York Teaching Hospital NHS
NHS Foundation Trust

Risk Management Framework

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Owner:	Chief Executive
Publisher:	Healthcare Governance
Version:	12.0
Date of version issue:	May 2015
Approved by:	Corporate Risk Committee Executive Board
Date approved:	3rd March 2015
Review date:	May 2018
Target audience:	All staff employed by the Trust
Relevant Regulations and Standards	Underpins all outcomes - CQC Essential Standards of Quality and Safety
Links to Organisational/Service Objectives, business plans or strategies	Patient Safety Strategy
Executive Summary This framework describes the processes and system for risk management utilised by the Trust	

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Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
5	March 2007			Various amendments – see previous version history on QPulse
6	May 2008	Elaine Miller Head of Risk & Legal Services		Various amendments – see previous version history on QPulse
7	July 2009	Elaine Miller Head of Risk & Legal Services	Bootham Park	Various amendments – see previous version history on QPulse
8	May 2010	Elaine Miller Head of Risk & Legal Services	Horizon	Updated re: RMSAT NHSLA Standards 2010
9	Sept 2011	Elaine Miller Head of Risk & Legal Services		Policy updated to reflect new Risk Management standard ISO 31000 and Corporate Governance arrangements
10	March 2013	Elaine Miller Head of Risk & Legal Services	Approved / Staffroom	Policy updated to reflect the enlarged organisation
11	Dec 2014	Fiona Jamieson Assistant Director of Healthcare Governance	Staffroom	Reviewed and updated into new template.
12	March 2015	Fiona Jamieson Head of Healthcare Governance	Staffroom	Reviewed and updated. Now Framework.

Contents

Introduction

This document provides the operational framework for the identification and consistent management of risk within York Teaching Hospital NHS Foundation Trust. It aims to do this by:

Defining risk as

‘the effect of uncertainty on the delivery of objectives and refers to any variation on the expected or desired objective or outcome’.

For example, we have an objective to keep patients and staff safe at all times, risk is therefore anything that is stopping or could stop us from keeping people safe whilst in our care.

The primary purpose of risk management is to:

- Reduce harm for patients, staff, visitors or contractors;
- Promote the success of York Teaching Hospital NHS Foundation Trust;
- Protect everything of value to the Trust (such as reputation, market share, exemplary clinical outcomes); and
- Continuously improve patient experience, safety and quality performance.

Identifying risk as:

- anticipating what could stop us from achieving our objectives or goals. To help identify areas of risk we look at our historical performance and trends, previous events, current challenges, and needs of people who use our services as well as thinking about future scenarios or potential outcomes that could help or hinder the delivery of strategy. We are all required to be open, honest, think ahead and take an active part in identifying risk.

Analysing risk by:

- estimating the severity (the impact the risk has on the Trust and people in our care) and likelihood (the probability of that impact happening). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk.

Within the Framework colleagues are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.

Treating Risk:

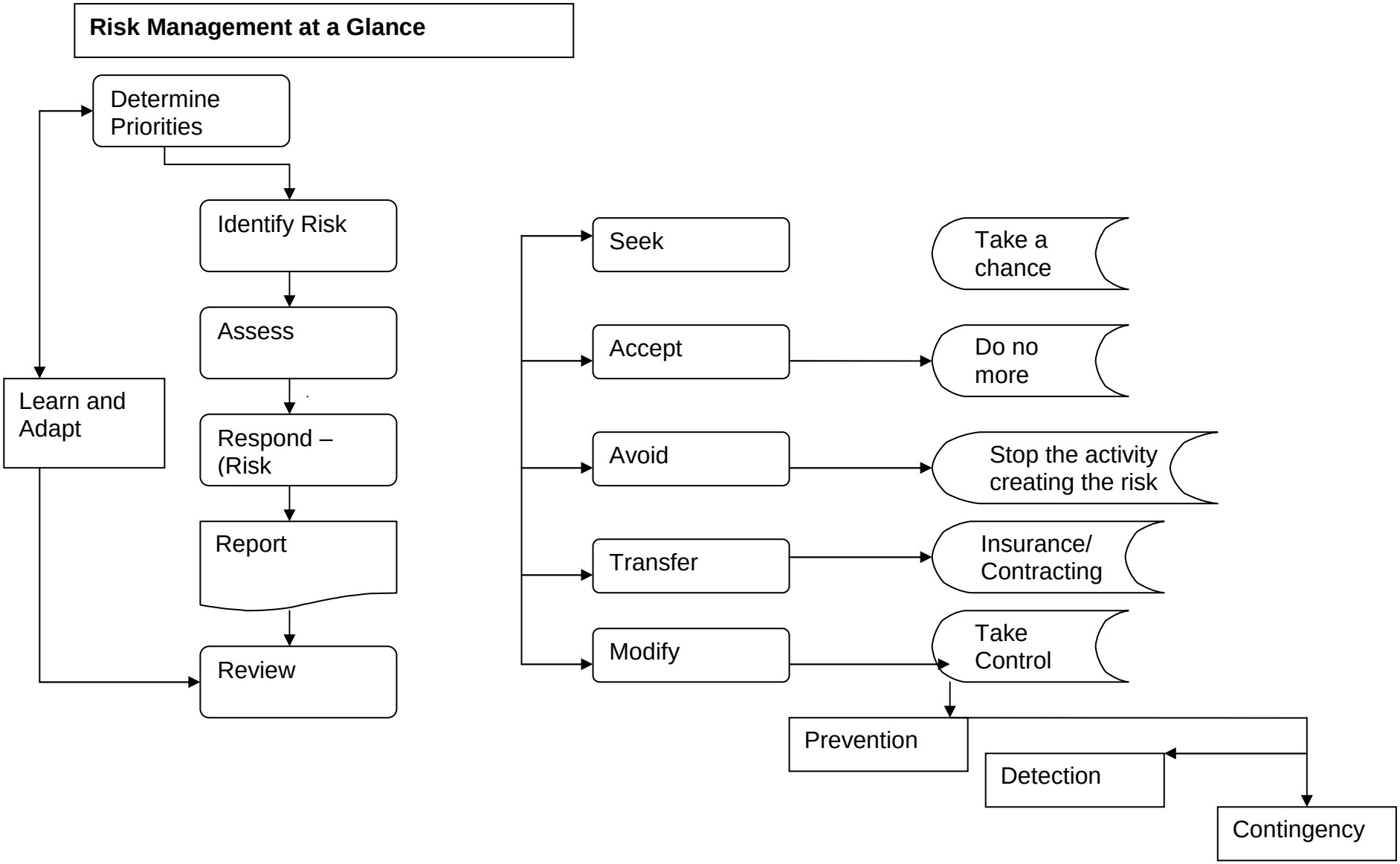
- Risk is treated proactively using a combination of prevention, detection and contingency controls. **Prevention** controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, training or computer systems. **Detection** controls alert management to any deficiencies preventing risk and typically involves performance monitoring, audits, alarms or tests. **Contingency** controls are designed to allow the Trust to recover from a failure to manage risk and allow the Trust to continue to function albeit in a modified way. Colleagues are required to understand and implement all controls designed to manage risk at the Trust.

Learning

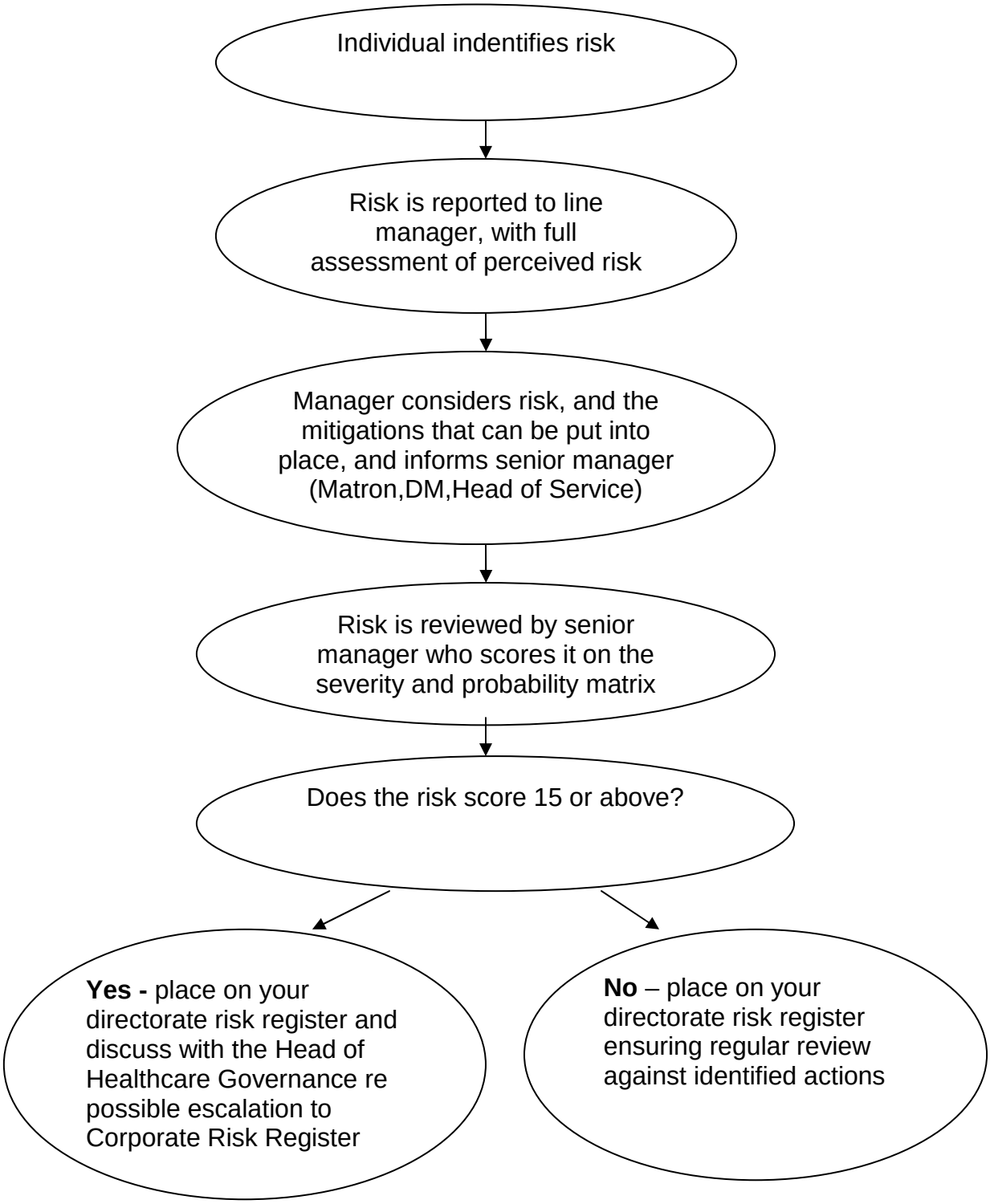
- Organisational learning is reflected in the Trust's ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim), and continuously improve performance. Controls are monitored and continuously improved as part of an open and learning culture.

Responsibility

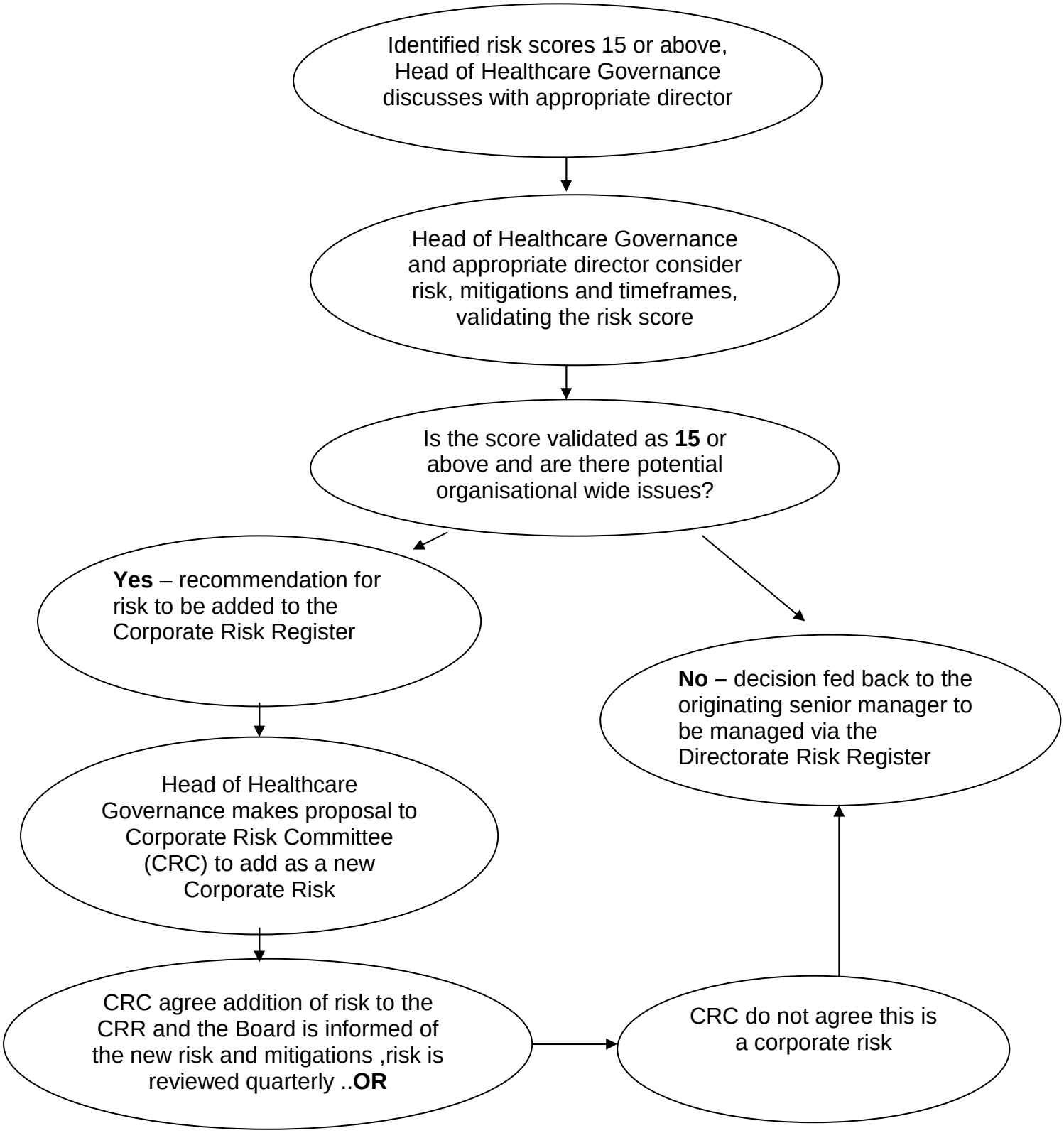
- This Framework identifies that risk management is everyone's responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.


Risk Management at a Glance
Determine Priorities
Identify Risk
Assess
Respond – (Risk
Report
Review
Learn and Adapt
Seek
Take a chance
Accept
Do no more
Avoid
Stop the activity creating the risk
Transfer
Insurance/ Contracting
Modify
Take Control
Prevention
Detection
Contingency

FLOWCHART: IDENTIFICATION OF LOCAL RISKS



FLOWCHART: IDENTIFICATION OF CORPORATE RISKS



1 The Framework

1.1 This document is the framework for the management of risk at York Teaching Hospital NHS Foundation Trust. Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

1.2 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks, and responding to them in an effective and resilient manner.

1.3 At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

1.4 The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality, and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

2 Objective

2.1 The overall purpose of risk management at the Trust is to:

a) **Reduce the level of exposure to harm for patients, colleagues or visitors** by proactively identifying and managing personal risk to a level as low as reasonably practicable
b) **Promote success and protect everything of value** to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income
c) **Continuously improve performance** by proactively adapting, remaining resilient to changing circumstances or events, and learning.

2.2 The Trust will establish an effective risk management system which ensures that:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff
- Controls are put in place which are effective in their design and application to manage risks, and risk treatment is understood by those expected to apply control
- All staff have a responsibility to comply with controls, whilst the operation of controls is monitored by management
- Gaps in control are rectified
- Management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes are embedded locally across directorate teams and in corporate services including business planning, service development, financial planning, project and programme management and education

2.3 The Trust shall achieve this by:

- Developing and driving a clear strategy to meet patient needs
- Actively engaging openly with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account

3 Scope of the Framework

3.1 Risk management is everyone's responsibility. This Framework applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities on pages 10-11.

3.2 Effective employee engagement is vital to our success and our ultimate objective to be trusted to deliver safe, effective and sustainable healthcare within our communities. Our values, drivers and motivators set out "*the way we do things around here*" and these guide our work patients, colleagues and stakeholders. Our guiding values, drivers and motivators are:

- We care about what we do;
- We respect and value each other;
- We listen in order to improve; and
- We always do what we can to be helpful.

And we enable and support each other by:

- Working in partnership and responding to local needs;
- Respecting differences and building on similarities;
- Empowering people to be involved in decisions about how we provide care; and
- Encouraging others to behave respectfully in line with our values.

3.3 By wholeheartedly embracing our values, drivers and motivators in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

4 Operational Framework for Risk Management

The Risk Management Process

Step 1: Determine Priorities

4.1 Risk is defined as the effect of uncertainty on the objective[1]; or in others words it is anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and Senior Management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

4.2 Evaluating what is stopping, or anticipating what could prevent, the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process and compliance requirements. Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and directorate teams should identify what is uncertain; consider how it may be caused and what impact it may have on the objective and service.

Step 3: Assess Risk

4.3 Estimate the magnitude of a risk by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating residual risk and risk scoring matrix guidance is provided in appendices 2 and 3.

Step 4: Respond to the Risk

4.4 There are a number of different options for responding to a risk[1]. These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement*.
- **Modify** - this strategy involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

  There are three types of control used to modify risk and comprise of:

  (i) **Prevention/Treatment** - these controls are <u>core controls</u> and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.
  (ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits
  (iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

[1] Based on BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International

A combination of all 3 types of control is usually required to keep risk under prudent control.

Step 5: Report Risk

4.5 All risks shall be recorded on the DATIX Risk Register. Key outputs from the risk management system shall be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥15 – each formal meeting of the Board of Directors via assigned sub committees of the Board
- ≥10 – [Relevant] Committee of the Board of Directors as part of the Committee's annual work plan
- ≥8 – Specialty/Directorate/Departmental Governance meeting at least quarterly
- ≤6 – Ward/Departmental Management at least annually

The **Board of Directors** shall receive summary reports at each formal meeting to inform them of all material risk, the nature of controls and action plans. The risk profile shall be part of the Chief Executive's report and cover as a minimum the risk source, description of the risk, the residual risk, main controls, date of review and risk owner.

The **Corporate Risk Committee** will receive reports to monitor the quality, completeness and utilisation of risk registers, and also oversee of the distribution of risk across the Trust. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

Directorates will have access to Datix and receive system generated directorate specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented.

The Executive Team will be informed by Head of Healthcare Governance (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

The Audit Committee will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

Urgent Escalation - in the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant Clinical Director, Chief Nurse, Directorate Manager and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

Step 6: Review Risk

4.6 Review risk at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥15 – at least monthly
- ≥10 – at least quarterly
- ≥8 – at least bi-annually
- ≤6 – annually.

4.7 The Committees of the Board

The totality of the Trust's risk governance infrastructure includes the oversight provided by Board committees in their risk-related roles. Committees of the Board of Directors comprise of Corporate Risk Committee, Workforce Strategy Committee, Audit Committee, Quality & Safety Committee, Remuneration Committee, and Finance & Performance Committee. These committees play a vital role in effective risk management and shall apply the following principles to enable the Board to keep risk under prudent control at all times:

a) oversee and advise the Board on current risk exposures and future risks to the Trust's strategy;
b) oversee risk appetite and tolerance for those areas under the Committees purview;
c) address risk and strategy simultaneously taking into account assurance on the operation of control, the current and prospective macro-economic, public policy and financial environment;
d) challenge the Trust's analysis and assessment of risk;

e) advise the Board on risk treatment and strategy;
f) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
g) evaluate risk management capability;
h) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
i) consult experts to optimise risk treatment where necessary.

5 Impact Upon Individuals with Protected Characteristics

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This Framework can be made available in alternative formats on request including large print, Braille, audio, and different languages. To arrange this please refer to the Trust's "Interpreter Services – guide for staff" on Staffroom.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

5.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of our Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

6 Roles and Responsibilities

The success of this framework is dependent on a range of individuals being involved in the implementation of this document. The responsibilities on individuals in ensuring compliance with this document are detailed below:-

6.1 Chief Executive, as Accounting Officer, has overall accountability to the Board of Directors for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board's appetite for taking risk. The Chief Executive is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. They shall also be responsible for: (i) risk management development; (ii) developing and communicating the Board's appetite for taking risk; (iii) establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these; and (iv) monitoring the management of risk across divisions. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure.

6.2 All Executive, Clinical Directors, Directorate Managers and Heads of Service, have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They shall intervene robustly to ensure teams within their sphere of control follow the risk management process. In addition, executive directors, clinical and all other directors shall also be responsible, where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.

6.3 Head of Healthcare Governance - has day-to-day responsibility for risk management process. They shall report to the Chief Executive for: (i) the development of risk management framework (ii) administration of risk management systems; (iii) oversight of risk exposures facing the business; (iv) provision of risk management training and support to divisions; and (v) the maintenance of the corporate risk/safety management plan. They shall be responsible for the maintenance and reporting of the Corporate Risk Register and carry out sufficient checks within and across divisions to monitor the management of risk alongside the Board's appetite for taking risk. They shall be responsible for the effectiveness of the Datix system, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness. The Head of Healthcare Governance shall take the lead in triangulating lessons for learning ensuring defective arrangements, alerts or changes in practice are conveyed to front line teams promptly and acted upon.

6.4 Foundation Trust Secretary – is the lead office for the BAF supported by the executive directors. The Foundation Trust Secretary is responsible for the coordination of the BAF, ensuring that the information is reported appropriately.

GENERIC DUTIES AND RESPONSIBILITIES

Main Duties	Board of Directors	Executive Director	Clinical Director/Directorate Manager/Heads of Service	Other Managers	All Employees
Strategy & Policy	• Determine the Trust's vision, mission and values • Set corporate strategy • Provide leadership	• Develop and oversee the implementation of strategic plans • Develop and communicate corporate objectives • Proactively anticipate risk • Provide leadership and guidance to employees, business partners and stakeholders	• Develop and Implement Clinical Strategy • Alignment of divisional objectives to Trust strategy	• Alignment of team/personal objectives to Trust strategy	• Deliver personal objectives • Abide by ***Trust values and behaviours***
Organise	• Establish an effective risk management system • Establish and keep under review the Board's appetite for taking risk • Focus on material risk and proactive anticipation of future risk	• Develop & apply Risk Management Process • Accept and allocate ownership for risk • Share ownership for cross-enterprise risk	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Follow Risk Management Process • Accept ownership for risk
Plan & Control	• Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks • Decide whether or not a risk can be accepted • Simultaneously drive the business forward whilst making decisions which keep risk under prudent control	• Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success • Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations • Allocate, structure and prioritise resources within and across divisions or directorates so that risk is managed in accordance with the Board's risk appetite.	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Prepare risk management mitigation plans • Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events • Manage resources to optimum effect • Develop policies, guidelines, procedures and standards to govern the management of risk locally	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Remain alert to risk • Manage resources to optimum effect • Develop and implement risk management plans	• Undertake and keep up to date with mandatory training and other relevant training • Follow policies, clinical standards and relevant procedures • Act on lessons for learning
Monitor	• Keep under review material risk exposures that are not accepted by the Board at each formal meeting	• Challenge, support, supervise and hold colleagues to account for performance and continuous improvement	• Monitor the operation of controls and address identified gaps in control	• Supervise the work of others to ensure controls are applied correctly	• Report concerns, defects, adverse events or failures to contain risk adequately.
Audit	• Determine Audit priorities using a risk-based approach • Take account of reports from the Audit Committee	• Determine Audit Priorities using a risk-based approach • Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required	• Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required • Undertake appropriate inspection/checks of controls for safety critical procedures	• Cooperate fully and assist Internal Audit, • Challenge recommendations if they are not agreed • Develop and implement changes in practice within the timescales agreed • Report when concluded.	• Cooperate with Internal Audit and act on their findings • Carry out instructions based on agreed audit recommendations
Review	• Effectively hold those responsible for managing risk to account for performance and continuous improvement. • Take decisions	• Report to the Board all material risks and significant gaps in control	• Report to the Board all material risks and significant gaps in control • Escalate risk in accordance with this Policy • Ensure all risks are reviewed correctly		

Appendix 1: Glossary of Terms used within Framework

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	A document setting out material risk and assurances on the operation of controls to manage those risks	**Risk**	Effect of uncertainty on objectives
Control	An intervention used to manage risk	**Risk acceptance**	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	**Risk aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	**Risk analysis**	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk appetite**	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk before any intervention to manage it	**Risk assessment**	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be significant, high, moderate, low or very low.	**Risk avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	**Risk management**	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk owner**	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	**Risk Register**	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Target Risk**	A level of risk being planned for
Residual risk	Current risk. The risk remaining after risk treatment		

Appendix 2: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity

Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest l risk score that must be referred to on the risk register**.

Appendix 3: Risk Grading

SCORE	Incident / Risk Grade (NPSA Cat.)	Level of Risk	Communicated to and overseen by	Investigation Level
15 - 25	Catastrophic	**SIGNIFICANT**	Alert Chief Nurse Reported to Board of Directors	SI Procedures RCA – 45 days (Board notification)
10-14	Major	**HIGH**	Alert Clinical Director Reported to Risk Management Committee	Divisional RCA – 28 days
8 - 9	Moderate	**MEDIUM**	Inform Divisional Manager Overseen at Divisional Level	Directorate Analysis – 28 days
4-6	Minor	**LOW**	Inform Ward/Departmental Manager Oversee at Ward/Departmental Level	Ward/Department Analysis – 10 Days
1-3	None	**VERY LOW**	Ward/Departmental Management	Ward/Department Analysis – 10 Days

5X5 MATRIX

X	LIKELIHOOD					
SEVERITY		1	2	3	4	5
	1	1	2	3	4	5
	2	2	2	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Appendix 4

Policy Management

1 Consultation, Quality Assurance and Approval Process

Consultation Process

This document has been subject to external assessment of the Risk Management Strategy.

Quality Assurance Process

The author has consulted with the following to ensure that the document is robust and accurate:-

- External experts
- Corporate Risk Committee
- Other Directors
- Sample users

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

Approval Process

The approval process for this policy complies with that detailed in section 3.3 of the Policy Development Guidance.

2 Review and Revision Arrangements

The Policy Author will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent reviews of this policy will continue to require the approval of the Corporate Risk Committee

3 Dissemination and Implementation

The Policy will be disseminated, posted onto the intranet and will be supported by training for the Board, the Risk Team, Risk Reviewers and Managers.

Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

Please refer to the Policy Development Guideline for detail

4 Standards/Key Performance Indicators

- Care Quality Commission - Essential Standards of Quality and Safety

5 Training

Risks may be identified proactively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register
The Risk Register is a part of Datix and provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto Datix.

b) Risk Management Training
This document recognises that training will be required to effectively manage risks in line with the process set out above. Details of all trust training programmes are set out in the Training Needs Analysis which can be found in the Mandatory Training Policy and associated documents.

i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by the Deputy Director of Healthcare Governance. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

ii) All staff shall receive an introduction to the Risk Management Process briefing as part of the Corporate Induction programme.

iii) Additional training will be provided through an e-learning programme.

iv) Directorate , Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Datix Risk Register database before access to the database is enabled.

v) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

6 Trust Associated Documentation

- Moore P., A. (2013) *Countering the Biggest Risk Of All: attempting to govern uncertainty in healthcare management*. London. Good Governance Institute
- Chapman R., J. (2012) *Simple tools and techniques for enterprise risk management (2nd Edition)*. London. Wiley Finance
- Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS Trusts get their assurance*. London. Audit Commission
- BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International
- NPSA (2004) *Seven Steps to Patient Safety*. London. NPSA
- DH (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*. London. Department of Health
- DH (2000) *An Organisation with a Memory*. London. HSMO

7 External References

- See above

8 Process for Monitoring Compliance and Effectiveness

This document does not utilise the standardised table but the following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Process shall be evaluated:-

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board
- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- The risk profiles (for risks ≥10) for all divisions are reviewed by the Corporate Risk Committee as part of a rolling programme of reviews
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months.

Compliance with the above will be monitored by the Deputy Director of Healthcare Governance, reviewed by the Chief Executive and reported within an annual report submitted to the Corporate Risk Committee.

The following mechanisms will be used to monitor compliance with the requirements of this document:

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Corporate Risk Committee at each formal meeting of the committee
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and revision)

Appendix 5 Dissemination and Implementation Plan

Title of document:	Risk Management Framework
Date finalised:	May 2015
Previous document in use?	No
Dissemination lead	Policy Author
Implementation lead	Policy Author
Which Strategy does it relate to?	Patient Safety Strategy

Dissemination Plan	
Method(s) of dissemination	Via Team Brief, Local Intranet, Briefings
Who will do this	Policy Author
Date of dissemination	On approval
Format (i.e. paper or electronic)	Electronic
Implementation Plan	
Name of individual with responsibility for operational implementation, monitoring etc	Policy author and those named in section 5 of this document
Brief description of evidence to be collated to demonstrate compliance	Agendas, Minutes and papers of relevant meetings Risk Registers