Risk Management Framework

Sheffield Health and Social Care NHS Foundation Trust

Category:	Framework & Procedure
Summary:	The overarching purpose of the risk management framework is to describe the approach and processes within Sheffield Health & Social Care NHS Foundation Trust to: • Identify, manage, eliminate, or reduce to an acceptable level, risks that threaten the delivery of high quality care and services. • Maintain a safe environment for individuals who are legitimately accessing Trust services. • Minimise financial loss to the organisation, and to • Demonstrate to the public, regulators, staff, and commissioners that the Trust is a safe and efficient organisation
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Executive Lead:	Chief Executive
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Introduction

1. Sheffield Health and Social Care NHS Foundation Trust (SHSC) is committed to putting the safety of service users, carers, staff, and the public at the heart of its business and as such is committed to ensuring effective risk management is a fundamental part of its management approach and underpins all activities. Our approach to risk management is one of proactively identifying, mitigating, monitoring, and reviewing risk.

2. Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

3. This Board-approved framework for managing risk identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation based upon the Board's identified risk appetite.

4. Effective risk management should protect and add value to the organisation and its stakeholders, and in turn robustly support the organisation's objectives by:

    - Providing a framework that enables future activity to take place in a consistent and controlled manner;
    - Improving decision making, planning and prioritisation by comprehensive and structured understanding of business activity, volatility and project opportunity/threat;
    - Contributing to the efficient use/allocation of capital and resources within the organisation;
    - Protecting individuals who come into contact with the organisation;
    - Protecting and enhancing assets and organisational reputation;
    - Developing and support people and the organisation's knowledge base;
    - Optimising operational efficiency.

5. We recognise that health and social care is, by its nature, a high risk activity. A positive risk management culture supports staff to make sound judgements and informed decisions concerning the management of risk and risk taking. In these circumstances, where staff have undertaken and documented a risk assessment, identified appropriate action, monitored the implementation of such action and complied with policies and procedures, they can be assured of commitment and support for their actions.

6. Successful risk management involves:

    - Identifying and assessing risks;
    - Taking action to anticipate or manage risks;
    - Monitoring risks and reviewing progress in order to establish whether further action is necessary or not; and
    - Ensuring effective contingency plans are in place.

Policy Statement

7. The Board is committed to delivering services to a high standard, with any risks minimised through organisation-wide robust risk management processes. Our strategic objectives demonstrate a commitment to raise standards and continuously improve the quality of services through making risk management part of normal daily work practice. Trust Board members are engaged annually on the review of risk appetite and scoring approach, which support understanding of the methodology. Training for the Board on risk is aligned to the Board's review of risk appetite.

8. In setting out processes which seek to effectively identify, analyse and control risk, this framework is consistent with requirements of the International Organisation for Standardisation (ISO) 31000:2018 Risk Management – Guidelines. In addition, this framework will support SHSC to demonstrate compliance with regulatory requirements.

9. We are committed to having a risk management culture that underpins and supports our business and improving the management of risk throughout the organisation.

10. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

11. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be explored in order to grow business and services, and take opportunities in relation to the risk.

12. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

13. **Senior management** will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

14. **Line managers** will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

Purpose and Aim

15. The aim of this framework is to set out our vision for managing risk. Through the management of risk, we seek to minimise, though not necessarily eliminate, threats, and maximise opportunities. The framework seeks to ensure that:

    - risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that assets, business systems and income are protected; and
    - the implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Board.

Scope

16. The objective of the Risk Management framework is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

17. We use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

    - All salaried employees;
    - Contractors, sub-contractors and External Consultants;
    - Agency staff, those seconded to the Trust from other organisations, those covered by a letter of authority / honorary contract, apprentices, trainees, volunteers and those on work experience; and
    - Board, Committee, sub-committee, Council of Governors and advisory group members (who may not be directly employed or engaged by the Trust).

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

Risk Appetite and Risk Tolerance

18. **Risk Appetite** is the level of risk the Trust **aims** to operate within for various areas such as safety, quality, finances and regulation. It is informed by the Trust overarching framework. It helps provide clarity on where we are more or less risk averse.

    The benefits of adopting a Risk Appetite are that it supports informed decision-making and reduces uncertainty. It improves consistency across governance mechanisms and decision making and supports performance improvement. It supports us to focus on priority areas and informs our spending review and resource prioritisation processes.

    Risk Tolerance – is the level of risk with which the Trust is **willing** to operate given current constraints. It helps us to set acceptable positions in pursuit of framework and vision.

    Our definitions for Risk Appetite and Tolerance are taken from the 'Orange Book – Risk Appetite guidance note', Government Finance Function (October 2020).

    These terms **should not** be used interchangeably.

Risk Appetite Statement 2024-2025

19. The Board of Directors reviews risk appetite annually.

20. The risk appetite statement below sets out the amount of risk the organisation is prepared to **tolerate** in pursuit of our strategic objectives. It should be read in conjunction with further detail provided in **Appendices 1 and 2.**

Assessment	Description of Potential Effect
Low Risk Appetite (minimal) Score – 1-3	The Board seeks to **avoid risks (expect in very exceptional circumstances)** preference is for a safe option with a low degree of inherent risk
Moderate Risk Appetite (cautious) Score – 4-6	The Trust Board is willing to **accept some risks in certain circumstances** preference is for a safe option with low degree of residual (current) risk
High Risk Appetite (open) Score – 8-12	The Trust Board is **willing to accept risks** preference for considering all options and choosing one that is most likely to result in successful delivery
Extreme Risk Appetite (eager) Score – 15 -25	The Trust Board **accepts risks that are likely** preference is to be willing to innovate and chose options that may suspend previously held assumptions and accept greater uncertainty

21. Appetite by domain category (agreed by the Board in May 2024)

Category	**Low** (minimal)	**Moderate** (cautious)	**High** (open)	**Extreme risk** (eager)
	1-3	4-6	8-12	15-25
Clinical Quality and Safety				
Statutory/ Compliance				
Financial Sustainability				
Business				
Reputation				
Workforce				
Environment				
Strategic				

22. Risks throughout the organisation should be managed **within the risk appetite**. Where this is exceeded, action should be taken to reduce the risk.

23. Risks on risk registers held locally, at divisional level, corporate level or on the Board Assurance Framework (BAF) should identify target risk scores determined by the Risk

Appetite Statement. The table below shows the target score range to be used.

Risk Appetite	Target Score Range (the optimal level we are aiming for to comfortably manage the risk)
LOW (minimal)	1-3
MODERATE (cautious)	4-6
HIGH (open)	8-12
Extreme risk (Eager)	15-25

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

Definitions of Risk and Risk Management

25. **A risk** is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.

26. **Risk Management** is the proactive identification, classification and control of events and activities to which the Trust is exposed. **See Appendix 2** for further definitions that relate to this framework.

Principles of successful Risk Management

27. It is the role of the Board of Directors to lead and support risk management across the organisation. The principles of successful risk management are:

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

Responsibilities and accountabilities for risk management

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

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

30. **All managers** are expected to make risk management a fundamental part of their approach to clinical and corporate governance and have the authority and responsibility for health and safety and the effective management of risks including the reporting and management of incidents and serious occurrences within their teams, services or

departments. They have the authority to assess and manage risks and directly manage risks graded very low to moderate reporting to their directors on completion. Their specific duties include:

- maintaining an up-to-date and live service level risk register so that they can demonstrate they have considered risks both reactively and proactively and that they have effective plans in place to control these risks
- making sure all incidents occurring in their area or affecting service users in their care are reported and investigated appropriately, following the Trust's Incident Management Policy;
- making sure that lessons learnt from when things go wrong (whether through incidents, complaints or national reports) are disseminated and implemented within their teams, services or departments as appropriate
- making sure health and safety assessments are carried out and any problems found are put right quickly
- making sure all staff in their teams, services or departments are aware of and work to all Trust policies and procedures
- making sure all staff are aware of any risks with their work and what plans they need to follow to control these risks as much as possible (e.g. personal safety plans, managing violence and aggression guidance)
- making sure all staff in their teams, services or departments have annual personal development reviews which include consideration of risk and safety aspects of their roles
- making sure all new staff receive Trust and local induction – local induction to include risk and safety issues as described in the Trust Induction policy
- identifying any staff training and development needs with regard to risk and safety, including all statutory or mandatory training needs (e.g. First Aid, clinical risk assessment and management) and make sure staff are enabled to undertake the necessary training and development
- making sure all staff are fit and well and able to carry out their duties safely (in line with the Trust's Promoting Attendance and Managing Sickness Absence Policy)
- making sure all equipment and devices provided for the team or department's work is safe and fit for purpose (Medical Devices Policy)
- making sure the environment is safe for staff, service users, carers and members of the public (Health and Safety checklist, PLACE assessment and reporting of RIDDOR incidents)

Risk Assessment and Management Tools

31. The Trust has developed a number of tools to support staff in the identification, assessment, actions and monitoring arrangements. These tools are to be used for clinical and non-clinical risk management.

32. NHS England's Risk Management Policy and Process Guide, 2015 sets out an overarching strategic direction to manage risk. More specifically, the Department of Health published Best Practice in Managing Risk, guidance on risk assessment and management in mental health in 2007. This document sets a framework of principles to underpin best practice in mental health settings and provides a list of tools for risk assessment and management. The philosophy underpinning this framework is one that balances care needs against risk needs and emphasises:

- positive risk management
- collaboration with the service user and others involved in their care
- the importance of recognising and building on service users' strengths
- the organisation's role in risk management alongside the individual practitioner

33. It stresses the importance of linking risk management with the Care Programme Approach and the Mental Health Act. Positive risk assessment, as part of a carefully constructed plan, is a required competency for all mental health practitioners.

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

35. The DRAM is available through the Trust patient record system.

Risk Management Process

36. The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

37. Risks are events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. Risk management also includes issues that 'have' happened and were not planned but require management action.

38. Risks are identified and managed in the following key stages:

- Risk identified
- Controls, gaps, actions and owners identified
- Scoring identified
- Risk agreed at directorate level and added to the Ulysses system
- Where risks are scoring 12 or above they must be agreed at directorate level and then with the Executive lead for consideration of escalation onto the Corporate Risk Register.
- Risks are then taken through Risk Oversight Group confirm and challenge, recommended to Executive Management Team and then agreed at EMT and recommended to Board Assurance Committees/Board of Directors.
- Completion of the risk register; *(risks should receive confirm and challenge at directorate level and permission sought from the Executive Lead in support of escalation onto the Corporate Risk Register)*
- Escalation, de-escalation and archiving of risks as appropriate. (Confirm and challenge to take place at directorate level and agreed with the Executive lead

and advised to Risk Oversight Group prior to EMT and Board Assurance Committees where a risk was scoring 12 or above.

Stage 1: Clarifying objectives

39. Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.

40. In order to clarify:

- Strategic (Corporate) Objectives – determine which Trust Strategic Objective(s) is relevant to the Directorate, Division or Service area.
- Local Objectives – determine objectives that are only relevant to the Directorate, Division or Service area.

Stage 2: Identifying risks to objectives

41. Once the objectives are clarified, risks are more easily identified.

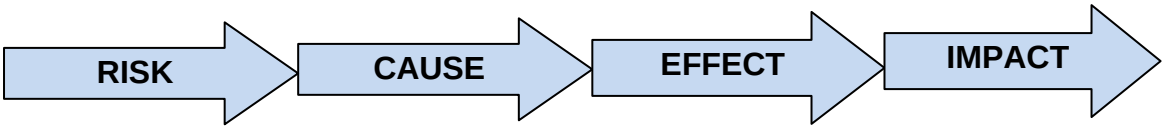
42. Where appropriate, working collaboratively with colleagues, with consideration of the following suggested questions. This enables stakeholders to more accurately identify risk:
    - What are the risks which may prevent the delivery of your objectives?
    - What risks have an impact on the delivery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

Stage 3: Describing Risk and Assigning Controls

43. Risks are described in a clear, concise and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

44. When wording the risk, it is helpful to think about it in four parts. For example:
"There is a risk that…. This is caused by …. and would result in…. leading to an impact upon ……."

45. The Trust's standard for recording risks is to define risks in relation to:



- A **Risk** is described as something uncertain that may happen and could prevent us from meeting our objectives.
- The **Cause** is the problem or issue that 'could' cause the risk to happen.
- The **Effect** is the result of something that will happen if we do nothing about the risk

- The **Impact** is the wider impact of the risk on the objectives if we do nothing.

46. An example of describing risk in the Trust standard is detailed in table 1 below:

Objective:	To ensure safe staffing levels
Risk:	There is a risk of failure to maintain safe staffing levels
Cause:	Caused by high sickness rate and difficulties in recruiting clinical staff
Effect:	Resulting in staff not receiving mandatory training in resuscitation or blood safety which leads to ….
Impact:	Increased safety risk to patient

47. **Key Controls** are identified and put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does. Where a gap in control has been identified you must ensure that actions to address this are identified. Each action **must have an owner** (i.e., a named individual, responsible for the action) **and target completion date**.

48. Key controls **must describe the practical steps** that are being taken to manage and control the risk.

49. Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted;
- **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
- **Terminate** – an informed decision not to become involved in a risk situation, e.g., terminate the activity; or
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

50. In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.

- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which

they need to be informed about.

51. Contingency Plans – if a risk has already occurred and cannot be prevented *or* if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the register. Good risk management is about being risk aware and able to handle the risk, not risk averse.

52. All risks and controls are to be described in accordance with the Trust standard and recorded in the risk register following assessment.

Stage 4: Completing the Risk Register

53. Trust Risk Registers are web based and stored electronically. It is a transparent system to enable users to share learning. Confidential risks are restricted to those staff with appropriate authority.

54. The process for completing risk registers

- Number (automatically assigned)
- Assign risk level
- Date identified
- Site
- Directorate/Care Network
- Team/department
- Add reference to Board Assurance Framework (BAF) Risk link (only for corporate level risks)
- Risk type (classification of the risk)
- Risk source (how and where the risk has been identified)
- Risk description (the risk plus the cause and effect)
- Nominated executive lead
- Assessor (the person who undertakes the assessment)
- Manager/owner of the risk (the person responsible for actioning and managing the risk)
- Nominated executive lead
- Monitoring group (only for corporate level risks)
- Reason for escalation or de-escalation if appropriate
- Initial risk assessment (rate the **likelihood** of the risk materialising against the **consequence** of the risk happening without controls in place)
- Identify and list controls (what already exists and is in place to control the risk)
- Controls effectiveness
- Current risk assessment (following the implementation of controls)
- Actions (with responsible person and following SMART principles (see paragraph 58))
- Review of risk frequency
- Target risk assessment (only for corporate level risks)
- Risk category and risk appetite to be identified for all risks.
- Review of risk (when a review is undertaken and why – for audit purposes)

- Review frequency
- Reviewed by
- Closing the risk (only when applicable)
- Notifications (to notify another person of a risk for alerting action owners, managers, directorate leads and executive leads)

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

    - **Risk Manager/Owner** is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the Action Owner or the Assessor. High severity corporate risks, for example, will be owned by one Executive Director (nominated executive lead), but there may be many Action Owners. However, the system only allows for one action owner to be identified. This must therefore be the primary individual. The Risk Owner must know, or be informed, that they are the owner, and accept this.

    - **Source** of how or where the risk was identified. This could include:

        - Business planning
        - Audit (can be internal, external, clinical)
        - Complaints
        - External Review
        - Incident
        - Legislation
        - Litigation
        - NICE guidance
        - Regulatory standard
        - Risk Assessment

    - **Initial Risk Rating** and **Residual Risk Rating (also known as current risk score)** – when identifying a risk the initial risk rating should be stated (the severity and likelihood of the risk occurring without any controls in place) followed by the residual risk rating (the severity and likelihood of the risk occurring with controls in place). The initial risk rating is the score for the risk with no mitigations and controls in place. Each time the register is reviewed or the risk score is updated, this **must be recorded in the review section**. This is so the history and progress of a risk can be reviewed and this is clear. The Trust's guidance on the matrix and advice on scoring in contained in **Appendix 4.**

    - **Review Date** should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls and detail on when the risk is next expected to be reviewed.

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

57. When including actions, it is essential that these are assigned to an individual who is able to take responsibility for them, and that they follow SMART principles. This means actions should be **specific** rather than general, should be **measurable** to enable assurance to be provided upon their completion, should be **achievable** from the outset so any exception reporting is meaningful, should be **relevant** to managing the risk to which they have been applied, and should be **time-based** – meaning they should set a clear deadline by which they will be completed.

Stage 5: Escalation, De-escalation and closure of Risks

58. The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Team Risk Register to a Directorate/Care Network Risk Register, or from the Directorate/Care Network Risk Register to the Corporate Risk Register. Corporate risks are reviewed by Board Assurance Committees prior to the Board of Directors.

    New risks being entered into the system for the first time and risks being closed need to be discussed and approved at Directorate Leadership Team meetings and agreed by Executive Leads prior to escalation.

59. Risks will be escalated or de-escalated within the defined tolerances. Further guidance on how to escalate a risk on Ulysses is contained in the Risk Management Handbook.

60. All risks scoring 12 or above should routinely be escalated to the Corporate Risk Register unless there is a clear, and recorded reason why a directorate accepts management of high scoring risks locally – this can be for example because the score is aligned to risk appetite i.e. there could be a high risk appetite and although the score may be high it is accepted and being appropriately managed. Confirm and challenge should take place on the scoring to understand the rationale for holding any highly scored risk locally. If in doubt escalate for discussion at the next level up (directorate, risk oversight group or board assurance committee level). Confirmation of decisions about risk escalation should be recorded on the Ulysses system. The Ulysses risk template has a dialogue box prompting an explanation for an escalation process.

61. Once on the risk register, the risk owner is responsible for updating the risk in accordance with the review frequency outlined this would usually be monthly. When considering directorate level risks for escalation onto the corporate risk register, this should be discussed, and the decision recorded in the appropriate governance meeting and approval sought from the executive director on next steps.

62. Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e. a risk rated 25 (red, or high) at Directorate level will be re-evaluated and may not be rated at 25 at Corporate level. Any discussion on this should be clearly recorded and re-scoring considered including looking at the score alongside the defined risk appetite.

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

risk monitored at the appropriate governance meeting to ensure that the risk continues to be contained and mitigated. In some instances it may be necessary to re-escalate the risk at a later date. Confirmation of decisions about risk de-escalation should be recorded on the Ulysses system. The Ulysses risk template has a dialogue box prompting an explanation for a de-escalation process

64. It is important that risks are reviewed regularly to ensure actions and controls reflect the current situation, to ensure actions are updated and timescales adhered to and to close a risk or action where necessary.

Department/Team/Service Risk Registers

65. Individual teams, departments and services hold their own risk registers to evidence that consideration has been given to risks and these should be reviewed monthly. In addition to a risk register, individual teams will complete generic risk assessments for risks such as lone working, manual handling, fire safety, environmental risks etc. Where risk cannot be managed by the application of local policies and standard operating procedures, they should be entered on the risk register where teams are responsible for implementing any required actions to mitigate, control or remove the risk. New risks, movement of existing risks including closure need to be discussed and approved by Directorate leadership Teams with agreement of Executive Lead. Where risk ratings reach 12 or above, they ***must*** be escalated to the appropriate directorate risk register, for confirm and challenge and consideration of escalation to the corporate risk register. Risks agreed for escalation to Corporate Risk Register must be referred to Risk Oversight Group for scrutiny prior to presentation to Executive Management Team, and then Board Assurance Committees for agreement in advance of the Board of Directors.

66. Directorate/Care Network Risk Registers; Each directorate will be responsible for holding their own risk register, and the continual review, monitoring and updating of that risk register through the directorate's local governance structure and Trust's agreed governance framework. Key directorate risks are also reviewed as part of the service review process undertaken with Executive Directors every six months. Where a residual risk is assessed as or above 12, this will be escalated onto the Corporate Risk Register, via the escalation process detailed above. Risks agreed for escalation to CRR must be presented or referred to Risk Oversight Group for scrutiny prior to presentation to Board committees for ratification.

Corporate Risk Register

67. Risks which have a residual risk rating of 12 or above, or risks that impact on several or all directorates/care networks are considered for inclusion onto the Corporate Risk Register. For example, there may be a number of lower level risks about a specific issue which would warrant escalation of a combined risk by the directorate or there may be risks which are raised in a number of areas which may not be high risk but cumulatively could become a more serious issue. The risk should be discussed within divisions and with the executive director who will make the decision as to whether to escalate the risk to corporate level. This decision and its date should be recorded within the risk. The corporate risk register is managed by the Head of Corporate

Assurance with oversight from the Director of Corporate Governance (Board Secretary) and regular monitoring takes place at Risk Oversight Group in advance of Executive Management Team, the Board Assurance Committees and Board. Individual risks within it are managed by the individual directorate(s)/care networks with accountable individuals responsible for their review. They are monitored through the appropriate operational governance group.

The Corporate Risk Register is currently reviewed at every public Board meeting (bi-monthly) and at each Board Assurance Committee. If committees have any concerns about the progress made to mitigate risks is escalated to Board via the Alert, Advise, Assure (AAA) report and the CRR report, and any referrals made back to the Risk Oversight Group where further operational scrutiny is required.

Board Assurance Committees will give consideration as to whether corporate risks have reached a level that compromises any of the Trust's strategic objectives and should therefore be escalated to the Board Assurance Framework.

Risk Review

68. Individual risks should be reviewed in line with their residual risk rating. Those entering risks on the risk register are responsible for ensuring they attribute the correct risk review to their risk. This is not done automatically. At each risk review owners are required to review controls in place, consider any new controls, provide an update to actions, consider any new actions and review of current scoring.

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

Risk Profile

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

Severity

Catastrophic (5)				**1**	
Major (4)			**4**	**1**	
Moderate (3)				**6**	
Minor (2)					
Negligible (1)					
Likelihood	(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost Certain

Example risk profile diagram

Project and Programme Risk

70. Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of project documentation.

71. Project and programme opportunities and threats are generally identified:

a. Through the escalation of risks from projects within the programme;
b. During project or programme start up;
c. By other projects or programmes with dependencies or interdependencies with this project or programme;
d. By operational areas affected by the project or programme.

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

- Identify the owners of a programme and individual projects within the programme;
- Identify any additional benefits of adopting risk management within this project or programme;
- Identify the nature and level of risk acceptable within the programme and associated projects;
- Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level;
- Identify mechanisms for monitoring the successful applications of this framework within the programme and its projects;
- Identify how inter-project dependencies will be monitored and managed;
- Clarify relationships with associated strategies, policies, and guidelines;
- Have clear processes for escalating programme risks to the Corporate Risk Register or Board Assurance Framework
- Identify risks suitable for escalation to the Corporate Risk Register with agreement of Programme Senior Responsible Officer and present these to Risk oversight Group for confirm and challenge and onward reporting to Executive Management Team, Board Assurance Committees and Trust Board.

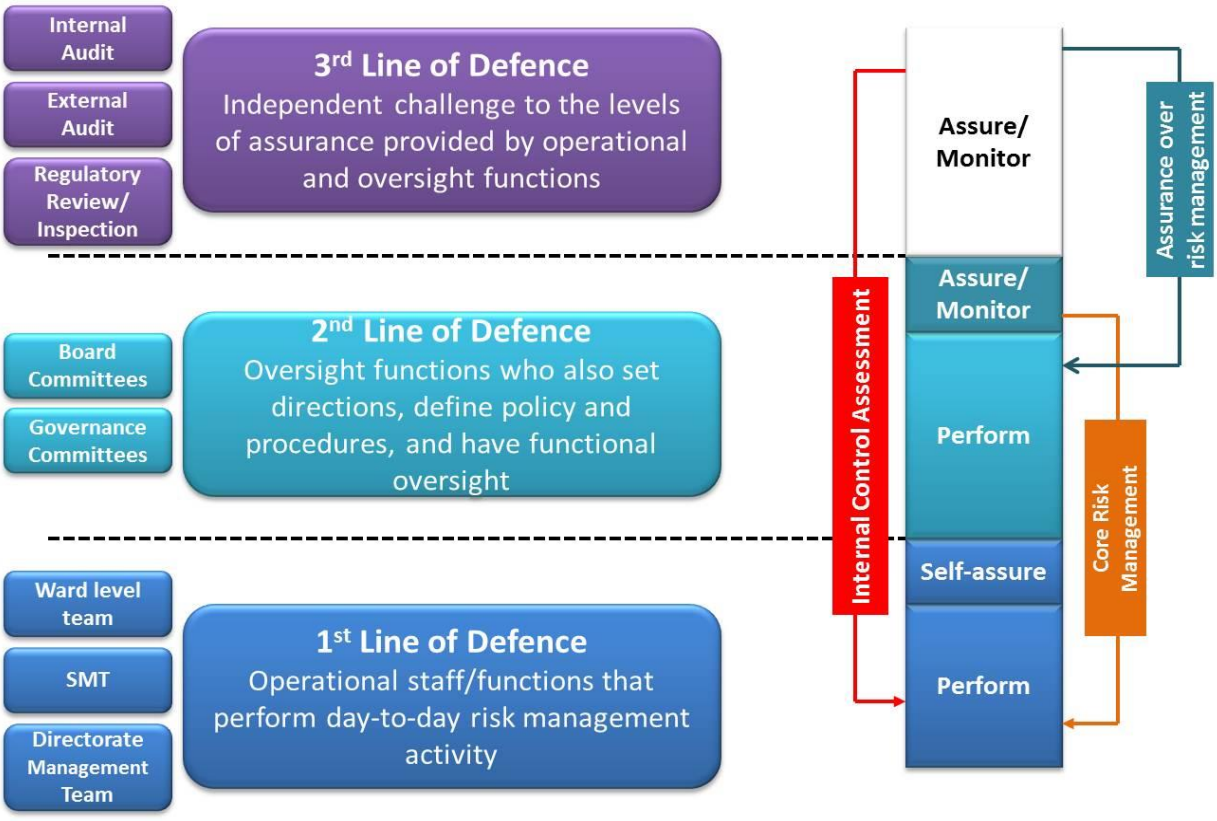
72. Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

73. In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising. This should be recorded in the risk description column of the risk register as part of the impact description. The cost of mitigating the risk should also be recorded in the 'Key controls and Contingency Plans' column if this can be determined. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

Risk Management and Assurance

74. Assurance is provided through transparent, timely and objective risk reporting. High quality and accurate risk management information helps to ensure that senior management is fully aware of material risks to which the organisation is exposed.

75. Appropriate internal control processes to manage risk can be demonstrated through the 3 lines of defence model.



76. The Trust's governance structure identifies the relevant Committees and their relationship to the Board. Specific responsibilities in relation to this framework, for the management of risk and assurance on its effectiveness are monitored by Committees and their reporting groups (further detailed in **Appendix 5**):

77. Additionally the Audit & Risk Committee and other Board Assurance Committees

provide assurance of the robustness of risk processes and to support the Board of Directors in its oversight of corporate and board assurance level risks.

78. Each Directorate and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.
79. Risks are correspondingly monitored at operational level (ward, team, service) through the appropriate governance team meetings.

80. Risk Management by the Board is underpinned by a number of interlocking systems of control: the Board reviews risk principally through the following three related mechanisms:

    a. The **Board Assurance Framework** (BAF) identifies risks in relation to each of the Trust's strategic objectives along with the controls in place and assurances available on their operation. Board agendas are structured to ensure appropriate discussion and assurance that risks which may result in non-achievement of Trust objectives are appropriately mitigated. The BAF is managed by the Director of Corporate Governance working with Executive leads prior to presentation to Board and its Assurance Committees on a quarterly basis. The BAF is also refreshed annually by the Board to reflect any risk to achieving operational priorities.

    b. The **Corporate Risk Register (CRR)** covers risks of 12 and above. The CRR is reviewed monthly by risk owners and quality assured by Executive Director owners of each risk who determine whether risks should be escalated onto the CRR or de-escalated back down to directorate/care network level or closed. The CRR is presented to every Board meeting and its assurance committees for oversight and assurance purposes. Currently received at all public board meetings.

    c. The **Annual Governance Statement** is developed by the Director of Corporate Governance and signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

	Board Assurance Framework	Corporate Risk Register	Directorate Risk Registers	Team Risk Registers
Risk Type	Risks to the organisation's strategic objectives	High level risks in the context of operational objectives	Broad range of operational risks	Risks specific to teams/services
Risk Owner	**Key focus**: Board of Directors. Risks managed by the executive team.	**Key focus:** Executive Directors. Risks managed by executive/ senior management.	**Key focus**: senior management. Risks managed by heads of service/ department.	**Key focus:** Senior Operational Managers. Risks managed by team/service managers.

	Board Assurance Framework	Corporate Risk Register	Directorate Risk Registers	Team Risk Registers
How risks are identified	Risks identified by the board and executives or escalated from the corporate risk register.	Risks identified through escalation from departmental risk registers and by senior management.	Risks identified through documented risk assessments and may be linked to incidents, audits, external assessments or other qualitative information.	Risks identified by team/service managers.
Coverage	**Includes:** Objectives, residual risk score, target risk score, controls (to mitigate the risk), gaps in control, assurances, gaps in assurances, action plan.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks deemed to impact upon the achievement of strategic objectives should be escalated to the assurance framework.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk framework) should be escalated to the corporate risk register.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk framework) should be escalated to the directorate/care network risk register.

Risk Oversight Group

81. The Risk Oversight Group reports into the Audit and Risk Committee and Executive Management Team and has responsibility to provide a check and challenge process to manage and mitigate principal risks, and to support with the assessment of principal and emerging risks to provide assurance to the Audit and Risk Committee with regard to compliance with the Trusts risk management system and processes.

- The group's responsibilities include, but are not limited to: Ensuring that an effective risk management framework is implemented throughout SHSC and supporting review of the Risk Management framework (policy)
- The group ensures that an effective risk management strategy and risk management framework is implemented throughout the Trust – making recommendations on any changes required to the Executive Management Team (EMT) and the Audit and Risk Committee.
- The group seeks assurance that risk management training is being managed and a systematic process is in place for provision of training.
- The group oversees and undertakes confirm and challenge of the Corporate Risk

registers (moderating risk scores, identifying themes and providing assurance of appropriate monitoring actions) for advising proposed changes to the Executive Management Team for agreement in advance of receipt at Board Assurance Committees and the Board of Directors,– this includes overseeing escalation of risks of 12 and above onto the Corporate Risk Register, de-escalation and closure of risks.

- Seeking assurance that risk management training is being managed
- Overseeing the Corporate Risk registers (moderating risk scores, identifying themes and providing assurance of appropriate monitoring actions) for advising changes to the overarching board Assurance Committees
- Sharing lessons learned and developing a positive risk management culture within the Trust
- Understanding and supporting the links between the Corporate Risk register and the Board Assurance Framework
- Supporting and advising on approach to cascade and understanding of risk appetite to ensure that risks throughout the organisation are managed within the risk appetite
- Ensuring robust confirm and challenge on risk management process are in place.
- Advice, Alert and Assure notices to EMT, Board Assurance Committees and Board of Directors as appropriate.
- Approval, noting and recommendations to Board Assurance Committees and risks owners on risk management process or movement of risks.

82. The scope of the Risk Oversight Group is Trust-wide. It reviews and monitors risk arrangements to ensure adherence to best practice across the organisation.

83. Operational Management Group (OMG)

Executive Management Team (EMT) has established an Operational Management Group (OMG) to oversee all operational policy, development, delivery, and performance issues. OMG considers, receives and implement recommendations for action from the Trust's clinical governance group. OMG escalate appropriate areas of concern and risk to EMT and take appropriate action on items escalated from care groups and Risk Oversight Group (RoG) risk panel.

Horizon Scanning

84. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. It can also support identification of areas of potential opportunities. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

85. By implementing mechanisms to horizon scan the Trust will be better able to respond to

changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

86. The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation;
- Government white papers;
- Government consultations;
- Socio-economic trends;
- Trends in public attitude towards health;
- International developments;
- Department of Health and regulatory body publications;
- Local demographics; and
- Seeking stakeholder's views.

87. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

88. Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

Training

89. Staff learning and development is critical to safety at work and safe working practices. All staff are expected to have a certain level of understanding of safety and risk management as determined by their job role.

90. Health and social care professionals will also be expected to meet core competencies with regard to service user safety, safe practice and risk assessment and management as part of their training and in their continuing professional development requirements.

91. Clinical risk assessment and management training, including familiarisation with the DRAM, is provided to staff in line with the Trust's Training Needs Analysis, incorporated within the Trust's Mandatory Training Policy. This training is required to be updated at least every three years (Best Practice in Managing Risk, DH 2007).

Training is provided to teams and individuals to support updating of Ulysses and understanding of the risk management framework and approach. Systematic formal arrangements for risk management training will be provided to ensure those identifying risks, those managing risks and those owning and responsible for risks are equipped with the knowledge needed to do so effectively and in compliance with this framework. Additional bespoke training is available to areas with high volume of risks or where support and guidance is needed.

Monitoring Compliance

92. The Risk Management framework is subject to Annual Review prior to presentation to Board.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency of Monitoring	Group or Committee
Risk Management framework	Review	Director of Corporate Governance (Board Secretary)	Annual or 3 yearly depending on circumstances	Risk Oversight Group, Audit & Risk Committee & Board
Annual Governance Statement	Internal/ External Audit	Director of Corporate Governance (Board Secretary)	Annual	Audit & Risk Committee & Board
Risk Management Process	Internal Audit	Director of Corporate Governance (Board Secretary) and Directorates	Annual	Audit & Risk Committee

93. The Risk Oversight Group, referred to separately in this document, provides ongoing review of the organisation's risk arrangements to ensure they are fit for purpose and prior to consideration at the stages detailed in the table above.

94. In addition, the Performance Framework includes review of risks at team, directorate and corporate level in a setting which is service-focused. Feedback is provided on risks in performance meetings and fed back to teams thereafter by the Executive Director of Finance, IMST and Performance or their nominee.

References

95. The references relating to this framework are:

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- NHS Audit & Risk Committee Handbook, Department of Health (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- HFMA – NHS Governance 2017
- Risk Appetite second edition – Leeds Hospitals NHS Trust March 2023

Equality Impact Assessment

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

Appendix 1: Categories of Risks and descriptions to support assessment.

Low (minimal) Risk Appetite 1-3	**The Board seeks to avoid risks (except in very exceptional circumstances) preference is for a safe option with a low degree of inherent risk**
Moderate (cautious) Risk Appetite 4-6	The Board is **willing to accept some risks in certain circumstances** preference is for a safe option with low degree of residual (current) risk
Clinical Quality & Safety	Issues impacting on: • Clinical or healthcare practice/or risks created or exacerbated by the environment such as LAPs or Cleanliness/IPC. • Service user, staff, or public safety. • Statutory and mandatory training requirements.
Statutory/Compliance	Issues Impacting on: • Non-compliance with a statutory duty or other regulatory compliance frameworks or inspections e.g. NHSE, Care Quality Commission, Health and Safety Executive, HM Coroner, individual data and data protection. • Compliance with statutory duties under the Equality Act 2010 and public sector duty and the Health and Social Care Act 2022.
Financial Sustainability	Issues impacting on: • Planning for existing and new services (as benefits to patient care may justify the investment). • Breakdown of financial controls, loss of assets with significant value. • Impact of wider financial system pressures on our ability to deliver the operating and financial plans.
High Risk Appetite 8-12 (open)	The Board is **willing to accept risks** - preference for considering all options and choosing one that is most likely to result in successful delivery
Business	Issues impacting on: • Sustainability • Ability to achieve plans. • Digital systems impacting on ability to function

	safely.
Reputation	Issues impacting on: • Potential for negative impact on the reputation of the Trust.
Workforce	Issues impacting on: • Attracting and retaining staff required to deliver our services/plans.
Environmental	Issues impacting on: • Estates and facilities infrastructure • Green Plan delivery
Strategic	Issues impacting on: • Delivery of transformation plans • Innovation
None currently	
Very high (eager) Risk Appetite 15-25	**The Board accepts risk that are likely - preference is to be willing to innovate and choose options that may suspend previously held assumptions and accept greater uncertainty.**
None currently	

Appendix 2: Definitions

Key term	Definition
Annual Governance Statement	Provides assurance that the Trust has a generally sound system of internal control that supports achievement of policies, aims and objectives and provides details of any significant internal control issues.
Assurance	Evidence that control measures are working effectively to manage risk. This can be internal (e.g. workplace review, scrutiny by a committee or the board) or external (e.g. Audit by external body). Assurance can be positive (providing evidence that controls are achieve the desired outcome) or negative (provide no such assurance and perhaps indicating the need for further action).
Board Assurance Framework (BAF)	A dynamic board-level summary identifying which of the Trust's strategic objectives are at risk because of inadequacies in the operation of controls of where the Trust has insufficient assurance that controls are effective. It also provides a summary of action being taken to address inadequate controls. It also records structured, positive assurances about where principal risks are being managed effectively and objectives are being

Key term	Definition
	delivered.
Clinical Risk	Any clinical activity which could have a direct effect on patient may include the lack of availability of services, supervision and competency of staff or adherence to Trust policies.
Control(s)	A measure in place to manage risk and assist in security the delivery of objectives. Controls are designed to make a risk less likely to happen or reduce its effect if it does happen. The controls recorded on the BAF should focus on the key strategic controls that help the Trust to manage principal risks and secure delivery of organisational objectives. The risk register may document additional controls in more detail, along with actions to address perceived gaps, as it serves as an action planning tool to manage risk, rather than a board level summary.
Corporate Risk Register (CRR)	A log of all high level risks that may threaten the achievement of the Trust's objectives. It is a dynamic document which is populated through the organisation's risk assessment and evaluation process. It enables risks to be quantified and ranked and provides a structure for collating information about risks.
Financial Business Risk	May include financial restraints, losses, irregularities or lost opportunities to deliver financial gain which may affect the Trust's ability to resource the services it provides.
Financial Impact	Where appropriate, risk should be assessed for their financial impact which is the cost the Trust accepts in order to achieve adequate management of the risk and should be considered alongside the maximum cost the Trust is willing to tolerate by way of losses if the risk were to materialise. It is acknowledged that not all risks are easily assessed in terms of their financial impact.
Health & Safety Risk	May include fire safety, security, buildings, plant and machinery, unsafe systems of work, failure to comply with health and safety legislation.
Internal Control	A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.
Inherent Risk	The level of risk before any control activities are applied.
Impact	The potential consequence if the adverse effect occurs as a result of the hazard.
Likelihood	The change or possibility of something happening.
Operational Risk	Results from day to day running of the Trust and includes a broad range of risks including clinical, financial, health and safety, information governance. These are usually managed by the service line in which they are identified.
Organisational Risk	Any activity which could have a detrimental effect on the day to day performance of the Trust and the services it provides. This

Key term	Definition
	may include the recruitment of staff, training and education, finance and information system, confidentiality and communication.
Principal Risk	Any risk that prevents the achievement of one or more of the Trust's strategic objectives as recorded in the BAF. Principal risks must be approved/removed by the Board. They may also be recorded on the CRR.
Residual Risk	The current risk "left over" after controls, actions or contingency plans have been put in place.
Risk	The change of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.
Risk Appetite	The level of risk the Trust is prepared to accept, tolerate or be exposed to at any point in time.
Risk Capacity	Maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in: • identifying, assessing and judging risks; • assigning ownership; • taking actions to mitigate and anticipate them; and • monitoring and reviewing progress.
Risk Owner	The individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation to risk (or a given level of the organisation).
Risk Rating	The total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 3: Roles and Responsibilities

Title	Responsibilities
Chief Executive	The Chief Executive is the responsible officer accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management.
Executive Directors	The Executive Directors have responsibility for overall strategic risk management within their portfolio area of responsibility. Executive Directors are expected to be able to speak about risks included on the Corporate Risk Register or Board Assurance Framework and will be informed of new or emerging risks on other registers as appropriate by their direct reports.
Those reporting to Executive Directors/Risk Owners	Those reporting directly to Executive Directors have responsibility for operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates. They also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk. They are also responsible for ensuring Executive Directors are appropriately informed of new or emerging risks and must ensure appropriate escalation of risks.
Director of Corporate Governance (Board Secretary)	The Director of Corporate Governance (Board Secretary) is accountable to the Chief Executive for the overall performance of corporate governance functions, including the risk management framework, monitoring and assurance of the system of internal control; including the system and supporting processes for risk registers and maintenance of the Board Assurance Framework and its supporting processes.
Executive Director of Nursing, Professions and Quality	The Executive Director of Nursing, Professions and Quality has responsibility for effective management of the electronic risk management system (Ulysses), clinical governance, patient safety, care standards and quality.
	Senior Managers take the lead on risk management and set the example through visible leadership of their staff. They do this by: • Taking personal responsibility for managing risk. • Sending a message to staff that they can be confident that escalated risks will be acted upon. • Ensuring risks are updated regularly and acted upon

Title	Responsibilities
	• Identifying and managing risks that cut across delivery areas. • Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focused approach. • Communicating downwards the top risks. • Escalating risks from the front line. • Considering risks from a number of perspectives including financial, business continuity, environmental, framework etc, not only from a service delivery perspective. • Ensuring staff are suitably trained in risk management. • Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve. • Ensuring that people are not blamed for identifying and escalating risks, and fostering a culture which encourages them to take responsibility in helping to manage them. • Ensuring that risk management is included in appraisals and development plans where appropriate. Senior managers are expected to be aware of and adhere to the risk management best practice to: • Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front line colleagues • Identify risk owners with the seniority to influence and be accountable should the risk materialise • Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do • Identify the actions needed to reduce the risk and assign action owners • Is there an opportunity to benefit from the risk or the work done to mitigate against the risk materialising? • Record risks on a risk register • Check frequently on action progress, especially for high severity risks • Apply healthy critical challenge • Implement a process to escalate the most severe risks, and use it •

Title	Responsibilities
All staff	All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they should be aware and encouraged to follow the Speaking Up: Whistleblowing Policy incorporating guidance on both whistleblowing and raising concerns.
Staff side representatives	Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate and providing advice in the event of a dispute to the validity of a risk assessment.

Appendix 4: Risk matrix and risk scoring guidance.

Calculate the consequence and likelihood rating using the scales below.

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

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

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15-25	Extreme Risk

Reminder of the Appetite scores and descriptions

Assessment	Description of Potential Effect
Low Risk Appetite (minimal) Score – 1-3	The Board seeks to **avoid risks (expect in very exceptional circumstances)** preference is for a safe option with a low degree of inherent risk
Moderate Risk Appetite (cautious) Score – 4-6	The Trust Board is willing to **accept some risks in certain circumstances** preference is for a safe option with low degree of residual (current) risk
High Risk Appetite (open) Score – 8-12	The Trust Board is **willing to accept risks** preference for considering all options and choosing one that is most likely to result in successful delivery
Extreme Risk Appetite (eager) Score – 15-25	The Trust Board **accepts risks that are likely** preference is to be willing to innovate and chose options that may suspend previously held assumptions and accept greater uncertainty

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

Consequence x Likelihood = Overall risk rating

3 x 5 = 15

Moderate x Almost certain = High Risk

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

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

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

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

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

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

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

Consequence Table

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
SAFETY	Minimal injury requiring no/ minimal intervention or treatment.	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity/disability	Incident leading to death
Impact on the safety of patients, staff or public (physical/ psychological harm)	No time off work	Requiring time off work for >3 days	Requiring time off work for 4-14 days	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
	Incorrect medication dispensed but not taken	Increase in length of hospital stay by 1-3 days	Increase in length of hospital stay by 4-15 days	Increase in length of hospital stay by >15 days	An event which impacts on a large number of patients
	Incident resulting in a bruise/graze	Physical attack, such as pushing, shoving or pinching, causing minor injury	RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	Unexpected death
	Delay in routine transport for patient	Self-harm resulting in minor injuries	An event which impacts on a small number of patients	Wrong drug or dosage administered with significant adverse effects	Suicide of a patient known to the service in the past 12 months
	Expected death	Grade 1 pressure ulcer	Wrong drug or dosage administered Physical attack causing moderate injury	Physical attack resulting in serious injury	

	Missing patient not AWOL (low risk)	Laceration, sprain, anxiety requiring occupational health counselling (no time off work required) Missing patient AWOL (medium risk)	Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare Acquired Infection (HCAI) Incorrect or inadequate information/ communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain Missing patient AWOL (high risk) Treatment or service has significantly reduced effectiveness	Grade 4 pressure ulcer Long-term HCAI Slip/fall resulting in injury e.g. dislocation/fracture/loss of consciousness/ concussion Post-traumatic stress disorder Missing patient/Absent without leave (AWOL) – with Ministry of Justice (MOJ) restrictions and public safety	Homicide (or suspected homicide) committed by a service user Incident leading to paralysis Incident leading to long-term mental health problem Rape/serious sexual assault Loss of a limb Death suspected related to staff actions
QUALITY	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Formal complaint (stage 2) complaint	Non-compliance with national standards with	Totally unacceptable level or

Quality/Complaints/ Audit	Informal complaint/ inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	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	significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report Major complaint / claim	quality of treatment/service Gross failure of patient safety if findings not acted upon Inquest/ ombudsman inquiry Gross failure to meet national standards
WORKFORCE 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 Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty	Multiple breaches in statutory duty Prosecution

				Improvement notices Low performance rating Critical report	Complete systems change required Zero performance rating Severely critical report
REPUTATIONAL 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. Total loss of public confidence MP concerned (questions in the House)
BUSINESS 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	Uncertain delivery of key objective Schedule slippage Key objectives not met Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met Non-delivery of key objective
FINANCE Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000 Vandalism / theft <£10k	Loss of 0.25–0.5 per cent of budget (change to 2 – 2.5%) Claim(s) between £10,000 and £100,000 Vandalism / theft £10-50k	Loss of 0.5–1.0 per cent of budget (change to 2.5 – 3%) Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Loss of >1 per cent of budget (change to 3%) Failure to meet specification/ slippage Loss of contract / payment by results

		Cosmetic damage to premises		Vandalism / theft £50k - £100k	Claim(s) >£1 million Vandalism / theft over £100k
ENVIRONMENTAL Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption >8 hours Minor impact on environment Cosmetic damage to premises Short term inability to meet environmental standards as per the NHS Green plan	Loss/interruption of >1 day Moderate impact on environment Structural damage to premises	Loss/interruption of > 1 week Major impact on environment Permanent irreparable damages to premises/damage up to £100k	Permanent loss of service or facility Catastrophic impact on the environment Serious fire Permanent/ irreparable damage to premises/damage over £100k
DIGITAL Infrastructure/ resources/ licencing	Preferred software and hardware models unavailable and unsupported Individual issues with equipment B53	Unavailability of equipment due to supply chain issues Infrastructure failure relating to a service of less than 5 people	Infrastructure failue of a service of between 5 and 20 people Lack of Digital resource necessary to develop EPR and department Current lack of digital skills in workforce and inability to adapt to new systems and ways of working	Infrastructure failure of a service between 20 and 100 people Reduction in current resource available to Digital team Inability to report against Statutory returns due to skills/systems gap	Complete infrastructure failure that is Trust wide and affects all staff ICO financial penalties to maximum level following Trust-wide data breach

			Lack of capacity in Digital workforce to deliver against Trust-wide projects Foreseen increases in licencing costs	Data breach affecting large numbers of patients and carers Unforeseen increases in licencing costs for major systems including Microsoft Failure of key infrastructure relating to EPR including 3rd party cloud hosting Lack of available budget to meet long term strategic ambitions of the Trust with reference to technology deployment ICO financial penalties Ransomware attack affecting connected systems	Unrecoverable systems following ransomware attack

Appendix 5: Committees and Governance Structures

Committee	Responsibilities
Board of Directors	The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust. The Board will receive and scrutinise the Board Assurance Framework at all its scheduled public meetings (bi-monthly). **Non-Executive Directors:** the role of Non-Executive Directors in the Board and as Chairs of Board Committees is that of oversight and challenge to ensure that internal systems of control and the process for management of risk is effective and fit for purpose.
Audit & Risk Committee	The Audit & Risk Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk: • To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. • To receive reports from Risk Oversight Group • To review the Trust corporate risk register on a quarterly basis. • To monitor and review the Board Assurance Framework and ensure its presentation to the Trust Board at intervals that the Board determines. • To assess the overall effectiveness of risk management and the system of internal control. • To challenge on the effectiveness of controls, or approach to specific risks.

Committee	Responsibilities
Finance and Performance Committee	The Finance& Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and the Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.
Quality Assurance Committee	The Quality Assurance Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care governance systems including risks for clinical, corporate, information and research & development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.
People Committee	The People Committee is responsible for providing information and making recommendations to the Trust Board on workforce and organisational development issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and the Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.
Risk Oversight Group	The Risk Oversight Group monitors compliance with the Risk Management framework, monitors the corporate Risk Register and associated actions and data analysis, reports assurance or gaps in assurance to the Audit and Risk Committee, the Executive Management Team and to the relevant Board Assurance Committees on risks they oversee makes recommendations on future improvements to the risk arrangements within the organisation.

Committee	Responsibilities
Digital Transformation Board	The digital transformation board oversees three portfolios: clinical systems, business systems and infrastructure and the projects and programmes underneath them. The group manages risks and issues that have been escalated from the framework groups that report into them and makes strategic decisions regarding digital products
Programme Management Boards	Providing oversight of transformation programmes.
Operational Management Group	Executive Management Team (EMT) has established an Operational Management Group (OMG) to oversee all operational policy, development, delivery, and performance issues. OMG considers receive and implement recommendations for action from the Trust's clinical governance group. OMG escalate appropriate areas of concern and risk to EMT and take appropriate action on items escalated from care groups and Risk oversight Group.