

## RISK MANAGEMENT POLICY AND PROCEDURE

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<b>Relevant staff group/s:</b>	All Trust staff

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## DOCUMENT CONTROL

Reference	Version	Status	Author
MR/Feb17/RM	7	Final	Risk and Compliance Manager
<b>Amendments:</b> Policy revised to reflect changes in the Trust's Risk Management Strategy, revised clinical risk and wider governance arrangements and changes in executive level responsibilities			
<b>Document objectives:</b> To set out the Trust's approach to Risk Management			
<b>Intended recipients:</b> All Trust staff			
<b>Committee/Group Consulted:</b> Heads of Division, Executive Team, Clinical Governance Group			
<b>Monitoring arrangements and indicators:</b> Current risk assessments within services across the Trust. Risk Registers within services across the Trust and assurance these registers are reviewed regularly. Assurance of action plans put in place to mitigate or eliminate a particular risk. Internal and external 'well led' and risk audits			
<b>Training/resource implications:</b> Introduction to risk management as part of Corporate Induction. Identify and train sufficient numbers of appropriate members of staff to act as Risk Monitors at a local level.			
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<b>Contact for review</b>	Risk and Compliance Manager		
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### CONTRIBUTION LIST Key individuals involved in developing the document

Designation or Group
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Chief Operating Officer
Head of Corporate Business
Head of Operations/Deputy Chief Operating Officer
Non-Executive Director
Executive Management Team

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## **1. INTRODUCTION**

- 1.1 This document sets out how all staff should approach the management of operational and corporate risks within their Team, Department, Service, Division or the wider Trust.
- 1.2 This policy complements the Board Assurance framework through which strategic risks to the Trust's objectives are managed.
- 1.3 All NHS Trusts are required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<sup>1</sup> to:
- assess the risks to the health and safety of service users receiving care or treatment;
  - doing all that is reasonably practicable to mitigate any such risks.

## **2 PURPOSE AND RATIONALE**

- 2.1 This document defines the standards and procedures applicable to all Trust staff for the effective management of operational and corporate risks. This is achieved by:
- setting out respective responsibilities for operational, corporate and strategic risk management for staff, the Executive Team, the Chief Executive and the Board, as well as other persons or Trusts working in cooperation with the Trust to deliver care (see section 5)<sup>2</sup>;
  - explaining the methods used to assess, monitor and mitigate both operational and corporate risks effectively<sup>1</sup>;
  - delivering a clear policy framework to deliver the Trust's Risk Management Strategy.
- 2.2 This policy applies to those members of staff who are directly employed by the Trust or for whom the Trust has legal responsibility. For those staff covered by a letter of authority/honorary contract or work experience, the Trust's policies are also applicable whilst undertaking duties for or on behalf of the Trust. This policy also applies to all third parties and others authorised to undertake work on behalf of the Trust.

## **3. POLICY STATEMENT**

- 3.1 The Trust is committed to ensuring the safety of its patients and staff and will do this by actively managing the uncertainties of operational and corporate risks through the implementation of a clear and robust risk

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1 Health and Social Care Act 2008, (Regulated Activities) Regs 2014, s17 (2b)

2 Health and Social Care Act 2008, (Regulated Activities) Regs 2014, s 17 (2a)

management framework<sup>3</sup>. We will seek to adopt best practice in risk management, employ new technologies to help manage risk and ensure our staff are appropriately trained to manage the risk associated with our activities.

- 3.2 The Trust acknowledges that it is not possible or desirable to eliminate all risks and we will encourage positive risk-taking in keeping with our statement of risk appetite where risks may result in positive benefits for our patients, staff and visitors.

#### **4. DUTIES AND RESPONSIBILITIES**

The following paragraphs set out the respective risk duties and responsibilities for specific groups and members of staff.

##### **4.1 The Board**

Executive and non-executive directors share responsibility for the successful management of the Trust, including the effective management of risk. In context of risk management the Board is responsible for:

- providing leadership on the Trust's Risk Management Strategy;
- ensuring assurances clearly demonstrate this policy is being applied consistently across the Trust;
- protecting the reputation of the Trust by managing risks effectively/

##### **4.2 The Chief Executive**

As Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's objectives. To fulfil this responsibility the Chief Executive will:

- ensure management processes fulfil the responsibilities for risk management as set out in this Risk Management Policy;
- ensure their full support and commitment to the Risk Management Strategy;
- plan for adequate staffing, finances and other resources to ensure the management of those risks which may have an adverse impact on patients and carers together with the staff, finances or stakeholders of the Trust;
- ensure an appropriate Board Assurance Framework (BAF) is prepared and regularly reviewed and updated and receives appropriate consideration and ensure an Annual Governance Statement,

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<sup>2</sup> Health and Social Care Act 2008, (Regulated Activities) Regs 2014, s 17 (2b)

<sup>3</sup> Health and Social Care Act 2008, (Regulated Activities) Regs 2014, s 12 (2a & 2b)

adequately reflecting the risk management within the Trust and is prepared and signed off each year.

#### 4.3 **The Executive Team**

Members of the Executive Team will act as senior responsible officers (SROs) for their respective areas and will ensure within their areas risks are managed effectively, including:

- notifying Heads of Division of any strategic or corporate risks to the delivery of defined Divisional objectives;
- scrutinising new risk assessments escalated to the Corporate Risk Register;
- ensuring Divisional Risk Registers are maintained and actively managed within their area;
- ensuring staff with responsibility for corporate risks implement short, medium or long-term action plans to mitigate those risks;
- ensuring all staff are aware of and fulfil their appropriate responsibilities for risk management;
- ensuring all activities undertaken within their area are consistent with the safe operation of the Trust. In the context of this policy this means reporting to the Trust Board the raising and closing of corporate risks, via the BAF or the Corporate Risk Register.

#### 4.4 **Executive Team**

Executive responsibility for specific areas related to risk management are outlined in the table below:

<p><b>The Medical Director</b> is the Caldicott Guardian for the Trust and has delegated responsibility for:</p> <ul style="list-style-type: none"> <li>• assuring the effective management of operational risk within the Medical workforce;</li> <li>• overseeing the quality and improvement of clinical services;</li> <li>• standards of professional practice (including appraisal and regulation) and codes of conduct for the medical and dental workforce;</li> <li>• research and development strategy, operations and governance;</li> </ul>	<p><b>The Director of Nursing and Patient Safety</b> is the patient safety lead for the Trust and has delegated responsibility for assuring the effective management of:</p> <ul style="list-style-type: none"> <li>• clinical governance processes (including clinical audit);</li> <li>• clinical risk;</li> <li>• overseeing the quality and improvement of clinical services;</li> <li>• patient safety;</li> <li>• infection prevention and control;</li> <li>• implementation of national safety alerts, untoward event reporting;</li> <li>• safeguarding children and vulnerable adults;</li> </ul>
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<ul style="list-style-type: none"> <li>• medicines management;</li> <li>• confidentiality, the Caldicott Guardian;</li> <li>• quality improvement and the quality account priorities of the Trust.</li> </ul>	<ul style="list-style-type: none"> <li>• standards of professional practice (including appraisal and regulation) and codes of conduct for the Nursing and Allied Health Professional workforce;</li> <li>• implementation of National Institute for Health and Clinical Excellence (NICE) guidelines.</li> </ul>
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<p><b>The Director of Strategy and Corporate Affairs</b> is the <b>CQC ‘Nominated Individual’</b> and the Data Protection Officer for the Trust and has delegated responsibility for assuring the effective management of:</p> <ul style="list-style-type: none"> <li>• the review, management and delivery of the risk management policy;</li> <li>• compliance with CQC Fundamental Standards;</li> <li>• Emergency Planning, Response and Recovery (EPRR);</li> <li>• civil litigation;</li> <li>• Information Governance (including Data Protection);</li> <li>• Freedom of Information;</li> <li>• the health and safety of staff and visitors as required by Health and Safety and other legislation;</li> <li>• security management;</li> <li>• fire safety;</li> <li>• environmental risk through waste disposal, pollution and food handling;</li> <li>• adverse media issues;</li> <li>• overseeing compliance with Mental Health Act legislation</li> <li>• overseeing compliance with the Equality Act.;</li> <li>• asset management, maintenance and insurance.</li> </ul>	<p><b>The Director of Finance and Business Development</b> is the Senior Information Risk Officer for the Trust and has delegated responsibility for managing:</p> <ul style="list-style-type: none"> <li>• overall financial risk;</li> <li>• financial and other fraud;</li> <li>• information security risk.</li> </ul>
	<p><b>The Director of Human Resource and Workforce Development</b> has delegated responsibility for managing:</p> <ul style="list-style-type: none"> <li>• recruitment;</li> <li>• pre-employment checks;</li> <li>• professional registration;</li> <li>• terms and conditions of employment;</li> <li>• advice on employment legislation;</li> <li>• policies and procedures relating to staffing issues;</li> <li>• training and workforce development.</li> </ul>
	<p><b>Chief Operating Officer</b> has delegated responsibility for managing:</p> <ul style="list-style-type: none"> <li>• operational risk within the Trust’s provider services.</li> </ul>

#### 4.5 **Heads of Division and Clinical Directors**

Senior managers are responsible for ensuring the requirements of this policy are effectively implemented within their areas of responsibility.

#### 4.6 **Heads of Division, Clinical Directors, Service and Team Managers, Matrons and Ward Managers**

Heads of Division, Clinical Directors, Service and Team Managers, Matrons and Ward Managers are accountable for:

- managing operational risk within their divisions, through the proactive, timely and accurate review and update of all risk assessments owned by their division or service. This will include supporting risk owners, those responsible for current controls and those responsible for action plans to scrutinise their existing risks and progress to reduce or eliminate a risk;
- managing and monitoring these risks on a Risk Register to provide a complete overview of all potential risks to which a Division or Service is exposed;
- escalating to the Senior Management Team and the Board, where appropriate, any significant risks to the safe and efficient delivery of Trust services, including clinical, financial and reputational risks, in line with the escalation process set out in Appendix F;
- ensuring that staff in their divisions, teams and services feel empowered to take action to identify (for example from incident reporting patterns or trends), assess and mitigate risks. Senior managers should seek assurance their teams are encouraged to proactively manage risk to improve the safety of care and services;
- making all staff in their divisions, teams and services fully aware of their responsibilities towards risk as listed below.

#### 4.7 **Responsibilities of all staff**

All Trust staff are, directly or indirectly, responsible for the safety of patients will:

- be familiar and comply with this policy in addition to the Trust's Risk Management Strategy and Health and Safety procedures;
- comply with all other Trust policies and procedures which are applicable to their area of work as this will, directly or indirectly enhance the safety of patients, colleagues and the public;
- be vigilant for potential risks and take responsibility for reporting or, where appropriate, completing a risk assessment. Potential risks should be reported to a line manager, Head of Division, Risk and Compliance Manager or Head of Corporate Business as appropriate;



- report adverse incidents and near misses in accordance with Trust policy;
- be aware they have a legal duty to take reasonable care of their own safety and the safety of others who may be affected by the Trust's business.

#### 4.8 **Board Committees**

The Trust Board delegates some of its responsibilities to its sub-committees.

**Audit Committee** – As set out in its Terms of Reference, the Audit Committee will review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

**Quality and Performance Committee** – As set out in its Terms of Reference, the Quality and Performance Committee will receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient safety and patient experience.

**Finance and Investment Committee** – As set out in its Terms of Reference, the Finance and Investment Committee is responsible for monitoring financial risk.

**Mental Health Legislation Committee** – As set out in its Terms of Reference, the Mental Health Legislation Committee is responsible for monitoring risk in relation to the Trust's compliance with the Mental Health Act, the Mental Capacity Act and all other aspects of mental health legislation.

#### 4.9 **Governance Groups**

The Trust Board has established Governance Groups which are responsible for the oversight and scrutiny of risks related to their area of work. These Groups are:

- (i) Health & Safety, Security and Estates Group Committee will review fire, environmental and health and safety risks;
- (ii) Clinical Governance Group will review clinical risks and risks to patient safety;
- (iii) Our Partnership Group will review workforce risks;
- (iv) Caldicott and Information Governance Management Group will review information governance risks;
- (v) SIRI Review Group will review risks arising from serious incidents, including patient suicides and homicides;
- (vi) Patient and Carer Involvement Group will review risks relating to patient experience, organisational reputation and equality and diversity.

Finance risks and cross-organisational risks will be monitored by the Senior Management Team.

#### 4.10 **Divisional Governance Groups**

Divisional Governance Groups are responsible for:

- reviewing the divisional risk register quarterly and considering risks escalated to the management board from their departments for adding to the Corporate Risk Register;
- presenting their divisional risks and reporting progress of mitigating actions to the Clinical Governance Group on a rotational basis;
- ensuring resource is allocated within their division to assess and manage their risks.

### 5. **DEFINITIONS:**

Board Assurance Framework	A report that provides the Trust Board with assurance(s) that the key risks associated with not achieving the corporate objectives are being mitigated
Corporate (High level) Risks	Risks that are rated and scored at 15 or above
Hazard	The source of a risk or an event with the potential to cause harm
Risk (Clinical or Corporate)	A measure of the probability and severity that an adverse event will occur in a specific time period or as a result of a specific situation
Risk Management	The systematic identification, reduction an/or elimination of risks
Risk Matrix	The mechanism through which all risks are rated and scored
Risk Register	The method used to record identified risks, their rating, scores, control measures and where evidence of controls can be located

## **6. THE RISK MANAGEMENT PROCEDURE**

- 6.1 The Trust has a statutory and ethical responsibility to assess, monitor and mitigate operational, corporate and strategic risks.
- 6.2 The procedure for the assessment, management and mitigation of risks set out in Appendix A.

## **7. RECORDING AND MANAGING RISKS ON A RISK REGISTER**

- 7.1 Where risks are of a significant level and cannot be immediately resolved, these will be recorded on a Local, Divisional or Corporate Risk Register (a summary table of risks).
- 7.2 Once a risk is identified and assessed it is recorded on to a local risk register (a template is available from the Risk Management page on the Trust Intranet). If the risk rating score is 15 or higher the Risk Assessment may be considered a Corporate Risk (see Appendix E).
- 7.3 The purpose of a risk register is to:
- provide a summary overview of all potential risks to which a Service, Division or the Trust may be exposed;
  - evaluate the level of existing internal control in place to manage the risk;
  - be an 'active' document to record and report risks using the Risk Management process. This means it is regularly reviewed and updated. Continuous monitoring and review of risk assessments encourages a safety culture. Regular risk assessment monitoring ensures new risks are identified and managed, action plans are implemented and managers and stakeholders are kept informed. The availability of regular information on risks can assist in identifying trends or areas for improvement.

### **Escalating a Risk Assessment to the Corporate Risk Register**

- 7.4 When a risk has been identified locally, which is estimated to be rated high (red) which are scored between 15 and 25 (using the Trust's risk assessment matrix) and cannot be managed solely by the local team, the risk should be considered for inclusion onto the Corporate Risk Register.
- 7.5 For recording on the Corporate Risk Register a completed risk assessment must be considered by the relevant governance group (see section 5.10 and Appendix F).
- 7.6 If considered a Corporate Risk the Responsible Risk Owner will then be the Head of Division and the Lead will be designated to an Executive Director. The Corporate Risk Register assures plans are put into place to lower the level of risk to the target risk (risk appetite).

7.7 This will be regularly monitored at Trust level and by the relevant governance group to assure effectiveness of these plans (please refer to section 5.12 of the Trust Risk Management Strategy (v.7 Sept 2016) for further explanation of the Trust's Risk Appetite).

## **8. MONITORING COMPLIANCE AND EFFECTIVENESS**

8.1 The Quality and Performance Committee has overall responsibility for monitoring compliance and effectiveness of this policy. The structure for monitoring and reporting is set out in Appendix F.

8.2 Other groups with responsibilities for monitoring are set out in Section 5.10 above. Each group will maintain a register of risks it identifies in relation to its terms of reference.

### **Methodology to be used for monitoring**

8.3 The type of audit and its frequency will be set out in an annual timetable by the Risk and Compliance Manager and they audits will be conducted in consultation with the Trust Audit team and in accordance with Trust Audit procedures.

- process audits of local and Divisional Risk Registers;
- process audits of local risk assessments;
- Trust internal auditors periodic review of risk management processes.

## **9. SPECIALIST RISK MANAGEMENT ADVICE**

9.1 The **Head of Clinical Governance and Risk** reports to the Deputy Director of Nursing and Patient Safety and has responsibility for monitoring clinical incidents, serious incidents requiring investigation and the maintenance of strategic level reporting to ensure that the executive team is fully aware of all clinical risks within the Trust.

9.2 The **Risk and Compliance Manager** reports to the Head of Corporate Business and provides specialist advice for managing risk to the Director of Strategy and Corporate Affairs, executive team, managers, lead clinicians, staff and appropriate agencies to assist the Trust in achieving risk awareness and compliance with relevant CQC regulations and other requirements. They will assist in the triangulation of intelligence information, including risks, incidents and CQC compliance and risk profiling, in order to identify possible areas of concern

9.3 The **Risk Management Information Officer** is responsible for the administration of the Trust incident reporting system, Datix, and will assist with incident reporting, thematic incident reports and incident pattern or trend analysis

## **10. SUSTAINING EFFECTIVE RISK MANAGEMENT THROUGH TRAINING**

- 10.1 Training is essential for the implementation of the Risk Management Policy and the success of the Risk Management Strategy. The Risk Manager and Head of Corporate Business will work in collaboration with the Trust Learning and Development Team to deliver a training programme for staff with risk management responsibilities. The Risk Manager will provide risk management advice and support to Managers and Risk Leads to facilitate local risk management. The Risk Manager will provide ad hoc risk management support or advice to Trust staff as and when needed.

## **11. EQUALITY IMPACT ASSESSMENT**

- 11.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

## **12. OTHER RELEVANT DOCUMENTS THAT SUPPORT TRUST RISK MANAGEMENT**

- 12.1 This policy should be read in conjunction with the following policies:

Business Continuity Management Policy  
Claims Handling Policy and Procedure  
Clinical Assessment and Management of Risk Policy  
Counter Fraud Response Plan  
Incident Response Plan  
Risk Management Strategy  
Serious Incident Requiring Investigation (SIRI) Policy  
Untoward Event Reporting Policy

- 12.2 All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

## **13. APPENDICES**

- 13.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and will be treated as such.

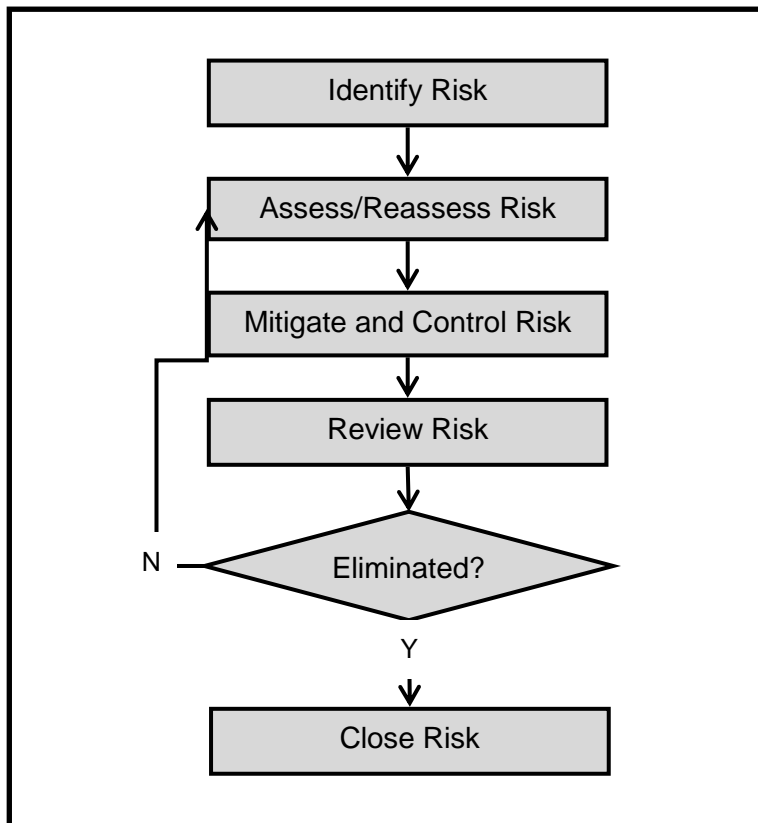
**RISK MANAGEMENT PROCEDURE**

**Important risk management concepts:**

As part of the Trust’s commitment to effective risk management:

- there should be an environment where risks are openly discussed and where mistakes and untoward events are dealt with in a non-punitive and responsive manner;
- human factors should be taken into account when assessing risks (advice on this can be sought from the Risk and Compliance Manager);
- risks should be assessed objectively not subjectively. This means when completing a (non-clinical) risk assessment refer to fact and not opinion, and explanation instead of judgement;
- when a risk assessment is completed it needs to be reviewed accordingly. The higher the risk rating score the more frequently a risk assessment should be reviewed;
- risk management is a dynamic continuous process.

The model below sets out the life-cycle for a risk within the Trust’s procedures:



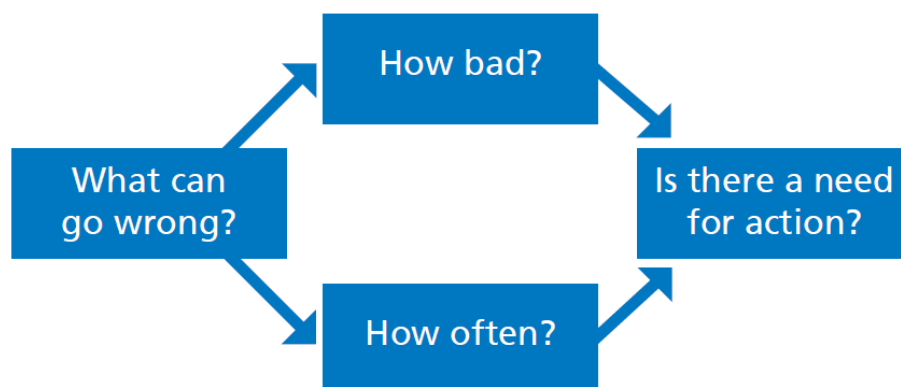
## 1. Identifying a risk

1.1 There are different ways to identify risks, for example:

- adverse incident trend reports (available from the Datix Administrator);
- a serious incident requiring investigation (SIRI);
- pro-active risk assessment (e.g. in preparation for a major project);
- audit, clinical, financial, process, internal or external;
- reports from assessments or inspections by external bodies;
- feedback from patient, carer or service user surveys or questionnaires;
- PALS enquiry or complaints;
- claims reporting;
- national and regional safety alert;
- asset registers or maintenance backlog;
- NICE and other professional guidance from regulatory bodies;
- observation.

## 2. Assessing a risk

2.1 A risk is assessed using the Trust Risk Assessment Form. A risk assessment seeks to answer four simple questions:



**Hazards** – the source of a risk or an event with the potential to cause harm.

**Risks** – are a measure of the probability and severity an adverse event will occur in a specific time period or as a result of a specific situation.

### **3. Grading a risk – how bad a risk is**

- 3.1 Risks can be prioritised by grading them. This will highlight risks which have a greater impact, and therefore require immediate action or need to be reviewed more frequently and managed more rigorously, from those that are more tolerable.
- 3.2 Risk grading should be consistent across the Trust. Risks are graded by combining estimates of consequence (also described as severity) and likelihood (frequency or probability) taking into consideration existing control measures (the context).
- 3.3 The rating of a given risk is established using a 5x5 grid (see Appendix B). The risk grading is an estimated score (the combination of likelihood and consequence) to show the magnitude of a risk from a specific hazard. A risk rating score needs to be an objective and appropriate reflection of the impact of risk.

### **4. Mitigating and Controlling Risks**

- 4.1 Each risk is allocated an owner and an assessor (they may be the same person).
- 4.2 It is the responsibility of the risk owner to ensure that suitable and adequate controls or mitigating actions are identified and carry out in order to reduce the likelihood or the impact of the risk, or both
- 4.3 Divisions are required to report progress of mitigating actions in respect of their key risks in their 'deep dive' reviews at the Clinical Governance Group.
- 4.4 Although an individual risk may be escalated and appear in another risk register, the original risk owner still maintains responsibility for the risk on their own register.

### **5. Risk reviews**

- 5.1 All 'live' risks will be subject to regular review. Risk owners are required to review their risks in accordance with review date set within individual local risk assessments, or when there are any changes which impact on the risk.



GRADING A RISK – HOW BAD IS A RISK?

Consequence score	Likelihood score				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
<b>5 Catastrophic</b>	5	10	15	20	25
<b>4 Major</b>	4	8	12	16	20
<b>3 Moderate</b>	3	6	9	12	15
<b>2 Minor</b>	2	4	6	8	10
<b>1 Negligible</b>	1	2	3	4	5

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

**How to use the grid**

- 1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
- 2 Use table 1 (see appendix B) to determine the consequence score(s) for the potential adverse outcome(s) relevant to the risk you are looking
- 3 Use table 2 (see appendix B) to determine the likelihood score(s) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
- 4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score).

## APPENDIX C

### THE CONSEQUENCE SCORE

Score	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Catastrophic
<b>Physical / Psychological Harm to Patients, staff or the Public</b>	No time off work	< 3 days off work	3 – 15 days off work (RIDDOR reportable)	> 15 days off work	Unable to return to work
	No increased length of stay	Increased length of stay by < 3 days	Increased length of stay 3 – 15 days	Increased length of stay > 15 days	Serious irreversible health effects
	Minor injury requiring minimal intervention	Minor injury requiring minor intervention	Moderate injury requiring professional intervention	Major injury or long term incapacity	Death or major permanent incapacity
<b>Information Governance</b>	Minor breach of confidentiality 5-20 people affected	Potentially a serious breach. Between 5-20 people affected  Encrypted files lost	Potentially a serious breach. Between 20-100 people affected.  Unencrypted files lost	Serious breach up to 1000 people affected or  Unencrypted sensitive data lost	Serious breach over 1000 people affected with potential for ID Theft
<b>Quality of Care or Best Practice</b>	Peripheral element of treatment / service sub-optimal	Clinical element of treatment / service sub-optimal	Overall treatment / service sub-optimal	Treatment / service has significantly reduced effectiveness	Totally unacceptable quality of treatment / service
	Potential failure to meet standards identified	Non-compliance with internal standards	Non-compliance with national standards	Non-compliance with national standards with significant risk to patients or staff	Non-compliance with national standards with serious risk to patient / staff safety
	Informal complaint or inquiry	Formal complaint with local resolution	Formal complaint with potential to go to independent review	Multiple complaints / independent review	Inquest or ombudsman inquiry

<b>Delivery of Objectives &amp; Projects / Business Interruption</b>	Barely noticeable reduction in scope or quality	Minor reduction in quality / scope	Reduction in scope or quality requiring client approval	Secondary objective not met	Key objective not met
	Insignificant cost increase / schedule slippage	< 5% over budget / schedule slippage.	5 -10% over budget / schedule slippage.	10 -25% over budget / schedule slippage.	> 25% over budget / schedule slippage
	Loss / interruption of service for < 1 hour	Loss / interruption of service for 1 to 24 hours	Loss / interruption of service 1 – 7 days	Loss / interruption of service for > 1 week	Permanent loss of service or facility
<b>Financial</b>	Single loss / capital spend > £10,000	Single loss / capital spend > £100,000	Single loss / capital spend > £500,000	Single loss / capital spend > £1,000,000	Single loss / capital spend > £3,000,000
	Recurring loss > £1,000 (e.g. loss of income)	Recurring loss > £10,000 (e.g. loss of income)	Recurring loss > £100,000 (e.g. loss of income)	Recurring loss > £500,000 (e.g. loss of income)	Recurring loss > £1,000,000 (e.g. loss of income)
<b>Adverse Publicity or Reputational</b>	Rumors Potential for local community concern	Local Media < 3 Days	Local Media > 3 Days	National Media < 3 Days	National Media > 3 Days Questions in the Commons Public Inquiry

**APPENDIX D**

**THE LIKELIHOOD SCORE**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Descriptor</b>	Rare	Unlikely	Possible	Likely	Almost Certain
<b>Frequency</b>	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
	< 1% above benchmark	1 – 5% above benchmark	6 – 20% above benchmark	21 – 50% above benchmark	> 50% above benchmark
<b>Probability</b>	< 1%	1 – 5%	6 – 20%	21 – 50%	> 50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

**RISK REGISTERS**

**1. RISK REGISTER**

1.1 The Trust’s Risk Register contains all risks raised in the Trust. To aid appropriate reporting and escalation, the risks are sub-divided:

Type	Contents
Corporate Risk Register	Risks to strategic objectives. Includes risks to strategic objectives that were scored 15 by divisional governance groups.
Divisional Risk Register	Risks to divisional objectives. Includes risks to divisional objectives that were scored 12 by local teams and services.
Local Risk Registers	Risks to service and team objectives. Includes all risks raised and logged against a department.

**Corporate Risk Register**

1.2 The Corporate Risk Register comprises risks that:

- (a) pose a risk to a strategic or corporate objective;
- (b) score 15 or above and are approved for entry into the Corporate Risk Register by the Senior Management Team.

1.3 The Corporate Risk Register is maintained by the Trust Risk and Compliance Manager.

**Divisional Risk Register**

1.4 Each division maintains a Divisional Risk Register.

1.5 The divisional risk register is populated by risks escalated from teams and services and risks to divisional objectives that have been identified by the divisional boards and management teams.

**Local risk registers**

1.6 In this context, the term ‘local’ is defined to include services and teams as well as corporate functions (such as IM&T, Estates and Facilities) so as to encompass different management structures within the Trust.

1.7 Individual local risk registers should be maintained by the Service or Team manager.

**Review of risk registers**

1.8 Minimum requirement for review of risk registers

Risk Register	Frequency	Meeting
Corporate Risk Register	Monthly	Senior Management Team, Trust Board
	Quarterly	Quality and Performance Committee
Divisional Risk Registers	Monthly	Divisional Governance Groups
	Six Monthly	Clinical Governance Group

1.9 Review of departmental risk registers is best practice. This policy does not set policy requirements for the review of departmental risk registers.

### **Project risks**

1.10 A project is a time-limited plan or a scheme designed to deliver specific objectives.

1.11 The identification of risks to those objectives, and risks that may result from the project, is a key part of project planning.

1.12 Project risk logs are treated as local-level risk registers for the purposes of this policy.

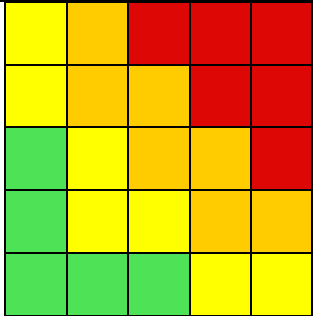
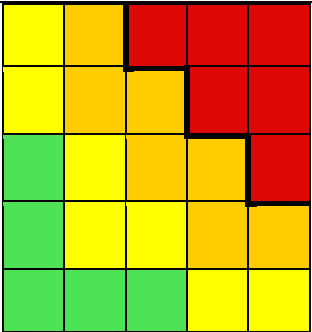
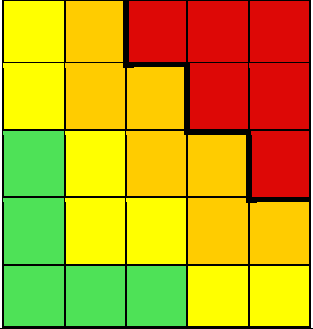
### **Escalating risks**

1.13 The Trust ensures appropriate oversight and scrutiny of significant risks by adopting processes for risk escalation.

1.14 There are three levels of risk register – departmental, divisional and corporate (also known as 'Board'). Risk escalation, determined by risk score, with escalated risks reassessed at each level. There is provision for escalating risks outside of the defined escalation process where a member of staff has immediate concerns about a risk.

1.15 Risk will be escalated through the organisation through three levels of risk register: local, divisional and corporate.

1.16 Decisions to escalate or de-escalate risks will be based on risk score and whether the risk is a posed to a divisional or Board objective, in accordance with the process set out in the graphic below:

			<b>CORPORATE</b>	
				<p>3. Risk re-evaluated against strategic objectives</p> <p>Board-identified risks added.</p>
			↑	
		<b>DIVISIONAL GOVERNANCE GROUP</b>		
				<p>2. Risk re-evaluated against divisional objectives.</p> <p>Division-identified risks added.</p> <p>Risks of 15 or above escalated to Board-level.</p>
			↑	
	<b>SERVICE/TEAM</b>			
				<p>1. Risks to the service/team.</p> <p>Risks of 12 or above escalated to division-level</p>

APPENDIX F

