Salisbury NHS
NHS Foundation Trust

RISK MANAGEMENT POLICY AND PROCEDURE.

Type of Document – Policy (must do)

Post Holder Responsible for Policy	Head of Risk Management
Directorate Responsible for Policy	Quality Directorate
Contact Details	Head of Risk Management Block 24 SDH South Extension 2496
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Target Audience	Senior Managers, Board Members,

VERSION INFORMATION

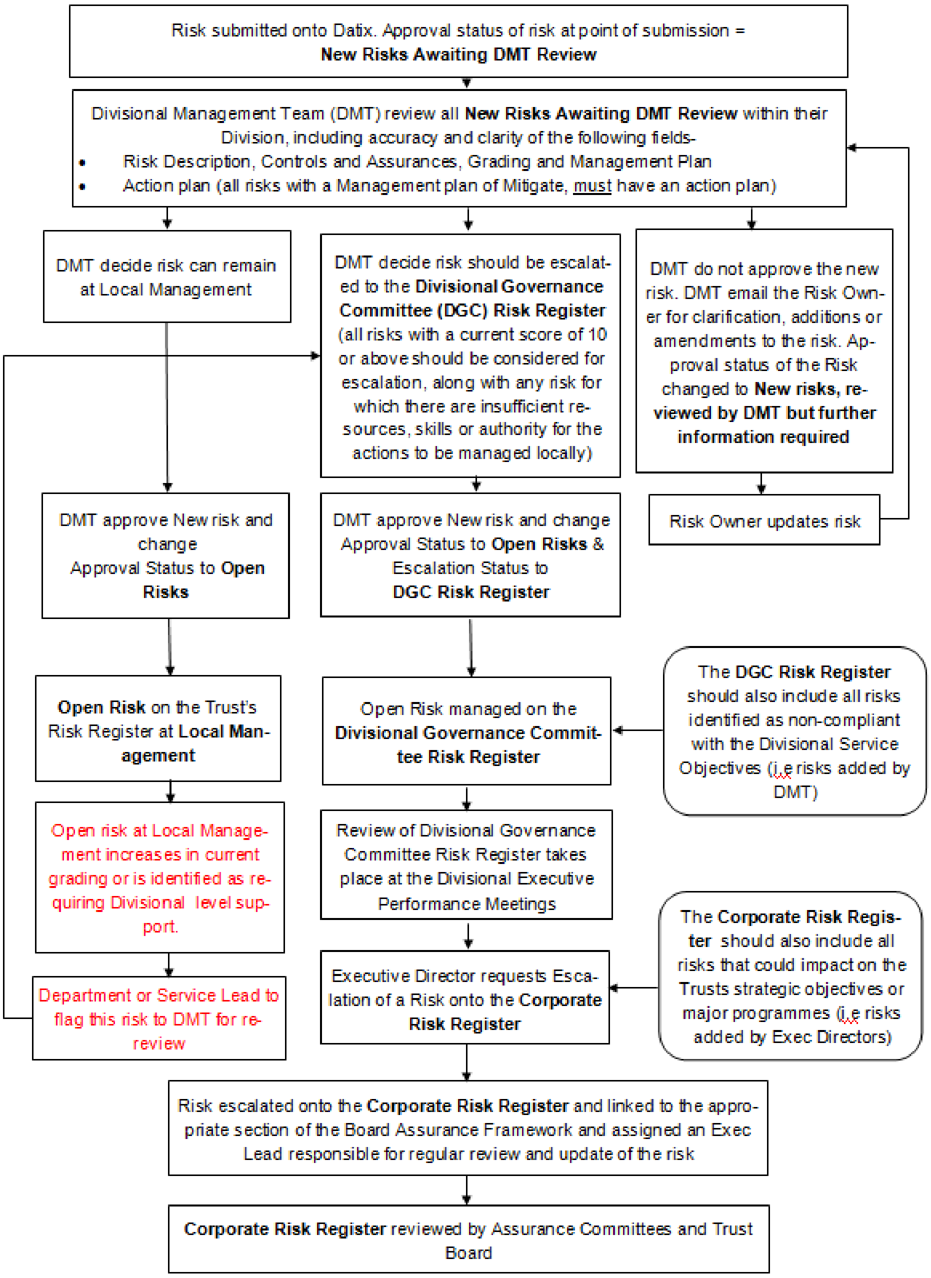
Version No.	Updated by	Updated On	Description of Changes
1.0	Head of Risk	07/12/2006	• Revised version
1.1	Head of Risk	10/04/2010	• Risk Manager replaced by Head of Risk Management throughout document • Section 2.1 – more detailed description of risk register process to add clarity for the reader. • Section 2.1.1 emphasis on all departments holding a departmental risk register • Section 2.3.5 – Addition of Risk Management Administrator responsibility in linking with DMTs to ensure capture of risks requiring input onto Trust Risk Register • Section 3 Monitoring: revised to reflect NHSLA requirements • Appendix 2 – risk assessment proforma revised to mirror Datix fields
1.2	Head of Risk	19.06.13	• Section 1.4 – Addition of specialist advice from Information Governance Manager • Section 2.1.1 Reviews of risk register amended to reflect current practice • Section 2.1.2 Addition to the Directorate risk register of all risks scoring 8 or above. Reviews of risk register amended to reflect current practice • 2.3.2 Addition of volunteers • 2.3.4 Change of Risk score for forwarding to the DMT to 8 or above to reflect all high and extreme risks. Addition of facilities reviews • Section 2.3.6 Addition of Security Management Committee.
2.0	Head Of Risk	October 2016	• Revised version, all existing sections updated • Addition of Escalation Flowchart • Addition of definitions • Addition of Acceptable Risk / Risk Appetite • Updated Assessing Level of Risk Matrix
2.1	Head of Risk	December 2017	• Amendment of Risk Appetite to reflect new strategic priorities
3.0	Head of Risk	July 2020	• Flowchart for the Escalation of risks replaced with updated version • Section 2: Introduction. Just Culture added • Reference to Directorates changed to Divsions/Directorates to reflect the fact that the Clinical Directorates are now Divisions, whilst the Non-Clinical Directorates remain as Directorates (throughout document) • Appendix A replaced with new Risk Assessment MLE package • ‘Datix ID’ box removed from appendix B (as Risk Assessments completed on paper would not be going on Datix) • Appendix D (previously E) was replaced with the 2019 Risk Management Training Needs

			Analysis • Appendix E (previously F) updated to reflect current extension numbers • Appendix F (previously G) updated to reflect policies are now on Microguide and not the intranet. Name and Author of Raising Concerns Policy updated. NHS Litigation website updated to NHS Resolution website • Appendix G (previously H) to be replaced with new Governance Committee Structure • 6. Organisational Structure – paragraph added regarding sub-committees • 7. Definitions - Corporate Risk Register definition update. • 7. Definitions – Directorate Management Committee Risk Register changed to Divisional Governance Committee Risk Register • 7. Definitions – Division Wide Risk Register added • 8.3 All paragraphs updated • 8.4 Changes to all paragraphs. 3:3 removed and replaced with Executive performance meetings. Score for considering escalation of risk to Directorate/Divisional Risk Register updated to 10. • 8.5 Paragraph 1 added. All other paragraphs updated. • 8.8 Paragraph 2, Trust Board Review of Corporate Risk Register updated • 9.2 List of risk register essential contents updated • 9.3 last paragraph updated to explain Initial, Current and Target scoring of risk • 10 Paragraph 1 – added reference to golden thread • 10 Paragraph 3 – wording updated • 10 – Paragraph 7 added • 10.1 Paragraph 6 – wording updated • 10.2 Paragraph 2 and 4 updated • 10.3 Changes to reporting schedule of Corporate Risk register • 10.5 Changes to the Board Assurance framework reporting schedule.
3.1			• Updated Reporting and Escalating Risks

Contents:

Appendices:

1. Flowchart for the Escalation of


Risk submitted onto Datix. Approval status of risk at point of submission = **New Risks Awaiting DMT Review**
Divisional Management Team (DMT) review all **New Risks Awaiting DMT Review** within their Division, including accuracy and clarity of the following fields-
• Risk Description, Controls and Assurances, Grading and Management Plan
• Action plan (all risks with a Management plan of Mitigate, must have an action plan)
DMT decide risk can remain at Local Management
DMT decide risk should be escalated to the **Divisional Governance Committee (DGC) Risk Register** (all risks with a current score of 10 or above should be considered for escalation, along with any risk for which there are insufficient resources, skills or authority for the actions to be managed locally)
DMT do not approve the new risk. DMT email the Risk Owner for clarification, additions or amendments to the risk. Approval status of the Risk changed to **New risks, reviewed by DMT but further information required**
DMT approve New risk and change Approval Status to **Open Risks**
DMT approve New risk and change Approval Status to **Open Risks** & Escalation Status to **DGC Risk Register**
Risk Owner updates risk
Open Risk on the Trust's Risk Register at **Local Management**
Open Risk managed on the **Divisional Governance Committee Risk Register**
The **DGC Risk Register** should also include all risks identified as non-compliant with the Divisional Service Objectives (i.e risks added by DMT)
Open risk at Local Management increases in current grading or is identified as requiring Divisional level support.
Review of Divisional Governance Committee Risk Register takes place at the Divisional Executive Performance Meetings
The **Corporate Risk Register** should also include all risks that could impact on the Trusts strategic objectives or major programmes (i.e risks added by Exec Directors)
Department or Service Lead to flag this risk to DMT for review
Executive Director requests Escalation of a Risk onto the **Corporate Risk Register**
Risk escalated onto the **Corporate Risk Register** and linked to the appropriate section of the Board Assurance Framework and assigned an Exec Lead responsible for regular review and update of the risk
Corporate Risk Register reviewed by Assurance Committees and Trust Board

2. Introduction

The Trust has a Risk Management Strategy which sets out the vision and key objectives for Risk Management within the organisation. Within the Risk Management Strategy it is stated very clearly that Risk Management should be part of both the operational and strategic thinking of every part of service delivery within the organisation. This includes clinical, non clinical, organisational, business and financial risks.

Risk management is the recognition of effective management of all threats and opportunities that may have an impact on Salisbury NHS Foundation Trust's (SFT) reputation, its ability to deliver its statutory responsibilities and the achievement of its objectives and values. Risk Management at Salisbury NHS Foundation Trust is based on a Just culture that encourages an organisational wide environment of openness and learning.

This policy and procedure for Risk Management should be read in conjunction with:

- Risk Management Strategy
- Adverse Events Reporting Policy
- Serious Incident Requiring Investigation (SI) Policy
- Duty of Candour and Being Open Policy
- A list of all other related policies can be found in Appendix F and are available on Microguide .

3. Aim/Purpose

The aim of this policy and process document is to:

- Evidence the importance of risk management to Salisbury NHS Foundation Trust;
- Support staff to understand their roles and have a consistent approach to risk management;
- Ensure that correct systems and processes are in place to manage corporate and operational risks across Salisbury NHS Foundation Trust;
- To deliver a risk management framework which highlights to the Executive Directors and Trust Board any risks, which may prevent the Trust from complying with its licensing authorisation and/or strategic objectives;
- To ensure that the risk of injury, damage, or loss to patients, staff, visitors and the organisation is managed in a way which minimises that risk as far as reasonably practicable; and
- To ensure that The Trust meets its statutory requirements to comply with UK Health & Safety legislation in which risk assessment is required.

Salisbury NHS Foundation Trust seeks to:

- Reduce risks that are a threat to the delivery of objectives and put in place actions that address the likelihood and impact of each risk to an acceptable level.
- This policy and process document supports this by:
- Setting out a risk management framework, which provides assurance to the Board that appropriate processes are in place to manage corporate and operational risks effectively;
- Recommending procedures for the effective identification, prioritisation treatment and management of risks to minimise or maximise the effect of an uncertain event or set of events on the delivery of objectives;
- Ensuring a cohesive approach to the governance of risk;
- Identifying risk management resources; and
- Establish risk management as an integral part of the Salisbury NHS Foundation Trust culture.

All risks that threaten or jeopardise the Trusts ability to meet their strategic, operational and corporate objectives will be required to:

- Be recorded with a core minimum amount of information on the Trust's Risk Register Module within Datix;
- Be assessed on the likelihood of the risk being realised and the level of impact should it be realised;
- Have clear actions that demonstrate how the 'Target' risk score will be achieved within agreed timeframes; and

- Have an identified risk owner and action owners.

The policy describes the governance structures and responsibilities in place to ensure that risks are managed and escalated through Salisbury NHS Foundation Trust as appropriate.

It sets out the respective responsibilities for corporate and operational risk management for the board and staff throughout Salisbury NHS Foundation Trust.

The policy describes the standard process to assist staff to identify, analyse and manage risks in their respective areas.

There are areas that remain as Directorates but for consistency of terminology throughout this Policy they are all referred to as Divisions.

Departments, for the purposes of this policy is a generic term and encompasses all departments/wards

4. Scope

This policy applies to **all** employees (including temporary staff, volunteers and contractors) of Salisbury NHS Foundation Trust and requires an active lead from managers at all levels.

This policy overarches both clinical and non-clinical including operational risk assessment and management processes.

5. Exceptions

There remains a need for Specialist personnel e.g. Tissue Viability Nurse, Manual Handling Advisor, Fire Officer and Information Governance Manager to use specific assessment tools for the purpose of stratifying risk in specialist key areas. However, any significant risks highlighted through these processes should be transferred onto the Trust's agreed risk assessment framework as set out in this policy.

6. Organisational Structure

The Chief Executive has overall responsibility for risk management within Salisbury NHS Foundation Trust.

The Director of Nursing has been designated as the responsible Executive Director and is supported in this role by the Head of Risk Management.

The sub committees of the Trust Board – the Clinical Governance Committee, the Finance and Performance Committee and the OD, People and Culture Committee- have been designated as the Assurance Committees. (See Appendix G for Committee structure).

The Audit Committee has a responsibility for monitoring the Assurance Framework processes.

The roles and responsibilities detailed within this policy clarify this process further (section 8).

7. Definitions

Action owner – Person whom the risk owner has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk and to provide regular reporting to the risk owner on progress**.**

Action plan - Sets out the activities that will address the identified gap and reduce, eliminate or minimise the risk.

Assurance - External evidence that risks are being effectively managed (e.g. planned or received audit reviews).

Control(s) - Arrangements in place to manage the risk.

Corporate risk register - A record of the risks identified through internal processes that will impact on the delivery of Salisbury NHS Foundation Trust's strategic objectives or major programmes. A risk can only be escalated to the Corporate Risk register via discussion and agreement with the nominated executive at the Performance review.

Divisional Governance Committee risk register - A record of the risks identified through internal processes that will impact on the delivery of Divisional objectives and / or plans.

Division Wide Risk Register – A record of all departmental risks within the Division.

Gaps in controls or assurances - Where evidence of effective management of the risk is lacking and an additional system or process is needed.

Impact - Is the result of a particular threat or opportunity should it actually occur.

Issue - A relevant event that has happened, was not planned and requires management action.

Likelihood - Is the measure of the probability that the threat or opportunity will happen, including a consideration of the frequency with which this may arise.

Operational risks - A risk or risks that have the potential to impact on the delivery of business, project or programme objectives. Operational risks are managed locally within teams and significant operational risks are escalated, where appropriate, through the Divisional Executive Performance Meetings.

Opportunity - An uncertain event that would have a favourable impact on objectives or benefits if it occurred.

Risk - A risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of business, project or programme objectives. A risk can be a threat or an opportunity.

Risk assessment - The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk.

Risk Management- The systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk.

Risk owner – The person who is responsible for ensuring that risk is managed, including the ongoing monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk and reporting on the overall status of the risk. It is the responsibility of the risk owner to escalate risks where appropriate in line with local risk procedure and the risk escalation process.

Risk proximity - The estimate of the timescale as to when the risk is likely to occur. It helps prioritise risk and to identify the appropriate response.

Threat - An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur.

8. Accountability and Responsibility

8.1 All Staff

It is the responsibility of **all** Trust employees to:

- Identify actual or potential hazards and risks and report/escalate these issues in accordance with this Risk Management Policy and Procedure and the Trust Adverse Event Reporting Policy.
- Be aware of existing risk assessments related to their area of work and relevant procedures or control measures to be adopted to reduce identified risks.
- Contribute to minimising risks wherever possible.
- Recognise their duty under legislation to take reasonable care for their own safety and the safety of others that may be affected by the Trusts business.
- Attend relevant Risk Management training as per job outline (also see Appendix D).

8.2 Contractors, Temporary Staff and Volunteers

It is the responsibility of **all** Contractors, Temporary Staff and Volunteers to:

- Follow Trust policies and procedures

- Be aware of risk assessments within their area and relevant procedures or control measures to be adopted to reduce identified risks.
- Report adverse events as per the Adverse Events Reporting Policy

8.3 Department/Service /Ward Leads

- All departments must have a risk register. The Departmental /Service lead is responsible for ensuring risks are identified, assessed, recorded, reported, monitored, and reviewed i.e. 'managed' within their area using the approach described in this policy and procedure, in conjunction with the Divisional Management Team and relevant risk specialists e.g. Health and Safety Advisor. This process is live and fluid and should include both proactive and reactive situations with updates captured within Datix as required.
- Departmental/Service leads to ensure that Risk Registers are representative of the concerns of staff working within the department, alongside those risks that may represent failure to meet operational/strategic targets or themes and trends from incident reporting.
- The Departmental/Service leads can choose to delegate responsibility of co-ordinating their risk register to a staff member with the authority and competence within their team, however the overall responsibility of the Departmental Risk Register would remain with the Departmental/Service lead
- The Departmental/Service lead is responsible for ensuring that staff within the area are focused on safety and are aware of the contents of the risk register including control/preventative measures and practices.

  The Departmental/Service lead is responsible for ensuring that each risk has a robust action plan that is developed and implemented to reduce risk to an acceptable level (the target score).
- The Departmental/Service Lead is responsible for ensuring that all risks are placed on the Trust Risk Register by entering the risk on to the Risk Register Module within Datix (via the intranet). This will ensure all risk issues are visible to the Divisional Management Team and can be pulled as evidence for scrutiny if required by internal or external stakeholders. Where a risk has a current score of **10** or above, or there are insufficient resources, skills or authority to manage the risk at local level, the DMT should consider whether the risk should be escalated to the Divisional Governance Committee Risk Register.

- Department/Service/Ward leads are responsible for ensuring all staff are made aware of at least the top 3 risks for their area and what is being done to address them.

*Maternity Services have their own Quality and Safety Manager in post who oversees the risk management process for Maternity and Neonatal Services (see appendix H).

8.4 Divisional Management Teams

- It is the responsibility of each Divisional Management Team to ensure that effective risk management is taking place across their Division
- The Divisional Management Team will follow the Escalation of Risks flowchart to ensure that all risks within their Division are put on the Trust Risk Register (Risk Register module within Datix), appropriately reflect the risk and to confirm agreement with grading, action plan and escalation requirements.
- The Divisional Management Team will ensure that the relevant risk specialists have been alerted to appropriate risks for information and action as necessary e.g. clinical risks, health & safety risks, manual handling, infection control etc.
- All Divisions are responsible for maintaining a Divisional Governance Committee Risk Register - identifying overarching risks, clinical, non-clinical, strategic, operational, and those associated with projects, which may cause damage to individuals, the environment, impact on activity, loss of reputation, and/or jeopardise the strategic objectives.

- The Divisional Management Team is responsible for ensuring that departmental risks with a rating of high or extreme (score of 10 or above) are reviewed and a decision documented about local management or inclusion on the Divisional Governance Committee Risk Register as stipulated in this policy.
- Risk identification should be proactive (e.g. risks associated with the achievement of service plan objectives) and reactive (e.g. as a result of adverse events). Divisional Management Teams have responsibility of identifying risks for inclusion on the Divisional Governance Committee risk Register that jeopardise achievement of the Divisional objectives.
- Risks associated with projects, service developments, changes to service delivery must be assessed, identified, recorded, reported and managed using the approach described in this policy and procedure. It is the responsibility of the Divisional Management Team to ensure these are included in the Divisional Governance Committee Risk Register. All schemes where a Quality Impact Assessment (QIA) assess the risk as scoring 12 or above will be monitored through the Trust Risk Register and via the Divisional performance meetings.
- The Divisional Governance Committee Risk Register must identify controls and action plans illustrating methods to reduce the likelihood/consequence of the identified risks to an acceptable level.
- The Divisional Management Team must undertake all achievable measures to reduce the risk, recognising restrictions of resources and finance thereby documenting the residual risk.
- Each Division/Directorate will maintain a comprehensive risk register, which will be formally reviewed in full at quarterly intervals, with key headlines and top risks presented monthly, through the Executive Performance Meetings. At these meetings the Divisions/Directorates will be expected to report on their Divisional risk register (high scoring risks and risks that require Executive knowledge and support), highlight any new or emerging risks that threaten their service delivery or Divisional objectives and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require escalation to the Trust's Corporate Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks that will change as risk reduction practices take place. The Directorate Governance Committee (DGC) has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in place to mitigate/reduce the risk.
- Divisional Management Teams are responsible for ensuring that the Divisional Governance Committee Risk Register is kept up to date and review dates/action plans are acted upon.
- Divisional Management Teams are responsible for ensuring that actions being taken to reduce risks are reflected in the Divisional Service Plan.

8.5 Risk Management Team

- Datix Risk Management Training is available on MLE and should be completed prior to submissions of risk assessments on the risk register. The Risk Management Administrator Co-ordinates the access to this training (see appendix D for further details).
- The Risk Management Team is responsible for providing professional risk management advice as requested and, where appropriate, assisting in the identification and development of Departmental/Divisional risk registers as per this policy.
- The Risk Management Administrator is responsible for liaising with the Divisional Management Teams to ensure that the Divisional Governance Committee Risk Registers are accurately reported for the Divisional performance meetings.
- The Risk Management Administrator is responsible for providing advice and assistance to Divisional Management Teams to ensure that all risks identified at the Divisional performance meetings or Corporate Directorate review meetings as requiring escalation to an assuring committee and/or inclusion on the Corporate Risk Register, are transferred accordingly.

- The Risk Management Administrator is responsible for maintaining and coordinating the Corporate Risk Register, and providing regular reports to the Assurance Committees and Trust Board.
- The Head of Corporate Governance is responsible for coordinating the Assurance Framework and providing reports to the Assurance Committees and Trust Board.
- (Training and development opportunities are described at Appendix D).

8.6 Trust Committees

In addition to the Assurance Committees a number of specialist committees are in place to monitor arrangements around specific risk areas e.g. Infection Prevention and Control Committee, Health and Safety Committee, Hospital Transfusion Committee and Security Management Committee (see Appendix G).

8.7 Assurance Committees

The Assurance Committees are responsible for:

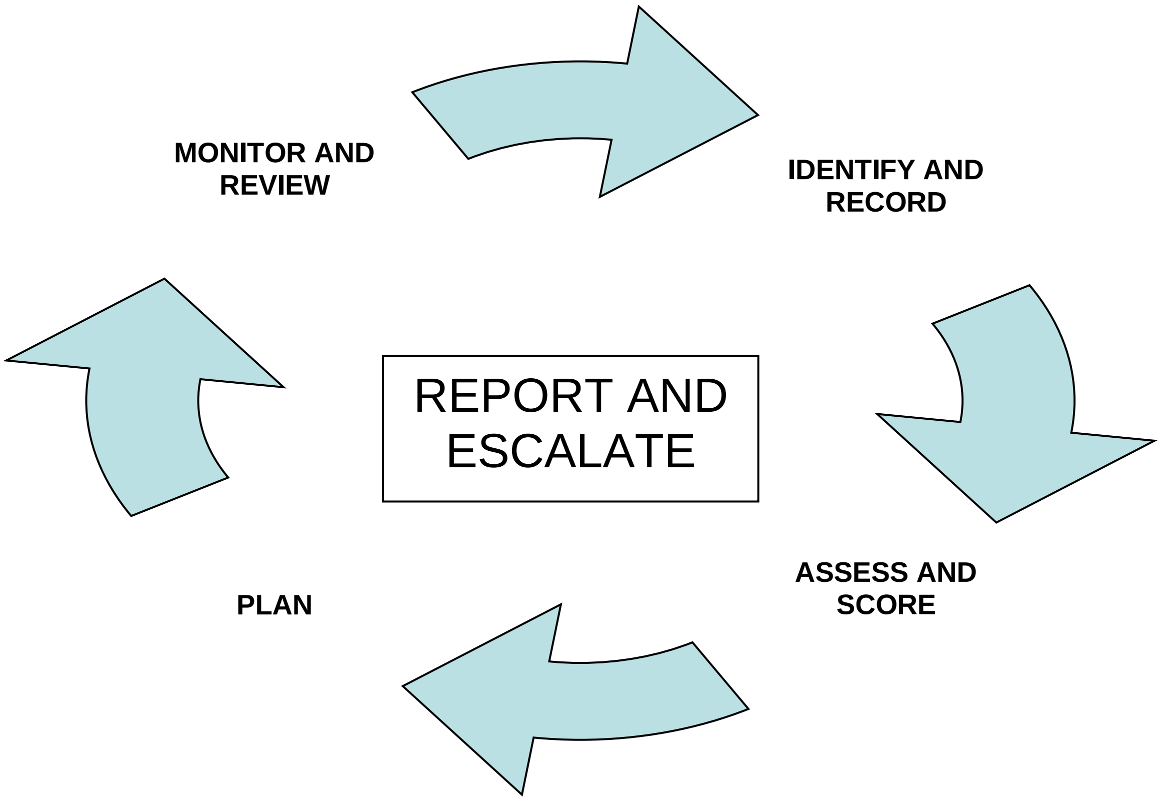
- Providing assurance to the Trust Board that high and extreme risks that threaten the corporate objectives have been escalated as requiring Executive support and are being managed via the Assurance Framework process.
- Reporting new extreme risks to the Trust Board and those where actions to mitigate the risk are out of the organisation’s control or resource.
- Prioritising actions in accordance with the risk assessment process in conjunction with Trust Board priorities.
- Contributing to the risk reduction measures where appropriate

8.8 Trust Board

- The Trust Board is collectively accountable for risk management and has a collective responsibility to ensure that the Board provide review and challenge to support the management of risk. The Board is made up of both Executive and Non-Executive Directors.
- The Trust Board shall review the Trust Corporate Risk Register, together with the Board Assurance Framework, a minimum of three times a year. Where the full Corporate Risk Register is not discussed, any new risks since the last meeting are highlighted to the Board. The Trust Board is responsible for reviewing the effectiveness of internal controls and sources of assurance, ensuring they are comprehensive and/or sufficiently independent. The Trust Board is also responsible for assessing the level of acceptable risk within the Trust Risk Register.
- The Executive Directors have specific responsibilities for managing the Trust’s principal risks, which relate to their portfolio. For example, the Director of Finance is the local risk manager for managing the Trust’s principal risks relating to ensuring financial balance, and the Director of Nursing for managing the principal risks relating to infection control.
- The Executive and Non Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role. Risk Management training sessions can be accessed via the Risk Department (see appendix D).

9. Risk Management Process

9.1 Identification of Risk



When identifying a risk, consideration should be given to what could pose a potential threat (or opportunity) to the achievement of objectives within the context of the organisation. For example, whether the risk is strategic, programme or operational.

Risks and Incidents often get confused and a useful way of remembering the difference is;

- Risks are things that might happen and stop us achieving objectives, or otherwise impact on the success of the organisation.
- Incidents are things that have happened, were not planned and require management action.

Once identified, the risk needs to be described clearly to ensure that there is a common understanding by stakeholders of the risk.

The recommended form for risk descriptions is to identify the cause, the event and the effect. Appendix A includes guidance on how to write a risk.

9.2 Risk register

As a minimum a risk register must contain:

- risk title;
- risk owner;
- risk description;
- current controls
- gaps in controls
- current assurances
- gaps in assurance
- ratings of likelihood and impact, for both current and after actions;

- management plan (Mitigate, Tolerate or Accept and Close)
- action plans;
- action owner for each action; and
- Completion date for each action.

9.3 Risk assessment and scoring

It is vital that all risks are assessed in an objective and consistent manner if they are to be managed, and to guide operational, project and programme planning and resource allocation.

Risks are firstly assessed on the probability (likelihood of the risk happening) and secondly on what would happen (consequence) should the risk occur.

When assessing how likely it is that a risk will occur, take into account the current environment. Consider the adequacy and effectiveness of the controls already in place within the environment, which could address the causes of the risk and therefore the likelihood of the risk being realised; for example, systems, policies, training and current practice.

When assessing what the consequence of the risk could be if it happened, consider what the consequence of the risk would be in most circumstances within your environment and what is reasonably foreseeable.

The assessment is completed by scoring the likelihood and consequence. Appendix C sets out the Trust's 5x5 matrix for assessing the level of risk.

The Trust's procedure is to score and rate a risk three times;

- Initial: This is the score of the risk at the initial risk assessment (this should remain unchanged)
- Current: The score of the risk as of the most recent review (when initially submitting the risk, the initial and current score will be the same)
- Target: The acceptable level that the risk will be reduced to once all the controls are in place

9.4 Action planning

Following completion of the risk assessment, consideration must be given to whether the risk requires further management actions that ideally minimise the likelihood and/or impact of a threat or maximise the likelihood of opportunities. For each risk an action plan to eliminate, minimise, or maximise the risk is required.

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the organisation makes and documents a decision to accept that level of residual risk in accordance with the risk management governance processes. This is known as the trusts Risk Appetite (section 10.4).

9.5 Monitoring and closure

The implementation of the action plan and the level of risk must be kept under review.

Where implementation of action plans is not producing the anticipated results, the risk should be re-assessed and a revised action plan agreed as necessary.

Once all possible actions have been completed or the event has passed, the risk should be closed and moved to the closed risk register for audit purposes.

10. Reporting and Escalating Risks

Risk assessment information filters up through the organisation from the departmental and Divisional risk registers through to the Corporate Risk Register, which informs the Trust Board of the high level risks within the organisation. In order to ensure a standardised approach, the same method of risk assessment documentation and scoring is used for all risks at all levels (clinical, health and safety, strategic risks). This section describes how risk information travels through the organisation as a golden thread via the risk registers.

Risk Assessments must be entered onto the Risk Register module of Datix (via the intranet) and therefore there is a requirement for each department to have at least one nominated individual who can access the system and undertake this role (see appendix D)

The risk assessment record on Datix provides information on how the risk was identified, risk details, area(s) affected, the controls and assurances currently in place to manage the risk, the overall level of risk (based on likelihood multiplied by consequence), the action plan in place to mitigate the risk, and the process for performance managing and monitoring the risk. (For guidance on how to complete a risk assessment please refer to Appendix A).

The risk matrix at appendix C provides a standardised format for scoring the level of risk associated with a risk assessment (based on consequence and likelihood). This matrix must be used with all risk assessments.

The Risk Register Module is overseen centrally by the Risk Management Department but each department and DMT has responsibility for ensuring the inclusion of their own risks and that they are being managed appropriately i.e. review, updating, closing when no longer a risk. The database ensures that the Trust has a clear view of the totality of the high level risks it is facing and the adequacy of controls and action plans in place.

Risks may be identified at departmental, Divisional, or Strategic level.

6 monthly Risk Register Summits are undertaken with the Chief Medical Officer, Chief Nurse, Risk and Divisional Management Team. Those that require executive support are escalated and monitored through the Executive Performance meetings to ensure appropriate discussion and challenge takes place. When escalating a risk, the escalation report should include the current controls, gaps in controls, current assurances, gaps in assurances, risk rating and mitigation and the rationale for escalation.

A paper risk assessment template (Appendix B) is available for carrying out Risk Assessments on risks that are not suitable for submission onto the Trust Risk Register (on Datix), i.e. risks relating to an individual employee, which should be kept in their personal file.

10.1 Departmental Risk Registers

All departments must hold a Risk Register. These must be developed and reviewed in accordance with the processes set down in this policy, using the standard format and agreed risk matrix (see appendices A-C).

Departmental Risk Registers should cover the breadth of risks associated with patient care, Trust wide service delivery and work practices (with a particular focus on health and safety).

Departmental risk assessments scoring 10 or above must be alerted to the Divisional Management Team for information and so that a decision can be made and documented about local management or inclusion on the Divisional Governance Committee risk register. Departmental risk assessments with a score below 10 can be managed locally unless actions cannot be put in place to mitigate. These risks must be brought to the attention of the Divisional Manager.

Department Risk Registers must be regularly monitored, reviewed, and updated at Department level meetings.

All high or extreme rated risk assessments must be formally discussed at Divisional level meetings where a Divisional plan of action can be agreed.

Any departmental Risk assessments with a rating of 10 or above (or lower if they threaten the department achieving their objectives) should be considered for inclusion onto the Divisional Governance Committee Risk Register to ensure ongoing monitoring and review at a senior level (see escalation of risks flowchart).

10.2 Divisional Governance Committee Risk Registers

The Divisional Management Teams have a key role where new risks are identified, at both a strategic and operational level, through which specific management action is taken in order to contain, manage, and mitigate identified risks.

The Divisional Governance Committee Risk Register should include all risks identified against the Divisional service plan objectives. Departmental risks scoring 10 or above should be considered for escalation onto the Directorate Governance Committee Risk Register. Where there are multiple departmental risks scoring 10 or above for the same issue i.e. staffing the Division may choose to include one Divisional risk for the issue and link the related risks as evidence.

The Divisional Governance Committee Risk Register should also include risks related to strategic and corporate objectives e.g. those relating to key performance targets.

Clinical Divisions Risk Registers shall be reviewed via the monthly performance meetings where the information and actions being taken will be scrutinised.

For all non-clinical areas (i.e. Finance, Facilities, IT, OD &P), where a risk requires escalation, this is through the Trust committee governance structure up to the Trust management Committee and further to Trust Board if required.

It will then be agreed which risks require escalation to the assuring committees and/or inclusion on the Trust's Corporate Risk Register. Risks may be appropriately escalated to the Trust's Corporate Risk Register if:

- All action has been taken to minimise the risk but the risk score remains 12 or above
- Trust wide consequences associated with corporate objectives have been identified
- Activity presents a risk at corporate level

The Risk Management Administrator and Head of Risk Management must be informed where it has been agreed to escalate a risk to the assuring committees and/or for inclusion on the Trust's Corporate Risk Register.

All Divisions have access rights to the Datix risk register module in order to manage their risk registers.

It is the Divisional Manager's responsibility to bring any new high/extreme risks to the attention of the Head of Risk Management and Risk Management Administrator.

10.3 The Trust's Corporate Risk Register

The Director of Integrated Governance reports on the Trust risk profile to the Board Assurance Committees– Finance and Performance Committee, Clinical Governance Committee, People and Culture Committee and to the Trust Management Committee 6 times a year. The Assurance Committees will review the presented Corporate Risk Register and Board Assurance Framework to ensure breadth and depth of information and for assurance that actions are being taken to control and mitigate the risks cited.

The Assurance Committee Chairs provide an escalation report to the Trust Board, highlighting any areas of concern or significant change in the risk profile as required the appropriate Assurance Committee or the Trust Board can recommend whether an extreme risk should be considered for inclusion onto the Assurance Framework.

A deep dive/further review of a corporate risk will be initiated by the Director of Integrated Governance for the action owner to undertake in the following circumstances;

- A corporate risk of 16 and above for a period of 6 months will initiate a deep dive
- A corporate risk score <16 unchanged for 12 months will initiate a deep dive
- An escalating risk score over a 3 month period will initiate a Board Committee discussion

10.4 Acceptable Risk/Risk Appetite

The Trust acknowledges that some of its activities may, unless properly controlled, create organisational risks and/or risks to staff, patients and others. The Trust will therefore make all efforts to eliminate risk or ensure that risks are managed and controlled so that they are as low as reasonably practicable.

However it is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. A balance needs to be struck between the costs of managing a risk and the benefits to be gained from eliminating it. A decision must therefore be made regarding the level which a risk would be deemed acceptable.

The levels and types of risk that the organisation are prepared to accept or not accept in pursuance of our goals, taking into account stakeholder expectations is known as the Risk Appetite.

Our General Statement/Principles are:

- The organisation must take risks in order to achieve its aims and deliver the strategic objectives
- Risks will, however, be taken in a considered and controlled manner
- Exposure to risk will be kept to a level deemed acceptable by the Board
- The acceptable level may vary from time to time due to internal and external factors
- Some particular risks above the agreed acceptable level may be accepted because of the benefit that may ultimately arise, the cost of controlling them, or the period of exposure
- No risks will be acceptable (and therefore must always be controlled) if they have the potential to cause significant harm, compromise the organisational reputation severely, have financial consequences that could endanger the organisation's viability, jeopardise substantially the organisation's ability to deliver its core services or threaten the organisation's regulatory or legal compliance

For each of the strategic objectives the Trust Executive Directors mapped the organisations risk appetite as follows:

Strategic Objective	Risk Appetite	Statement
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.	Open	We will be prepared to consider all delivery options and select those with the highest probability of productive outcomes, in order to deliver a comprehensive range of services accessible to our local population. This will require innovation and at times therefore elevated levels of associated risk
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.	Open	We will be prepared to consider all delivery options and select those with the highest probability of productive outcomes, in order to deliver a comprehensive range of services accessible to the wider population using our tertiary services. This will require innovation and at times therefore elevated levels of associated risk
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	Open	Innovation will be pursued including use of technology as an enabler for our future operational delivery and sustainability to capitalise on opportunities. This at times may be associated with elevated levels of risk.
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	Cautious	We will endeavour to only accept the lowest levels of risk in relation to patient care. We will have an overall preference for safe delivery options.
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	Open	We will be prepared to consider all options for optimising our current workforce, attracting high calibre recruits and ensuring measures are in place to develop and support staff. This at times may be associated with elevated levels of risk.
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	Open	We will be prepared to consider all options in order to ensure resources are utilised appropriately, we secure a return on investment where possible, and achieve a financially sustainable future. This at times may be associated with elevated levels of risk. The availability of cash and external relationships with regulators may determine this risk appetite further.

The risk appetite is currently under review and once approved by Trust Board, this policy will be updated.

10.5 The Board Assurance Framework

The Director of Integrated Governance coordinates the Board Assurance Framework.

The Assurance Framework documents the high level strategic risks, which could jeopardise the achievement of the corporate objectives and threaten the viability of the Trust.

The Assurance Framework documents the controls in place to mitigate these risks. Assurance sources are identified so that the Trust Board can objectively assess how well each risk is being managed and how effective the control measures are. Where assurance cannot be gained, remedial actions are documented and pursued.

The Trust Board is required to provide assurance through the Annual Governance Statement that there are robust mechanisms in place across the organisation to recognise and manage risks effectively. The Assurance Framework is the vehicle to achieving this. It identifies through assurance where aspects of service delivery are being met to satisfy the organisational objectives and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

The whole Assurance Framework is presented and reviewed three times a year by the Trust Board at the public meetings. Each principal risk has an Executive Director identified as the local risk manager who is responsible for managing and reporting on the overall risk. An Assurance Committee is also identified to assure the Trust Board that each principal risk is being monitored, gaps in controls identified, and processes put into to place to minimise the risk to the organisation. The Director of Integrated Governance presents the Assurance Framework bi-monthly to the respective Assurance Committees along with the escalated risks from the Risk Register. It is the responsibility of the Assurance Committee Chairs to report to the Trust Board via the committee escalation report, on a bi-monthly basis any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors.

The Director of Integrated Governance and Risk Management Administrator meet regularly with Risk Leads to ensure that the document remains dynamic and is linked to the business planning cycle. Additionally, throughout the year the lead managers for the Principal Risks will be asked to provide information and updates for inclusion within the Assurance Framework.

If the financial, quality or performance reporting and/or risk management processes indicate that there is a serious risk of the Trust being unable to comply with CQC registration requirements or the strategic, financial or governance matters set out in the NHS Improvement guidance [the NHS Oversight Framework] then the Board must notify the relevant regulator.

The Audit Committee monitors the overall Assurance Framework process twice a year to ensure it is fit for purpose.

11. MONITORING AND MANAGING RISK MANAGEMENT PERFORMANCE

The Risk Management team alongside the Divisional management Teams and Departmental Leads are responsible for monitoring the process of risk assessment within the organisation to ensure that the risk assessment process and risk matrix (Appendix C) are utilised for risk assessments across the Trust. Where deficiencies are recognised then direct contact will be made with that department to ensure that the correct process is used and identify any training needs. If the problem persists, actions will be agreed with the Department and Divisional Management team.

Internal audit review the assurance framework and risk register process annually to ensure that this policy is followed and is providing a systematic approach to risk assessment. Where deficiencies are identified recommendations are made, and actions agreed. This forms part of the Internal Audit report, which is reported via the Audit Committee who will also ensure that actions are completed.

The Head of Risk Management is responsible for monitoring that the approach to risk assessments and risk registers complies with this policy.