South West London and St George's NHS
Mental Health NHS Trust

Trust Board

7th May 2015

Paper Reference:	TB(15-16) 35
Report Title:	Risk Management Strategy and Policy
Executive Summary:	The Risk Management Strategy has been reviewed following feedback from the recent Monitor review of the Trusts Quality Governance Framework as follows: • Further clarification of the risk management reporting and assurance lines between departments and the Trust Board. (Appendix C.) • Trust Board will receive the BAF/Corporate Risk Register (Risk scores 12 and greater) no less than four times per year and the full BAF/Corporate risk register annually. • The Executive Management Committee (EMC) will receive the BAF/Corporate/Directorate Risk Register (Risk score 12 and greater) every month and the full BAF/Corporate/Directorate Risk Register annually. • Further clarification on the definition of key principles in the management of risk with the introduction of the Trust Risk Management Information System which provide the facility to log and report risks on-line. • Introduction of metrics to better support the Board in agreeing its Risk Appetite Statement (Appendix C).
Action Required:	For approval
Link to Strategic Objectives:	The Risk Management Strategy and Policy is relevant to all strategic objectives.
Risks:	Risk Management Strategy and Policy.
Quality Impact:	Risk Management Strategy and Policy supports the quality of patient care.
Resource Implications:	None at this time.
Legal/Regulatory Implications:	An embedded system of risk management, including risk

	registers, is an essential element of robust governance and safety requirements.
Equalities Impact:	None at this time.
Groups Consulted:	Executive Management Committee.
Author:	Niall Smyth, Head of Health Safety and Emergency Planning
Owner:	Andrew Clough, Interim Director of Nursing and Quality Standards

Risk Management Strategy and Policy

Date:	07.05.15	**Status:**	final
Current Version:	V4.0		
Transparency :	Public		
Commissioned by:	Executive Management Committee		

Distribution & approvals history

Version	Distributed to	Date	Action required / taken
V3.1	Executive Management Committee	21.04.15	Approved
V4.0	Trust Board	07.05.15	For Approval

Risk Management Strategy

1. Introduction

1.1. This paper sets out the Board's arrangements for the management of risk at the South West London and St George's Mental Health Trust. Risk management is an integral component of the Trust's governance framework. By complying with the organisational arrangements described within the strategy services will ensure the effective identification, assessment and control of risk; thereby ensuring the delivery of the Trust Strategic Objectives.

2. Background

2.1. The Risk Management Strategy was last reviewed by the Board in January 2015.

2.2. The Board acknowledged that it needed to agree its risk appetite in the context of each strategic objective to inform the strategy and requested further work on introducing metrics to support the Board in agreeing the organisations Risk Appetite.

2.3. Feedback from Monitor's Quality Governance Framework review identified a number of gaps

- address gaps in the risk escalation process to the BAF
- enhance processes for risk and performance escalation from directorates
- complete implementation of the new electronic risk management system

2.4. The identified gaps in processes have been incorporated into the revised Risk Management Strategy and Policy document.

3. Issue/proposal

3.1. The Risk Management Strategy and Policy has been reviewed following feedback from the recent Monitor review of the Trusts Quality Governance Framework as follows:

- Further clarification of the risk management reporting and assurance lines between departments and the Trust Board. (Appendix B.)
- Trust Board will receive the BAF/Corporate Risk Register (Risk scores 12 and greater) no less than four times per year and the full BAF/Corporate risk register annually.
- The Executive Management Committee (EMC) will receive the BAF/Corporate/Directorate Risk Register (Risk score 12 and greater) every month and the full BAF/Corporate/Directorate Risk Register annually.
- Further clarification on the definition of key principles in the management of risk with the introduction of the Trust Risk Management Information System which provide the facility to log and report risks on-line.
- Introduction of metrics to better support the Board in agreeing its Risk Appetite Statement (Appendix C).

3.2. The Executive Management Committee are asked to review the revised Risk Management Strategy and Policy and recommend for approval at the Trust Board changes to reporting lines.

3.3. The Executive Management Committee are asked to review the Risk Appetite Statements (Appendix C) and to discuss the measures/metrics appropriate for each strategic objective.

4. Recommendation

4.1. The Board is asked to approve amendments made to the Risk Management Strategy and Policy.

5. Appendices

Annex A Risk Management Strategy and Policy v4.0

South West London and St George's NHS
Mental Health NHS Trust

Risk Management Strategy and Policy

Date:	21/04/2015	**Status:**	Final
Current Version:	4.0		
Transparency level:	Public		
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Reason:			
Author:	Head of Health Safety and Emergency Planning		
Commissioned by:	Director Of Nursing and Quality Standards		

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Version	Distributed to	Date	Action required / taken
v1.1	Trust Board	20.12.12	Approved
v1.2	Executive Management Committee	10.12.13	Approved
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1. Strategy Statement

The aim of risk management at South West London and St George's Mental Health Trust is to:

- ***Minimise harm to patients, colleagues or visitors*** *to a level as low as reasonably practicable*
- ***Protect everything of value*** *to* South West London and St George's Mental Health Trust *(such as high standards of patient care, colleague safety, reputation, community relations, assets or income streams)*
- *Maximise opportunity by* ***adapting and remaining resilient*** *to changing circumstances or events in order to achieve the Trust strategic objectives.*

South West London and St George's Mental Health Trust will establish and support an effective risk management system which ensures that:

- Objectives are clear and understood across the organisation
- Risks to the achievement of objectives are identified
- Controls are clear, effective to mitigate the risk and understood by those expected to apply them
- The operation of controls is monitored by management
- Gaps in control are rectified by management
- Management are held to account for the effective operation of controls
- Assurances are sought, reviewed and acted on.

The Trust Board of South West London and St George's Mental Health Trust shall achieve this by:

- Effective strategic planning and objective setting
- Effective learning and responsive management action
- Effective employee engagement and training
- Effective liaison with enforcing authorities, regulators and assessors
- Effective team and committee structures
- Formulation of policies and procedures for all high consequence events
- Provision of training and advice to managers and staff
- Investigation of incidents and implementation of remedial actions
- Systematic identification, assessment and control of risks
- Effective reporting arrangements.

Trust Strategic Framework

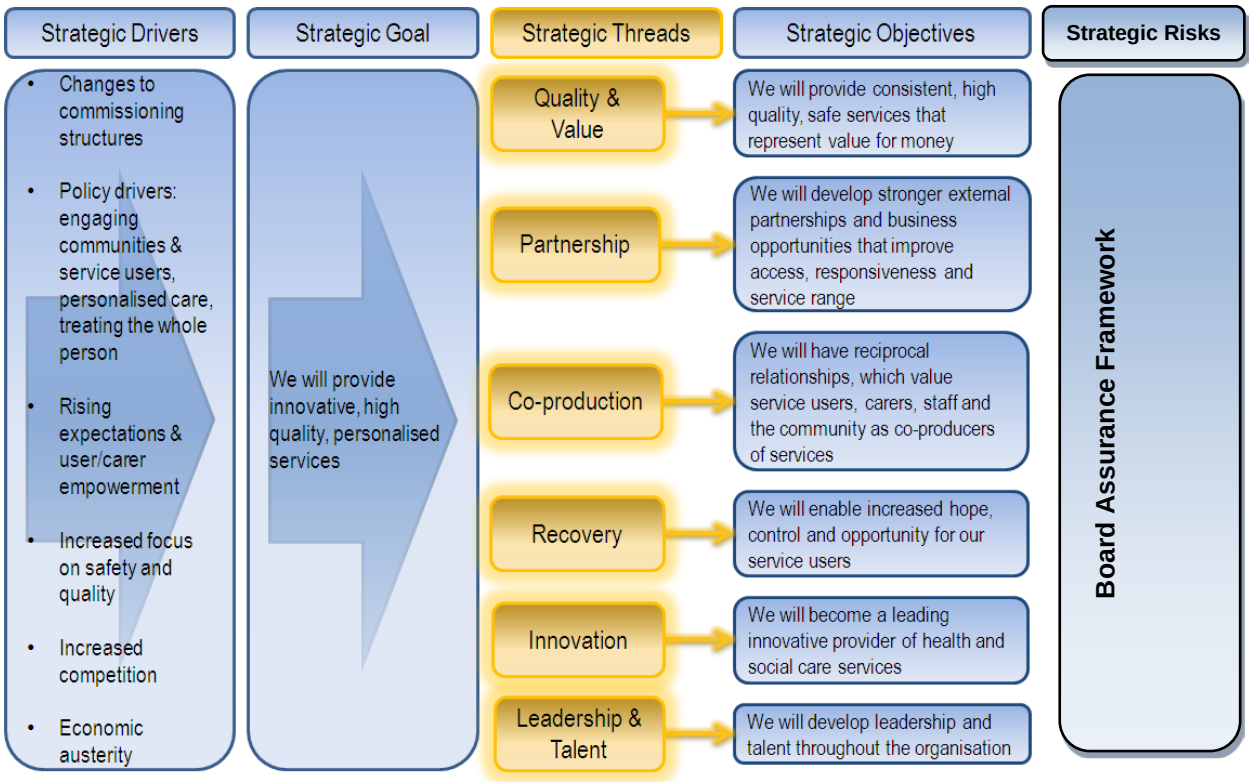


Figure 1: Trust Strategic Framework

…What this means for staff and service users…

Staff and people who use our services live and work in environments, and circumstances, which are often high risk, and where many decisions have to be taken which are by nature risk management decisions, or a weighing up of relative risk options, and the balance between opportunity and the possibility of adverse outcomes. The Trust Board acknowledges the importance of acting to maximise opportunities for staff, people using services and the Trust as a corporate body, while taking into account the risk of adverse outcomes.

Every person employed by the Trust has a responsibility to manage risk. The Trust Board acknowledges that commitment from the top level of management in the Trust is necessary if the Trust is to achieve its goal of establishing a positive risk and opportunity management culture throughout the organisation. This strategy is designed to achieve that goal. The Trust Board recognise that to achieve that goal it is necessary to endorse statements of openness and honesty in reporting and managing risks, and responsible risk and opportunity taking.

2. Policy Statement

Risk Management is essentially the process where an organisation adopts a proactive approach to the management of future uncertainty and facilitates the evaluation and control of risk.

The Trust recognises that the provision of healthcare and the activities associated with the delivery of services, including the maintenance of premises and managing finances by their nature will incur risks. The Trust accepts its corporate responsibility to provide the highest standards of patient care and staff safety, and as such, the process of Risk Management is viewed as an essential component in maintaining and improving standards at the Trust.

This document describes the risk management arrangements within the Trust.

3. Scope

This policy applies to all areas and activities of the Trust and to all individuals employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

4. Framework

This section describes the broad framework for the management of risk. It should be noted that the management of risk is supported by other Trust documents and performance frameworks which are referenced further in this document.

Definitions:

Risk – Risk is the effect of uncertainty on the achievement of objectives. It is, therefore, anything that is stopping or could stop the achievement of objectives.

Impact/Consequences – Impact/Consequences are those factors that provide a result or effect on an objective

Likelihood/Frequency – Is a measure of the chance of occurrence.

Hazard – Anything that has the potential to cause harm.

Risk Level – Corporate, Directorate, Department, Portfolio, Programme, Project.

Board Assurance Framework (BAF) Risks - BAF risks are those risks identified that may impact upon the Trust's Strategic Objectives.

The following table shows the differing levels that risks are managed and the groups that risks are reported/monitored.

Managing Risk at different levels of the organisation.

Risk Level	Descriptor	Reporting/Monitoring Group
Corporate Level	Risks identified at this level may impact upon the Trust's Strategic Objectives or may have a significant impact on the organisation.	Trust Board, Audit Committee, Executive Management Committee
Directorate Level	Risks identified at this level tend to be operational in nature but where significant should be escalated upwards.	Executive Management Committee, Directorate Performance Reviews, Directorate Management Reviews
Department Level	Risks identified at this level are operational in nature but where significant should be escalated upwards.	Directorate Clinical Governance Reviews, Operational management Groups
Portfolio Level	These are risks identified against portfolio level objectives and may impact on the organisation at the corporate level.	F&CI Committee/Portfolio Board
Programme Level	These are risks identified against programme level objectives.	Portfolio/Programme Boards
Project Level	These are risks identified against the project objectives.	Project/Programme Boards

Figure 2: Managing risk at differing levels within the organisation.

Further terms are described in the Glossary of terms – Appendix D

Risk Management Process

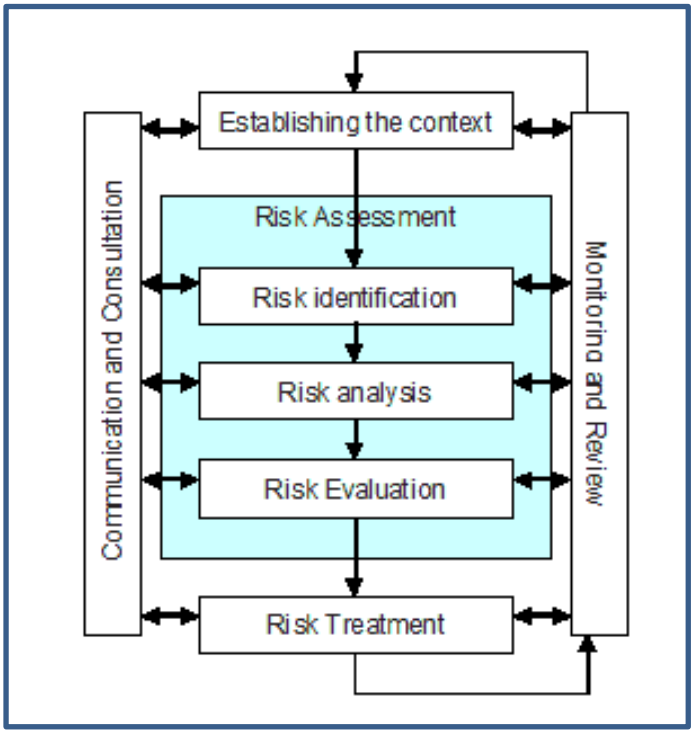


Figure 3: Risk Management process –- adapted from ISO 31000:2009 Risk Management Principles and Guidelines

Establishing the context

Establishing the context that risks are to be managed is important as they can impact upon both the internal and external environment. Internal risks tend to be those that impact on internal objectives where there is more influence on controls and therefore outcomes. E.g. Quality and safety. External risks tend to be those that are influenced by external stakeholders and involve a high degree of communication and consultation to be able to influence positive outcomes. E.g. Estates Modernisation Programme.

Risk is the effect of uncertainty on the achievement of objectives. It is, therefore, anything that is stopping or could stop the achievement of objectives.

Identification of Risk – what is the risk? - Risks associated with the achievement of corporate objectives

Each year the Trust Board shall develop and agree annual objectives in line with the Trust strategic objectives. All significant risks identified which may prevent the Trust from achieving these objectives will be detailed in the Board Assurance Framework.

To identify risk, directors and managers are required to anticipate what is stopping them, or could stop them, from achieving their objectives at least annually.

Risks associated with carrying out local work related activities

The identification of risks arising from work-related tasks or activities will continue to be undertaken by ward and departmental managers and will be identified with specific reference to safety inspections, investigation of incidents, complaints, claims, feedback, ad-hoc assessments or external reviews.

Directors and managers are required to take into account, and keep under review, analysis of ward and team early warning information via the Service Intelligence Risk Evaluation Network (SIREN), incident reports, complaints, claims, service user feedback, staff feedback, inspections, assessments or audits in order to identify risk.

RISK Assessment – How significant is the risk?

The purpose of risk assessment is to estimate the level of risk exposure and provide input to any decisions on where responses to reduce or exploit risk are necessary or likely to be worthwhile. The risk assessment stage will involve the analysis of individual risks to identify the consequences, likelihood, controls and assurance.

All directorate managers / ward or department managers and deputies with delegated risk management responsibility must have received appropriate training as set out in the Trust training matrix on the risk management process in order to validate the accuracy of risk assessments; overview the quality of assessment; ensure that controls are appropriate and proportionate; and that action plans exist to address gaps in control and assurance.

Risk assessments will be logged onto the Trust's Risk Management Information System (RMIS). The template ensures every aspect of the risk and its control is addressed, including **what** the risk is, the **source** of the risk (i.e. how it was identified), **where** it is, **who** may be harmed, how it is **controlled,** how it is **assured**, what further **action** is required and the **risk score**.

All wards, departments and directorates will keep under constant review risks within their service or ward or department, but will formally undertake and or review risk assessments at least annually or more frequently if required.

Risk response – How is the risk managed?

Controlling risks

Control setting and implementation is intended to improve resilience. Controls may be actions that are repeated, either regularly or in response to events, or they may be one-off actions or decisions. A control may be implemented to:

- avoid risk (stop the activity which gives rise to the risk);
- seek risk (take opportunity);
- modify risk (do something to change the severity of likelihood or both);
- transfer risk (insure against any potential losses); or
- retain risk (accept the risk and take no further action).

Risk mitigation is also used as a term to describe a 'risk control' by introducing a measure that reduces the impact of a risk, should it occur.

At South West London and St George's Mental Health Trust control falls into three main types:

- **Prevent/Treatment** – these controls are aimed at preventing a risk or problem from occurring
- **Detect** – these controls provide an early warning of a control failure; and
- **Contingency/Mitigation** – these controls provide effective reaction in response to a significant control failure or overwhelming event and are designed to limit damage and maintain resilience.

Prevent/Treatment (How you prevent risks or problems from occurring)	Policies, Procedures, Guidelines, Techniques, Processes, Training, Use of Equipment, Checklists, Computer Systems, Protective Clothing etc
Detect (How you know if a control is not working or if a hazard presents a threat)	Audit, Inspection, Monitoring, Investigation, Incident Reporting, Smoke detectors, Complaints, Surveys, Tests etc
Contingency/Mitigation (What you do if a control fails)	Evacuation Plan, Escalation Procedure, Continuity Plan, Backup Generator, Locum/Agency cover, Insurance, Financial reserves etc.

Figure 4: Typical controls adopted to modify risk in healthcare.

Ward, departmental and directorate managers shall ensure action plans are in place and the actions identified address gaps in control.

Verification of control & action plans

Controls and action plans must be verified as correct, in place or in progress by a relevant Manager depending on the risk level and score and in accordance with the Trust risk management process.

Implement action

Ward, departmental and directorate managers retain responsibility for ensuring that action plans address gaps in control; have specific, measurable, appropriate, realistic and timely actions described; and are delivered by the required date.

Risk reporting and review – Who is informed about the risk and who and how often are risks reviewed?

The trust uses a 5 by 5 matrix tool to determine the severity and likelihood of a risk and gives a maximum score of 25 and is set out in Appendix A. Risks are scored by the person undertaking the risk assessment and validated by a relevant manager depending on the risk level and score.

Risk Level	Risk Score	Validated by	Frequency
Ward/Department	6 or greater	Operational Manager/Senior Manager	Monthly
Directorate	12 or greater	Director of relevant service	Monthly
Corporate	12 or greater	Executive Management Committee, [Trust Board, Audit Committee]	Monthly [Not less than 4 times per annum]
Portfolio, Programme and Projects	8 or greater	Relevant Senior Manager	Monthly

Figure 5: Validation and review table.

The Trust Board will receive the BAF/Corporate Risk Register (Risk scores 12 and greater) no less than four times per year and the full BAF/Corporate risk register annually.

Audit Committee - The Audit Committee has overall responsibility for providing the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical). Terms of Reference for the Audit Committee are maintained by the Director of Corporate Affairs and available within the Trust Quality Manual. The Audit Committee shall receive the BAF/Corporate Risk Register (Risk scores 12 and greater) no less than four times per year and the full BAF/Corporate risk register annually. The Audit Committee shall also consider the appointment of independent Auditors to assist in the review and adequacy of the trusts risk management arrangements.

The Executive Management Committee (EMC) will receive the BAF/Corporate/Directorate Risk Register (Risk score 12 and greater) every month and the full BAF/Corporate/Directorate Risk Register annually. The EMC is responsible for reliable management of the BAF. The BAF is owned and managed through the Executive

Management Committee. Any risk issue may be raised, discussed and action taken at any Executive Management Committee meeting.

Directorates will ensure that they have a risk register in place, which is managed through their governance structures. Each Directorate's risk register is reviewed at the relevant monthly Directorate Performance Review and all risks that are score 15 or more are discussed for possible escalation to the BAF/Corporate risk register. If this is agreed the risk shall be escalated by the risk owner on the Risk Management Information System (RMIS).

Ward/Departmental Meetings shall review all risks identified within their wards or departments as required depending on the risk score, but each risk must be reviewed at least annually. Any changes agreed shall be recorded on the Risk Register and communicated to relevant managers and staff. Risk of score 6 or greater shall be reviewed at the monthly governance/management meetings.

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

Quality and Safety Assurance Committee - The Quality and Safety Assurance Committee has overall responsibility for providing the Trust Board with a means of independent and objective review of quality and safety governance, assurance processes and risk management across the whole of the Trust's activities where this is relevant to care delivery. The chair of the Quality and Safety Assurance Committee shall be a member of the Audit Committee and will report the findings of the Quality and Safety Assurance Committee to the Audit Committee in line with the role of the Audit Committee. Terms of Reference for the Quality and Safety Assurance Committee are maintained by the Director of Corporate Affairs and available within the Trust Quality Governance Manual.

Integrated Quality Governance Committee shall undertake reviews of significant risk where required in order to support the Executive Management Committee and provide assurance to the Audit Committee and Quality and Safety Assurance Committee. The Integrated Quality Governance Committee shall receive reports and assurances from Directorates on the adequacy of their systems of quality, safety and risk management on a monthly basis.

The relationship between Executive Management Group, Integrated Governance Group, Audit Committee and Quality and Safety Assurance Committee

To ensure effective oversight and scrutiny of the entire business of South West London and St George's Mental Health Trust, the relationship between the Executive Management, Integrated Governance Group, Audit Committee and Quality and Safety Assurance Committee is based on inclusiveness, clarity of purpose and constructive challenge. The Executive Management Committee (EMC) is an executive committee and will oversee the management of all significant risks and as such, manages the BAF/Corporate risk register.

The EMC, or members thereof, will provide the Audit Committee and Quality and Safety Assurance Committee with assurance on the effectiveness of internal controls as required.

The Integrated Governance Group (IGG) will oversee the management of and review assurances on the operation of clinical/ and operational risks. This will include the detailed review of clinical and operational controls and provision of assurance to the Audit Committee and Quality and Safety Assurance Committee. In addition, the IGG may undertake reviews of significant clinical and operational risks in order to support the EMC and provide additional assurance to the Audit Committee.

The Audit Committee will oversee and satisfy itself that system of internal control is effective. It will receive but not be limited to reports and assurance from the Chairs of the EMC, IGG and Quality and Safety Assurance Committee in addition to independent assurances from Internal and External Audit.

5. Duties (Roles and Responsibilities)

The Trust Board

Executive and Non-Executive Directors share responsibility for the success of the organisation including the effective management of risk and compliance with relevant legislation. They have a collective responsibility as a Board to ensure prudent control of risk through effective internal controls that: *protect the reputation of* South West London and St George's Mental Health Trust *and everything of value to the organisation:*

- provide visible leadership on the management of risk
- reduce, eliminate and exploit risk in order to achieve objectives, maintain prudent control and increase resilience
- determine the risk appetite for South West London and St George's Mental Health Trust
- ensure the approach to risk management is consistently applied; and
- ensure assurances demonstrate that risk has been identified, assessed and all reasonable steps have been taken to manage them effectively and appropriately.

Chief Executive is the Accountable Officer with overall responsibility for risk management including Health and Safety. As such, the Chief Executive must take assurance from the systems and processes for risk management and ensure that these meet statutory requirements and the requirements of the regulators. The Chief Executive chairs the Executive Management Group and, as Accountable Officer, will sign the Annual Governance Statement in accordance with South West London and St George's Mental Health Trust governance arrangements. He/she shall ensure that reporting mechanisms clearly demonstrate that the Chief Executive is informed of all significant risk issues and that their responsibility for management can be fulfilled. The Chief Executive will ensure, via the lead Executive Director, robust oversight of the risk management process and the production of reports on risk. The Chief Executive shall attend the Audit Committee and Quality and Safety Assurance Committee to discuss matters pertaining to the management of risk as required.

Executive Medical Director is the Board lead for Safeguarding and acts as the Caldicott Guardian. He/she is accountable to the Chief Executive for risks arising from these areas.

He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Director of Finance and Performance is the Board lead for finance and accountable to the Chief Executive for risks arising from all financial activities. He/she is the Trust SIRO (Senior Information Risk Officer) and the Lead Director for Performance Management. He/she is responsible for ensuring that the Trust carries out its business in accord with Monitor's Finance Regime for Foundation Trusts and all relevant accounting policies and standards. He/she shall ensure that activities are controlled and monitored through effective audit and accounting mechanisms that are open to public scrutiny and presented annually. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Director of Operations is responsible for the day to day operational management of the Trust's clinical services, ensuring that the required standards of performance and behaviours are achieved to deliver clinical and financial viability. He/she is accountable to the Chief Executive for risks arising from these areas. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility. He/she is Lead Director for Security, Fire and Waste Management. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Director of Nursing and Quality Day to day responsibility for overseeing the processes for management of risk at corporate level, within the framework set by the Board. He/she is the Board lead for Infection Prevention and Control, Health and Safety, Emergency Planning, Controlled Drugs and Design Champion. He/she is accountable to the Chief Executive for risks arising from these areas. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Director of HR, OD and Workforce Transformation Responsibility for managing employment risks (recruitment, registration and staff management). Board Lead for Staff Wellbeing. He/she is accountable to the Chief Executive for risks arising from these areas. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Clinical Directors and Associate Directors are responsible for ensuring the identification, assessment, response, reporting and review of all risks to the achievement of objectives and delivery of services in line with the requirements set out in this document. They shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulations.

Directorate Managers, Ward Managers, Departmental Managers or Heads of Service are responsible for identifying, assessing, responding, reporting and reviewing risks within their ward, department or service. They shall ensure risks are reviewed and updated at least annually. They will ensure there is effective coordination and oversight of risk management within their area of responsibility and will ensure risks and assurances on the operation of controls are fully documented, maintained and updated on their Risk Register. In addition, they will ensure that all their employees have an understanding of the risks to their service and at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulations.

All Employees, Partners and Contractors have a responsibility to:

- observe and comply with the policies and procedures of South West London and St George's Mental Health Trust
- take reasonable care for the health, safety and welfare of themselves and others
- co-operate fully on matters of risk management and health and safety
- participate in induction and all relevant mandatory training as defined by the Induction and Mandatory Training Policy (as amended)
- report all identified hazards and adverse incidents and act to prevent a recurrence
- undertake reasonable actions as required to reduce or eliminate risks associated identified hazards or adverse incidents.

Chair of the Audit Committee is responsible for keeping the Board of Directors informed of any material matters which have come to the Committee's attention. He/she will provide the Board with an opinion letter about the proposed Annual Governance Statement, and report to the Board on the effectiveness of the risk management system.

Chair of the Quality and Safety Assurance Committee is responsible for keeping the Trust Board informed of any material matters which have come to the Committee's attention. He/she will report to the Board on the effectiveness of the Quality management system.

6. Risk Management Tools

Risks may be identified proactively by anticipating what is stopping or could stop the achievement of objectives, or from the analysis of incidents, complaints, claims inspections and audit findings. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:-

Risk Management Information System (RMIS) – The Trust uses a Risk Management Information system to record information and produce reports. A number of modules are being used namely the Incident reporting module, Risk Register Module and Safeguarding module. The Risk Register module is web –based and allows risks to be logged onto the system in a systematic way to record the source of risk, risk description, risk category, risk controls, initial risk rating, current risk rating, risk treatment, risk actions, target risk rating and review date. Supporting documents can also be attached to the risk log.

Risk Register - The Risk Registers (reports generated from RMIS or viewed on-line) provide a mechanism for viewing details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels.

SWOT/PESTLE – Strength, Weakness, Opportunities, and Threats analysis and Political, Economic, Social, Technical, Legal and Environmental analysis tools are used to help identify business risk to the organisation.

Root Cause Analysis – Root cause analysis is used during incident investigations to assist in identifying the root cause or causal factors involved in an incident. The analysis reviews the underlying contributing factors which led to the incident and are critical in understanding what went wrong and learning lessons.

Risk Management Training - This document recognises that training will be required to effectively manage risks in line with the process set out in section 4. Details of all trust training programmes are set out in the Training Needs Analysis.

The Trust Board and Senior Managers (which for the purpose of this document are defined as Directors, Service Directors, Heads of Department, Heads of Profession, Associate Directors and Assistant Directors) will receive training and/or briefings on the risk management process on appointment. In addition, supplementary briefings will be provided on an 'as required' basis following publication of new guidance or relevant legislation

All staff shall receive an Introduction to the Risk Management Process briefing as part of the Corporate Induction programme

Directorate, Ward and Departmental managers will have further more detailed risk management process training incorporating how to identify and record risks.

Staff designated to regularly undertake Root Cause Analysis will receive Root Cause Analysis training.

7. Monitoring Effectiveness

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

- Evidence of monthly reporting of significant risk exposure to the Trust Board ;
- Evidence of review of significant risk exposure by the Executive Management Committee; and
- Annual internal audit of aspects of the Risk Management process as determined by the Audit Committee.

Key Performance Indicators

The following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Process shall be evaluated:-

- All new significant risks (Risk score of 15 and above on BAF/Corporate risk register) are reported to the Trust Board at each formal meeting of the Board;

- The risk profiles (for risks ≥12) for all Directorate risk registers are reviewed by the Executive Management Committee at least monthly;
- Departmental risk registers are in place, maintained and available for inspection at departmental level; and
- Organisational risk registers show details of the risk description, control, location, owner, action plan (where necessary) and 80% of risks are within review date and show the source of the risk.

Compliance with the above will be monitored by the Head of Risk, reviewed by the Director of Nursing and Quality Standards and reported within an annual report to the Executive Management Committee.

8. Dissemination, Implementation and Access to this document

This document will be submitted to the Trust Board for approval and following approval will be disseminated to staff via the management structure and made available on the trust intranet under the policy section. New and existing staff will be made aware of its contents during induction and other relevant risk management training in line with the Training Needs Analysis as outlined in *Training and Development Policy*. The previous version(s) of this document will be archived in line with Trust policy.

9. Equality Impact Assessment

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	

		Yes/No	Comments
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

Figure 6: Equality Impact Assessment Checklist.

Appendix A – Risk Descriptor Tables and Risk Matrix Tool

Table 1. Measure of Severity of Impact/Consequence

Score ⇨	1	2	3	4	5
Descriptor/ type ⇩	**Low**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Safety	Safety incident with no harm occurring	Safety incident involving minor injury	Safety incident leading to serious harm	Safety incident leading to a fatality	Safety incident leading to multiple fatalities
Quality	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint with Local resolution Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint with local resolution	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Critical report following inspection/ external investigation	Totally unacceptable level of quality of treatment / service Ombudsman inquiry Gross failure of patient safety if findings not acted on Failure of National quality standards, such as CQC, resulting in suspension or closure of service
Reputation	Rumors: Minimal Impact Local Press coverage for <1 day	Regular concern/coverage in local media for 1 to 7 days	Moderate loss of confidence National Media < 3 days	Major loss of confidence National Media > 3 days	International adverse publicity severe loss of confidence. Public inquiry
Economic/ Finance	Minimal Impact	0.5% of turnover of the Trust	0.5% to 1% of Trust turnover	1% to 2% of Trust turnover	Over 2% of Trust turnover

Workforce	Low staffing level impacting on the quality of service delivery for 1 shift	Low staffing level negatively impacting on the quality of service delivery 1-2 days	Low staffing level negatively impacting on the quality of service delivery > 2 days Late delivery of key objective due to lack of staff (recruitment, retention or sickness) Low staff morale findings from local or national survey Poor staff attendance at mandatory training	Low staffing level negatively impacting on the quality of service delivery > one consecutive week Uncertain delivery of key objective due to lack of staff / Loss of key staff Very low staff morale indicated in local or national survey No staff attending mandatory training	Low staffing level negatively impacting on the quality of service delivery > one consecutive month Non-delivery of key objective due to staff shortage/ Loss of key staff
Political	Minimal political threat that impacts upon service level strategies	Minor political threat that impacts upon service level strategies	Moderate political threat that impacts upon Trust strategic objectives	Major political threat that impacts upon Trust strategic objectives	Significant political threat that impacts upon Trust strategic objectives
Business Continuity	Loss / interruption Minor loss of non-critical service	Loss / interruption in more than one non-critical areas	Service Loss in critical area	Extended loss of essential service in one or more areas	Loss of Multiple services in critical areas

Table 2 Measure of Likelihood

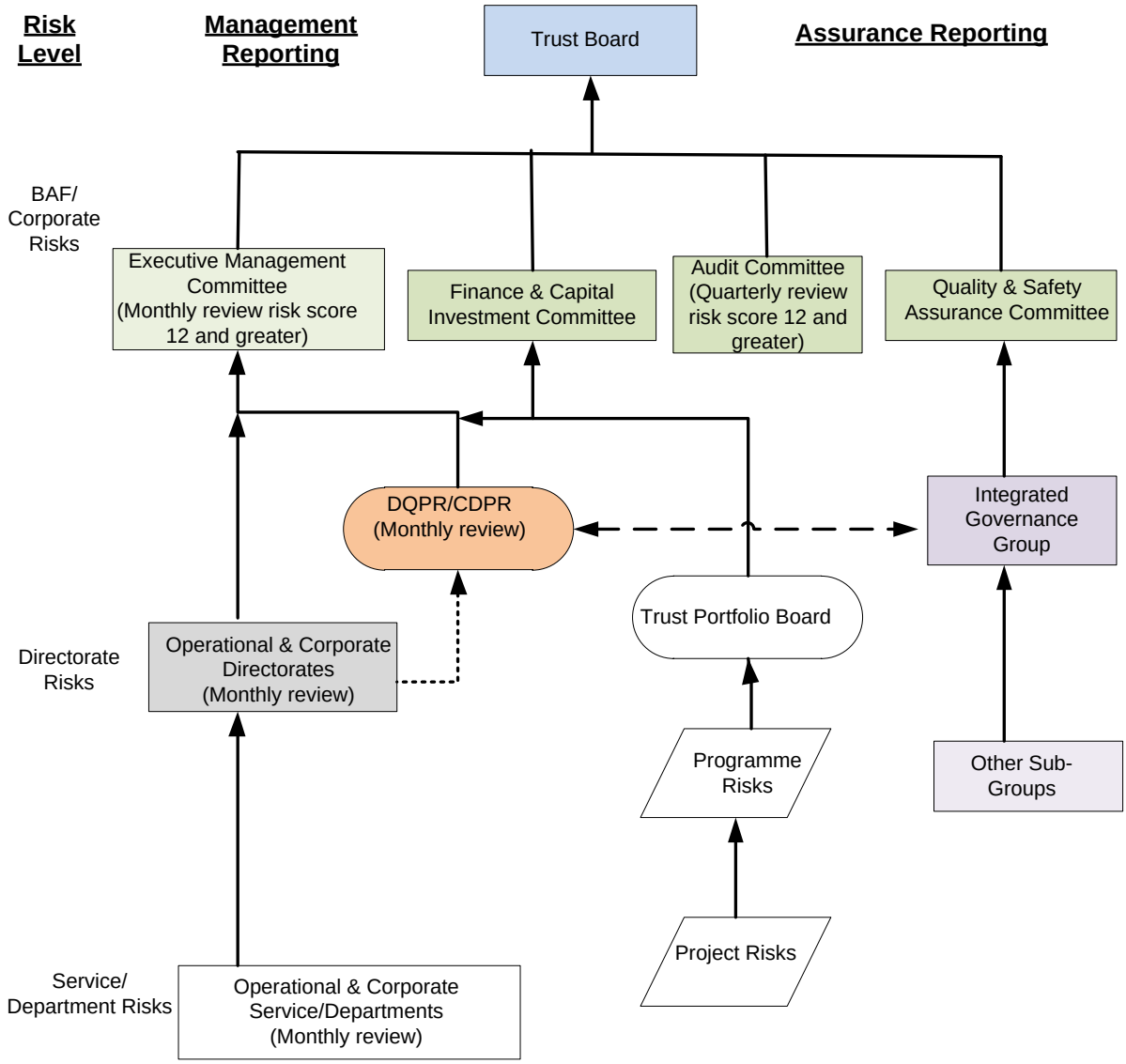
Level →	1	2	3	4	5
Descriptor ↓	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency of event	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability of event occurring	Less than 6% chance of occurrence	6% to 20% chance of occurrence	21% to 50% chance of occurrence	51% to 80% chance of occurrence	Greater than 80% chance

The final step in quantification is to combine the measures of severity and likelihood in a Risk Matrix, refer to Table 3.

Table 3 Risk Matrix

Severity	**Likelihood**				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Low	5 Low
2 :Slight	2 Very Low	4 Low	6 Low	8 Medium	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Low	8 Medium	12 Medium	16 High	20 High
5 Catastrophic	5 Low	10 Medium	15 High	20 High	25 High

Appendix B – Risk Management Reporting Chart



Appendix C – Risk Appetite Statement

SO1: Quality & Safety

Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk averse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

Measures:

- No appetite for 7-day follow-up to be less than 95%,
- No appetite for 30 day Re-admission rates (Adult Acute Services) to exceed 8.5%,
- No appetite for Patient Safety incidents involving harm to be an increasing trend,
- No appetite for Serious incident reporting to be an increasing trend,
- No appetite for waiting times to be below the target threshold,
- No appetite for Friends and family test to be a declining trend,
- No appetite for lack of action on any identified compliance concerns.

SO2: Partnerships

This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

Measures:

- No appetite for an increasing number of partnership tenders that don't add value,
- No appetite for losing partnerships that have added value and are sustainable,
- No appetite for lack of progress on the development an influencing map,
- No appetite for less than 10 expressions of interest in the trust as a partner.

SO3: Co-production

This Trust has made a commitment to utilise the potential of co-production to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services, as well as contribute to the development of the people and communities we serve. The trust is risk averse (Low) to co-production without validating and verifying what outcomes are possible and desirable with all stakeholders.

Measure:

- No appetite for lack of progress on developing a clear strategy for co-production with appropriate agreed measures from stakeholders.

SO4: Recovery

As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk averse (Low) to recovery that does not provide high levels of compliance with service user outcome framework measures.

Measures:

- No appetite for less than 75% Service user agreed recovery goals (CPA Service users),
- No appetite for less than Double Rate of Service user access to Recovery College over 18 months,
- No appetite for less than 95% achievement of Service user outcome framework measures.

SO5: Innovation

Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

Measures:

- No appetite for less than four published articles a year on innovation,
- No appetite for lack of progress on the adoption of new ways of working,
- No appetite for less than 5 awards for successful innovation schemes.

SO6: Leadership & Talent

The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

Measures:

- No appetite for a reduction in staff recommending the Trust as a place to work in the Staff Friends and Family Test
- No appetite for a deterioration in the ‘Overall Staff Engagement’ indicator in the Trust Staff Survey results
- No appetite for the number of staff in receipt of a PADR in the last 12 months to be below 95%

Appendix D – Glossary of terms

Control	Something done to respond to a risk	**Risk**	The effect of uncertainty on objectives
Exposure	Extent to which the organisation is subject to an event	**Risk acceptance**	Informed decision to take a particular risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Unmitigated risk	Exposure arising from a specific risk before any action has been taken to manage it	**Risk analysis**	Process to comprehend the nature of risk and to determine the level of risk
Significant Risk	Most significant risk or those on which the Board or equivalent focuses. These are risks with a risk estimate of ≥15	**Risk appetite**	Amount and type of risk the organisation is prepared to seek, accept or tolerate
Level of Risk	Magnitude of a risk expressed in terms of the combination of consequences and their likelihood	**Risk assessment**	Overall process of risk identification, risk analysis and risk evaluation
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Operational Risk	The risk of loss or gain, resulting from inadequate or failed internal processes, people and systems or from external events	**Risk management**	Coordinated activities to direct and control the organisation with regard to risk
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Risk owner**	Person or entity with the accountability and authority for managing the risk and any associated risk treatments
Residual risk	Risk remaining after all treatment is implemented		