?	☐ Yes ☒ No	
If so, can the impact be avoided?	☐ Yes ☐ No	N/A
What alternative is there to achieving the document/guidance without the impact?	☐ Yes ☐ No	N/A
Can we reduce the impact by taking different action?	☐ Yes ☐ No	N/A

If you answered **NO** to **all** the above questions, the assessment is now complete, and no further action is required.

If you answered **YES** to any of the above please complete the **Equality Impact: (B) Full Analysis**