Tameside and Glossop Integrated Care NHS Foundation Trust

Risk Management Strategy
Policy and Guidance

EQUALITY IMPACT
The Trust strives to ensure equality of opportunity for all both as a major employer and as a provider of health care. This policy has therefore been equality impact assessed by the Associate Director of Integrated Governance to ensure fairness and consistency for all those covered by it regardless of their individual differences, and the results are shown in the attached Appendix 5.

Version:	**12**
Authorised by:	**Trust Board**
Date authorised:	**January 2019**
Next review date:	**January 2020**
Document author:	**Head of Assurance and Governance**

VERSION CONTROL SCHEDULE

Risk Management Strategy, Policy and Guidance

Version: 12

Version Number	Issue Date	Revisions from previous issue
9.5	April 2013	Interim Policy – minor role/responsibility amendments made relating to the implementation of the role of Deputy Director of Quality and Governance and the Risk, Complaints and Litigation Manager only, as new processes and structures are being implemented which will be reflected in the reviewed policy due October 2013.
10.0	April 2014	Policy aligned to revised risk management processes and new committee structures
10.1	July 2014	Minor amendment to reporting Committees in Appendices (Hospital Transfusion Committee and HTA Organ donation) IPEG amended to PLACE
11.0	May 2016	Amendments to monitor change of title and Risk Management Group Terms of Reference/ Membership Revisions following review of Risk management processes and reporting
12.0	January 2019	Refinement of policy to reduce repetition and reflect changes in the Trust structure in relation to roles and responsibility. Inclusion of Risk Appetite table and gap risk score. Amended to reflect Organisational and Committee structure changes and revised BAF and risk tables. Removal of Board sub-committees full TOR.

Contents

1. STRATEGY AND POLICY STATEMENT

Strategic Aim:
The strategic aim of the Trust is to make risk management the key system through which clinical, organisational and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. Those key systems need to be established and embedded across the organisation. Compliance with the CQC registration requirements and NHS Improvement Terms of Compliance are monitored.

The aim of this continuing strategy is to:

- Further embed these systems and processes at every level of the organisation and provide a framework for risk management to reduce risk to services users, staff and visitors and others affected by the undertakings of the organisation.
- Monitor risk management, ensuring compliance with current and future standards and legislation.

Risk management is the key system through which strategic, clinical (Quality & Safety), operational, corporate and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. It is through this system of internal control and accountability the Chief Executive fulfils their responsibility as accountable officer and the Board fulfils its responsibility of stewardship. Key systems are fully embedded at every level of the organisation and ensure compliance with current and future risk management related standards and legislation.

Assurances of risk management and mitigation are provided to the Trust Board through an agreed scheme of delegation according to principles and systems which will allow the Board to be able to make accurate judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. The Board Assurance Framework (BAF) contributes to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Account and it is through this process we monitor adherence to Care Quality Commission and other regulators.

2. INTRODUCTION

Risk management and internal control is central to the effective running of any organisation. At its simplest, risk management is good management practice. It be seen as part of the overall management approach. Tameside & Glossop Integrated Care NHS Foundation Trust will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

This document sets out the approach, taken to ensure the Trust maintains a robust approach to the management of all risks and assurances in the organisation.

The Board's Intent
Tameside & Glossop Integrated Care NHS Foundation Trust is committed to leading

the organisation forward to deliver a quality service and achieve excellent results, thereby ensuring that the organisation makes the very best possible use of public funds. The organisation sets itself annual strategic goals and objectives. The Board uses the risk management processes outlined in this strategy and Policy as a means to help achieve these goals and objectives.

The Risk Management Strategy supports a culture that encourages staff to:

- identify and control risks within their sphere of authority which may adversely affect the Trust's operational and strategic ability;
- comparatively analyse risk using an agreed grading system as explained in the risk management system section of this document;
- where possible, fund, eliminate or transfer risks or else reduce them to an acceptable and cost effective level;
- otherwise ensure the organisation is informed and openly accepts the remaining risks.

Who This Strategy Applies To
This strategy is intended for use by all directly employed and temporary staff and contractors engaged on Tameside & Glossop Integrated Care NHS Foundation Trust work in respect of any aspect of that work. Although the key strategic risks are identified assessed and monitored by the Trust Board, operational risks are managed on a day-to-day basis by staff throughout the organisation. In order that progress in managing all risks can be acknowledged, the Trust has in place a process for managing Risk Registers proportionate to the level of risk. This process enables provision of a record of all risks to the organisation.

What the Trust Must Achieve
The Board is responsible for driving the Trust forward to achievement of organisational principal objectives. These objectives are agreed by the Board and consider all the requirements of the Secretary of State for Health and include statutory obligations.

The Department of Health (DH) and our Regulators require that the Chief Executive signs a Governance Statement once every financial year on behalf of the Board. It is however an iterative process and document. This is a comment on how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed. To support achievement of the organisational objectives and in order to fulfil its responsibilities, the Trust Board has developed a management system which allows decisions to be taken in a structured and equitable way. This Risk Management Strategy is a key component within that management system.

The Way We Work – Fair Blame Culture
All members of staff have an important role to play in identifying, assessing and managing risk. To support staff in this role the Trust provides a fair, consistent environment. This encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report any situation where things have, or could have gone wrong. Balanced in this approach is the need for the Trust to provide

information and support, and training for staff in response to any such situation.

At the heart of this policy is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate changes will be made to the Trust's systems to enable this to happen.

In the interest of openness and candour, the process of learning from mistakes, formal disciplinary action will not usually be taken as a result of a risk management investigation. However, the Trust's Disciplinary Policy outlines the circumstances in which disciplinary action will be taken. Disciplinary action may, therefore, be appropriate where it is found that a member of staff has acted in a way that is:

- Criminal or gross/repeated professional misconduct, including fraud
- an abuse of clients/patients
- fails to report an incident in which a member of staff was either involved or about which they were aware
- is a breach of statutory duties

Should disciplinary action be appropriate, this will be made clear as soon as the possibility emerges. The investigation would then be modified to take account of personnel policies with advice from Human Resources as appropriate.

3. DUTIES, ROLES AND RESPONSIBILITIES

The Trust Board is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy. These responsibilities are met in a variety of ways: Trust Management Responsibility for Risk Management – key roles *
Note this list summarises duties and responsibilities for key organisational risk areas. This list is not exclusive and there will be Trust Policies which identify responsibilities for risk areas not listed below. Individuals will have specific roles as defined in specific Trust Policies and procedures and will fulfil these roles as required

Role and Responsibility of the Trust Board
The Trust Board is accountable for ensuring a system of internal control and stewardship which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- The Trust's Principal Objectives are agreed.
- Principal risks to those objectives are identified
- Controls which eliminate or reduce these risks are implemented.
- The effectiveness of these controls are independently assured.
- Reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors.
- Actions are agreed to improve control over serious or unacceptable risks.

- Policies are in place to determine acceptabilities and thus informing what level of risks should be accepted / retained.

This system (of internal control) is managed through the accountable officer who is the Chief Executive and supported by an effective Trust committee structure.

Role and Responsibility of the Chief Executive

The Chief Executive provides leadership and strategic direction to risk management processes. This responsibility includes consideration of the Trust's Risk Register and resource allocation relating to the significant risks of the Trust.

The Trust Board has the Executive Management Team which operationally manages key policies and strategies. The Executive Management Team is chaired by the Chief Executive.

The Chief Executive is the Accountable Officer and is accountable for ensuring:

- The Trust's Principal Objectives are agreed.
- Sound systems of internal control which are based on an ongoing management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically.
- Internal Audit Plans which review the effectiveness of the system of internal control.
- Systems of internal control which are underpinned by compliance with the core controls assurance standards of Governance, Financial Management and Risk Management.

The Chief Executive uses the Trust Board Sub Committees as the principal means by which these responsibilities are made operational and effectiveness is monitored.

The Chief Executive prepares and signs an annual Governance Statement on Control for inclusion in the Annual Accounts and the Trust Annual Report.

The Chief Executive delegates lead responsibility for risk management to Executive Directors who are accountable to the Board for the management of a specified group of risks.

They have specific roles as defined in specific Trust policies and procedures and will fulfil these roles as required

Role and Responsibility of Non-Executive Directors

Non-Executive Directors have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical). This supports the achievement of quality and the organisations objectives. In particular, as members of the Audit and Quality and Governance Committee and Finance Committee, Non-Executive Directors will review the adequacy of the Risk

Management Strategy, and receive regular monitoring information against the management of risks judged as 'significant' and provide verification to the Trust Board through the Board Assurance Framework on the systems in place for the management of risk within the Trust.

Role and Responsibility of the Director of Finance
The Director of Finance is accountable to the Trust Board and Chief Executive for the Trust's financial risk management activities. The Finance Director is responsible for ensuring that the Trust carries out its business of providing healthcare within sound financial Governance arrangements that are controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis. They will have an infrastructure in place across the organisation to fulfil these requirements.

They have accountability for financial risk management, and control is through the Chief Executive and Chairman of the Trust. There are close working arrangements with other Executive Directors with regard to ensuring that financial planning and financial risk management integrates with the Trust's clinical and organisational risk management activities and is closely involved in consideration of the recommendations of the Audit Committee and the Quality and Governance Committee. The Director of Finance seeks the Internal Auditor's opinion on the effectiveness of internal financial control.

Role and Responsibility of the Medical Director
The Medical Director with the Director of Nursing and Integrated Governance has responsibility for identifying the clinical governance arrangements for the management of clinical risk and through working with the appropriate Divisional Directors, Clinical Director, Clinical Lead, Executive Director, Senior managers and clinicians ensure risks identified and assessed and actions identified to eliminate or reduce these risks.

They act as the Executive lead for Research and Development.

They are the Lead Executive Director for implementation of the Central Alerts System (CAS).

They act as Caldicott Guardian.

They have lead executive responsibility for, Learning from Deaths, Clinical Audit, National Clinical Guidance/NICE Guidance, medical staff education, medical equipment.

Role and Responsibility of the Director of Nursing and Integrated Governance
The Director of Nursing and Integrated Governance is accountable to the Trust Board and Chief Executive for the Trust's nursing Governance and Integrated Govenance Unit and associated risk management activities. They are responsible for ensuring that standards of responsible risk management are applied at all levels within the Trust.

They acts as the Executive Lead Director for Infection Control.

They are responsible for the management of risks within their area of operational

responsibility and for ensuring that mechanisms are robust so as to assure the Trust Board that risks are being managed.

They are responsible in partnership with the Medical Director for ensuring that the Trust has systems to learn from experience and that lessons learned are systematically shared across the organisation.

They have responsibility with the Medical Director, for identifying the principal risks to the Clinical Governance arrangements and through working with the appropriate Divisional Director, Clinical Directors, Assistant Chief Nurses, Executive Directors, Senior Managers or clinicians to ensure risks identified through risk profiling/ assessment are managed, reduced or eliminated.

With responsibility for, governance, and patient experience advocacy for the Trust they provide a clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements on behalf of the Trust Board.

Role and Responsibility of the Director of Human Resources
They are accountable to the Chief Executive for Human Resource issues across the Trust. There are close working arrangements with the Executive Team with regards to ensuring that workforce planning and risk management integrates with the Trust's clinical and organisational risk management activities and is closely involved in consideration of the recommendations of the Board sub-Committees.

They are responsible for ensuring provision of occupational health and employment services across the Trust and ensuring that there is a systematic approach to managing the risks of employment checks and professional clinical registration.

They have specific roles including management of risk associated with health and wellbeing, sickness absence, bullying and harassment and workplace stress.

Role and Responsibility of Director of Operations
The Director of Operations is a member of the Executive Team and are responsible for the overall management of all patient services, ensuring that all key access targets are met together with finance, waiting lists, human resources management.
They are responsible for the management of risks within their area of operational responsibility including bed and patient flow management and patient discharge. They are the lead director for business continuity, emergency preparedness and major incident planning.

Role and Responsibility of the Director of Informatics and Performance
The Director of Informatics and Performance is a member of the Executive Team and is responsible for the overall management of Informatics and Performance relating to all patient services, ensuring that all key information requirements are met together with ensuring systems are in place in relation to information on performance management.

They are responsible for the management of risks within their area of operational responsibility including Information Management and Technology and Information

Governance.

They act as the Trust's SIRO Senior Information Risk Officer.

Role and Responsibility of the Associate Director of Integrated Governance
The Associate Director of Integrated Governance is one of the senior team of managers in the Trust's Integrated Governance Unit (reporting to the Director of Nursing and Integrated Governance) who collectively have the responsibility for enabling corporate compliance with the national requirements and standards set by the Care Quality Commission and regulatory bodies. They support the Executive and Non-executive Directors in carrying out their responsibilities for risk management and assurance and takes the management lead within the Trust for developing and implementing the Board Assurance Framework and specifically for:

- Developing, implementing and sustaining the Trust's Integrated Quality, Governance, Assurance & Safety agenda.
- Having overall responsibility as lead operational manager for the Trust's risk, Health & Safety, incident management, complaints and leads on clinical audit and effectiveness, Coroners inquests, and litigation functions and has overall responsibility for ensuring the development, planning and implementation of these aspects of the Trust's governance programme.Providing key information and reports to ensure risks are identified, reduced/eliminated.
- Providing expert senior level advice on the Trust's systems of risk management and Governance both clinical and non-clinical.
- Overall responsibility as lead manager for ensuring that systems are in place to monitor progress against the Care Quality Commission's Standards of and Regulatory Requirements.

They ensure all identified serious incidents are managed appropriately and has responsibility for the maintenance of the electronic data base (Safeguard) and implementation of the Trust Incident and risk reporting systems and processes

Role and Responsibility of the Company Secretary
The Company Secretary is responsible for ensuring that the Trust operates in accordance with statutory regulations and that there is appropriate stewardship and corporate governance of the business of the Trust. They are responsible for facilitating the smooth operation of the Trust's formal decision and reporting processes maintaining the registers of interests of members of the Board, hospitality, use of the Common Seal and tenders

The Company Secretary ensures that Committees of the Board are properly constituted with clear enforceable terms of reference and is responsible for ensuring they are observed and reviewed as required and on at least an annual basis. They ensure effective and well managed meetings and effective management of the Board and Sub Committee business programme, in accordance with the governance agenda and Trust Standing Orders and Standing Financial Instructions ensuring actions required in relation to risk management and corporate governance are completed.

They also act independently of the Trust Board to provide advice on corporate governance issues to the Trust Board and the Chairman and ensures that effective

arrangements for the proper induction of Directors are in place and provides advice and support regarding the discharge of their duties.

Role and Responsibility of the Director of Estate and Facilities
As the responsible Director, the Director of Estate and Facilities has lead responsibility for fire safety, security, waste management medical devices across the Trust. They are responsible for the management of risks within Estates and Facilities and for ensuring that the Trust has in place a security policy and strategy with associated assessments and action/work plan reflecting surrent security risks of the organisation. They will ensure that the Trust has in place a Security Group with PFI partner engagement reporting through the Trust Governance structures.

Role and Responsibility of the Assistant Chief Nurse
The Assistant Chief Nurses are members of the Corporate Nursing Team who collectively has the responsibility for enabling corporate compliance with the national requirements and standard/professional standrds set by the Care Quality Commission and other regulators.

They manage moderate and significant risks and provide key information and reports to ensure risks identified are reduced / eliminated.

They have specific roles as defined in specific Trust policies and procedures and will fulfil these roles as required.

Role and Responsibility of the Fire Safety and Emergency Planning Manager
The Fire Safety and Emergency Planning Manager promotes and manages fire safety and emergency prepardness throughout the Trust ensuring compliance with statutory requirements. The Fire Safety and Emergency Planning Manager reports to the Director of Estates and Facilities for all matters in relation to fire safety and ensures an annual work plan is in place with regard to fire safety and emergency planning.

Operational Local Management for Risk Management – Key individual roles

Role and Responsibility of Divisional Directors and Directors of non-clinical services
Divisional Directors, of clinical divisions and Directors of non clinical services will ensure the Trust's risk management processes are fully implemented within their services, risk registers are maintained, and will therefore be able to ensure principal risks to the Trust's objectives are systematically identified, evaluated, eliminated or reduced and managed.

In addition, in respect of their areas of responsibility, ensure reports on unacceptable and extreme risks are escalated according to Trust policy through to Trust Board via the Integrated Governance Unit according to Trust Policy.

They will encourage the proactive management of risks including business risks emerging from the Integrated Business Plan and Quality & Safety Strategy through the development, implementation and monitoring of risk education and training

programmes attendance at mandatory training and the effective functioning of Divisional / Directorate Committees responsible for Governance.

Role and Responsibility of Divisional / Directorate Managers, Business Managers, Clinical Directors / Clinical Leads / Midwifery Leaders / Matrons / Service Quality Leads and Departmental Heads

As Leaders will implement the Trust's risk management processes within their services and will therefore be able to systematically identify, evaluate, eliminate or reduce and manage risks.

In addition they will, on behalf of their services provide reports on significant risks, and the effectiveness of the controls to the appropriate Divisional Directors and Clinical Director and through the escalation process as described in the risk management system section of this document. They will meet their own identified training needs, participate in risk awareness training through mandatory training and also identify and meet the education and training needs of staff so that they are aware of and understand risk management and ensure risks are reduced.

Will have specific roles as defined in specific Trust Policies and procedures and will fulfil these roles as required.

Role and Responsibility of Divisional Governance Leads

Each clinical Division have identified individuals with responsibility for risk management as 'Governance Leads'. The 'Governance Leads' support the Trust's Clinical Divisional and Directorate teams in ensuring that the Trust becomes imbued with a 'Culture of Governance' quality, safety and risk management.They facilitate the management of Governance and risk management with their Divisions and Directorates. In smaller Corporate Divisions/Directorates the Director or a Senior Manager may assume this responsibility.

Nominated individuals will be responsible for managing their Divisional Risk register ensuring that risk assessments populate the risk registers according to risk score utilising the agreed process and methodology. As a minimum they are required to provide a Governance report which includes quality and safety focus to their Divisional Governance Group or Senior Team Meeting at each meeting.

The Governance Leads work closely with the Trust's Integrated Governance Unit in supporting the Trust's governance structure and its supporting mechanisms, ensuring that all governance issues are appropriately reported and co-ordinated.

Role and Responsibility of all Staff and Volunteers

Trust Employees and Volunteers
All employees of the Trust and volunteers have a responsibility to:

- Ensure they work in accordance with all Trust Policies and Procedures.

- Ensure they undertake corporate induction, local induction and mandatory update training on risk management policy and procedures as determined in the Trust policy.
- Ensure they identify through risk assessment, any risks they feel exist within their department or during the delivery of their services and take action to minimise such risks.
- Escalate risk in accordance with this policy

Individual Clinicians Employed by the Trust
In addition to the requirement to fulfil the duties of an employee - All clinicians employed by the Trust have a responsibility to:

- Ensure they maintain their professional registration and practice within the standards of their professional bodies, any other national standards and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible;

Divisional Lead responsibility – Specific risks

Safeguarding the Unborn and Children
The Trust Safeguarding Children Policy outlines the arrangements for child protection in the Trust. The Division of Surgery Women's and Children's lead this agenda reporting to the Director of Nursing and Integrated Governance, Executives and Board through the structure defined in the Safeguarding Children Policy.

Safeguarding Adults, DOLs and Prevent –
The Trust Safeguarding Adults Policy outlines the arrangements for adult safeguarding and protection within the Trust. The Safeguarding Adult and Prevent Lead leads on this agenda reporting to the Director of Nursing and Integrated Governance. The Executive Lead is informed through the structure defined in the Safeguarding Adults Policy.

The Trusts Internal Safeguarding Board reports to SQOGG and discusses and evaluates risks in relation to safeguarding and also recieves the reports from Security Group and Dementia Steering Group

Trust Corporate Commitees

A Board subcommittee structure chart is included in the Appendices to this policy which demonstrates the Board subcommittee strructure and relationships between these committees. (Appendix 4)

Trust Board
At the head of the Trust risk management structure is the Trust Board, which is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy. The Trust Risk Management Strategy was formally approved by Board. It has been subsequently reviewed and approved once every financial year thereafter. Review of the strategy will take place as required, or in line with formal review arrangements annually.

Audit Committee – This Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), and support the achievement of the organisation's objectives.

In particular, the Committee reviews the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

- underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification and annual plans/ reports from the Local Anti- Fraud Specialist

Finance Committee - Is a delegated Board sub-committee with responsibitites for risk management in relation to fianance and financial related performance. In particular the Committee is to review and advise the Board on in year performance against previously agreed board financial objectives/targets (monitoring) and scrutinise in detail and recommend for approval the Trust's longer term business plan.

Quality and Governance Committee – Is a delegated Board subcommitee which includes Non Executives Directors.This Group receives reports from Service Quality and Operational Governance Group and Risk Management Group. The Committee provides oversight and assurance regarding the operation of systems and processes to ensure the safety and quality of care provided to users of the Trust's services. The Committee considers the identification, management and mitigation of risks to the safety and quality of care provided to the Trust's service users in line with the Committee's Terms of Reference.

Workforce Committee – This Board sub-committee receives reports from Equality and Diversity Group, Health and Wellbeing and Workforce Operational Board and Educational Governance Group is responsible for reviewing risks relating to workforce and workforce planning and training and education.

Service Quality and Operational Governance Group (SQOGG)
This Group reports directly to the Quality and Governance Committee. It is chaired by the Director of Nursing and Integrated Governance. It is the engine room for quality and safety, risk management and Governance in the Trust.

SQOGG has delegated authority for managing the corporate significant risk register. It will:

- Receive a report at each meeting from the Trust Integrated Governance Unit. The report will identify newly received significant risks by local risk processes

for inclusion on the corporate risk register, risk monitoring updates and details of risks that have reduced below 15 thus rendering them suitable for removal from the significant corporate risk register and exception reports in relation to risk treatment plans that are not proceeding to plan or where there is limited assurance that the risk treatment plan is progressing.

- Review the risk ratings escalated from divisional risk registers with a score rating of 15-25 to ensure consistency across the Trust.
- Agree the proposed risk description, amend or approve the risk rated score before submission to Trust Board.
- Seek clarity from Divisions/ Directorates prior to inclusion on the Corporate register and ensure that the mitigation plans in place are sufficient prior to acceptance.
- Receive reports from divisions and report progress against risk treatment plans.
- Monitor actions for each of the risks on the register and receive exception reports from Divisions and the Integrated Governance Unit when mitigation/treatment plans are not on track.
- Have access to the full significant Risk Register at each meeting.
- Agree and report to Quality and Governance Committee risks for removal from the risk register delegating appropriately scoring risks (those below 15) back to Divisions to accept and manage.
- Agree and report to Quality and Governance Committee the Annual Reconcilliation of learning report.

The following groups all have specific responsibilities in relation to their spheres of responsibility and report into SQOGG and collectively these inform the Quality & Safety agenda across the organisation, including, but not limited to:-

- Integrated Medicines Optimisation Group
- Patient Safety Programme Group
- Mortality Steering Group
- Educational Governance Group
- The Patient Experience Group
- Radiation Protection Group
- Trust Internal Safeguarding Board
- Infection Prevention Committee
- Divisional Governance Forums
- The Learning from Experience Group
- End of Life Steering Group
- Clinical Audit and Effectiveness Group
- Research and Development Group

- Hospital Transfusion Committee
- Health and Safety Committee
- HTA and Organ Donation Committee
- Medical Devices Group
- Records Management Group

The duties and roles of these groups are outlined in the respective Trust Policies for these areas.

Risk Management Group
The Executive led Risk Management Group reports to Quality and Governance Committee and also reviews risk assessments and manages risk within the Trust. The Risk Management Group provides a mechanism by which Board are kept informed of all significant risks and provides assurance. It has a function in the development and maintenance of the Corporate Significant Risk Register to ensure that it is comprehensive and that actions are being taken. It co-ordinates and maintains the review of the Board Assurance Framework

Executive Management Team
Executive Management Team (EMT) assists the CEO in the implementation of specified strategies reports by exception to the Board and its sub committees on key governance and risk issues relevant to terms of reference by exception.

The following groups report into EMT

- Operational Group
- Emergency Planning
- Estates and Facilities Operational Group
- TEP Assurance Group
- Capital and Revenue Investment Group
- Clinical Leaders Forum
- Nursing and Midwifery Leaders Forum
- Trust Liaison Group
- IM&T Group
- Contract Management Group

Remuneration Team
Agrees remuneration and terms and conditions of services for Specific Directors.

Divisional/Governance (Local) Risk Management/Governance Groups
The Trust requires divisional structures for reporting governance and risk to be in place. Each Directorate within divisions must ensure that good internal control mechanisms

are in place to be able to provide the necessary assurance to the Division. Divisions are required to submit risk management reports and updates to Service Quality and Operational Governance Group and/or Risk Management Group.

Internal Audit
The Internal Audit Department carries out audits of the Trust's systems according to an audit schedule determined by the Trust Board and Audit Committee in the light of information provided by the BAF and Principal Risk Register. Internal Audit play a pivotal role in the monitoring of process for managing risk corporately and locally and in providing assurance to the Trust Board.

4. RISK MANAGEMENT OBJECTIVES

To:-

1. Maintain and monitor the Trust Board Assurance Framework. Ensure that the Framework identifies the Principal Risks to all Strategic / Corporate Objectives. The Trust will ensure that the framework will continually meet the requirements our regulators throughout the financial year and that it is monitored at Trust Board at least 2 times per year.
2. Ensure that the Trust will identify and record risks according to impact and likelihood and collate a record of these risks on ward/department, Divisional risk registers dependent upon the risk score (in accordance with risk escalation mechanisms).
3. Ensure the Trust has in place policies and procedures that systematically outline the Trust's expectations in relation to identified risk areas, statutory responsibility and regulatory requirement - demonstrate that these policies and procedures are systematically managed, reviewed, updated and archived.
4. Ensure the Trust has in place an incident reporting and management system, ensuring accidents, incidents and near misses (no harm incidents) are recorded on the Trust Incident System and assessed for impact/harm and that these are reported in accordance with statutory and regulatory requirements.
5. Ensure the Trust has in place a complaints and claims management system ensuring complaints and claims are assessed for the likelihood and impact.
6. Ensure the Trust take action to control or mitigate risks, prevent recurrence of adverse incidents, complaints and claims and share learning with others. – produce as a minimum once every financial year an aggregated learning report from Incidents, Complaints , PALS contacts and Claims which identifies risk themes and areas for improvement. Measure the impact of incidents by aiming to systematically reduce the level of harm caused by these events across the Trust.
7. Ensure the Trust continue to develop the organisational risk management culture embedding risk management as a natural by product /part of day-to-day activity. This will be measurable through the extent and degree to which risks are being assessed, treated and monitored across the organisation.
8. Ensure the Trust maintain and use the Trust Integrated Performance Framework to monitor and benchmark key performance indicators relating to Quality outcomes, Targets and Resources. Specific focus will be upon Patient Experience, Quality and safety.
9. Ensure the Trust, as a minimum, comply with the Care Quality Commission and NHS Improvement's compliance requirements.

10. Ensure the Trust increases knowledge and understanding of risk management by ensuring that the Trust has a programme of governance and risk management training based on a training needs analysis. This will be measured through % uptake of Induction and Trust Mandatory Training and systematic monitoring and audit.
11. Ensure the Trust provide assurance that the Trust has defined its key priorities and risks and is acting positively to address them through completion of the Annual Governance Statement.
12. Ensure the Trust systematically progress the Audit committee work programme to provide assurance that the process for managing all types of risk is in place and that the trust has a systematic process of risk assessment.

5. RISK MANAGEMENT SYSTEM

5.1 Introduction

Central to the Trust Risk Management Process is the concept of a risk register, which in essence represents a repository for information on the management of identified significant risks. The Trust has an electronic risk register system (Safeguard). Local Managers and Senior Managers have access to the system and manage the risk registers locally.

Risk registers allow organisations to:

- Store information on significant risks in a meaningful way that can be distributed to key stakeholders and included into risk reports including reports to Trust Boards.
- Rank risks by risk rating in order that they may be prioritised for action.
- Group risks by meaningful categories that permit more detailed analysis.

A record/register of risks should be maintained as a minimum for:

- Individual management units or locations (divisions, Directorates) risks which should be considered include:- financial, clinical, operational and / or those with regulatory impact.
- For the organisation as a whole (an organisational risk register).

The risk register will typically combine key strategic risks faced by the organisation, along with an aggregate of those significant operational risks identified within larger projects, divisions and individual management units, locations or clinical areas.

The Turnbull report requires that Boards be informed of the significant risks that face the organisation. Significant risks being defined as “risks that are significant to the fulfilment of the (organisation’s) objectives”.

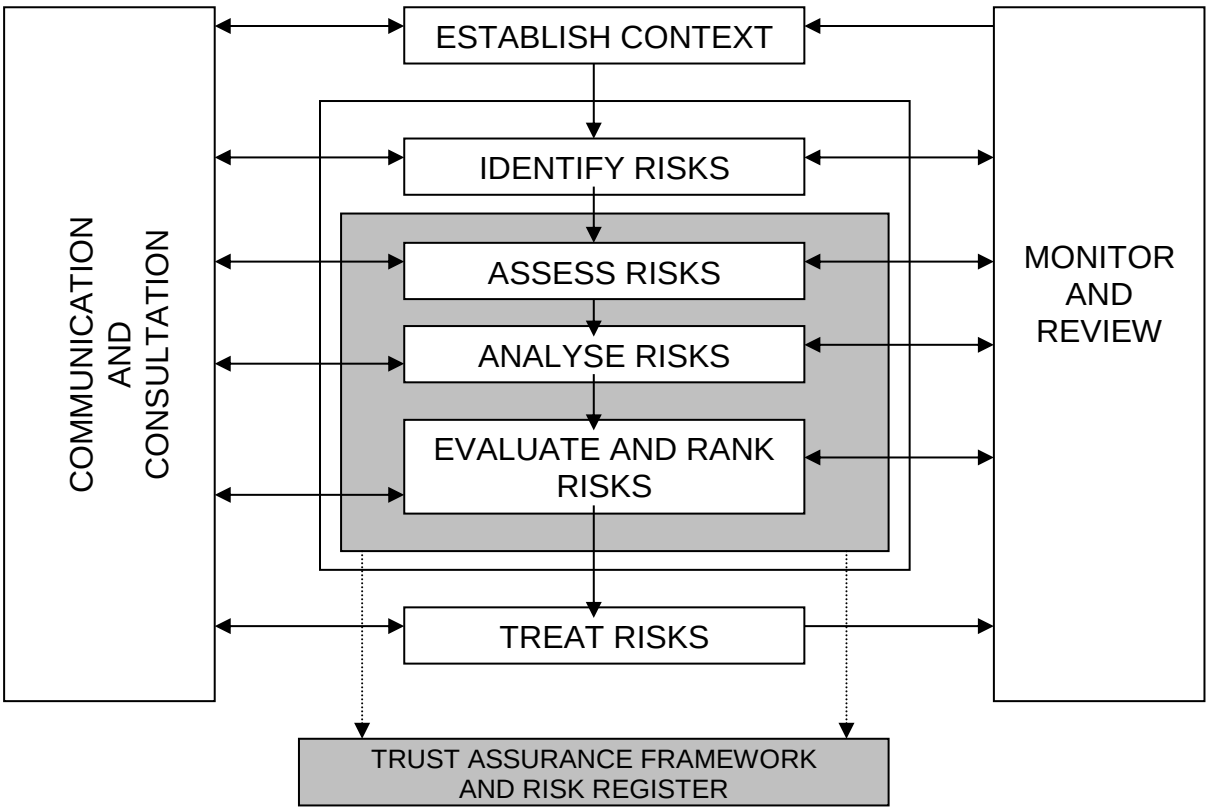
Risk management is a multifaceted process, appropriate aspects of which are often best carried out by a multi-disciplinary team. It is an iterative process that can contribute to organisational improvement.

The systematic approach to risk management in Tameside & Glossop Integrated Care NHS Foundation Trust will be based on the following model:

5.2 Risk Management Process – (AS/NZS 4360:1999 – Risk Management)

Establish the context	Define the activity What are the goals and objectives?
Risk identification	What can happen? How can it happen?
Risk assessment	How could risks occur? What would be the effect if they did? How could they be reduced?
Evaluation and Ranking	Evaluate options for reducing risks Quantify costs of actions to reduce risks Identify actions, which reduce total, cost of risk and give best value for money Compare costs against benefits
Risk Treatment	Avoid: not proceeding with activity likely to generate the risk Reduce: reducing or controlling the likelihood and consequences of the occurrence Transfer: arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint ventures, etc. Accept: some risks may be minimal and retention acceptable.
Monitor and review	Monitor risk impact Review effectiveness of action Has the risk priority changed?
Communicate and Consult	Who needs to know, internal/external? Who is affected?

Risk Management Process



NHS organisations are required to produce a comprehensive organisation-wide risk register that must be capable of recording clinical, financial and organisational risks.

The risk register also needs to provide evidence that the Trust is:

- Using a common currency to evaluate initial risk ratings for both strategic and operational risks
- Able to ensure that the initial risk ratings can be altered to reflect the results of risk assessment and risk treatment

The Trust's system of internal control will be based on an ongoing risk management process that:

- Identifies the principal risks to the achievement of the organisation's objectives;
- Evaluates the nature and extent of the risks;
- Manages them efficiently, economically and effectively.

5.2 Process for the Management of Risk

Overview of risk strategy
The Trusts strategy is to apply the following principles to the management of risk

Establish the context

- A strategic, organisational and risk management context will be established in which the process will take place. Criteria against which risk will be evaluated should be established and the structure of the analysis defined.

Identify risks

- Identify what, why and how things can arise as the basis for further analysis. Using the Trust's generic risk assessment form or electronic risk system.

Analyse risks

- Determine the existing controls and analyse risks in terms of consequence and likelihood in the context of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. Consequence and Likelihood will be combined to produce an estimated level of risk.

Evaluate risks

- Compare estimated levels of risk against the pre-established criteria. This enables risks to be ranked so as to identify management priorities. It is essential that the evidence used to compare the risk to these criteria is of known standards of quality and reliability, otherwise the risk may be over or under rated or not identified at all.

Treat risks

- Accept and monitor low priority risks. For other risks, develop and implement specific management actions which include consideration of the resources required to address the risk, the impact that treating the risk as well as not

treating the risk will have in other service areas, whether the risk, if realised would be reversible and in what context, if any, realising the risk would be defensible.

Service Development and Business Planning Process
Where there are actual or potential risks with high consequence and/or likelihood that require additional resources, the relevant division will submit service development plans via the divisional and corporate business case and capital bid processes. Sources of revenue and capital will be sought where appropriate.

Monitor and review
Monitor and review the performance of the risk management system and changes that might affect it.

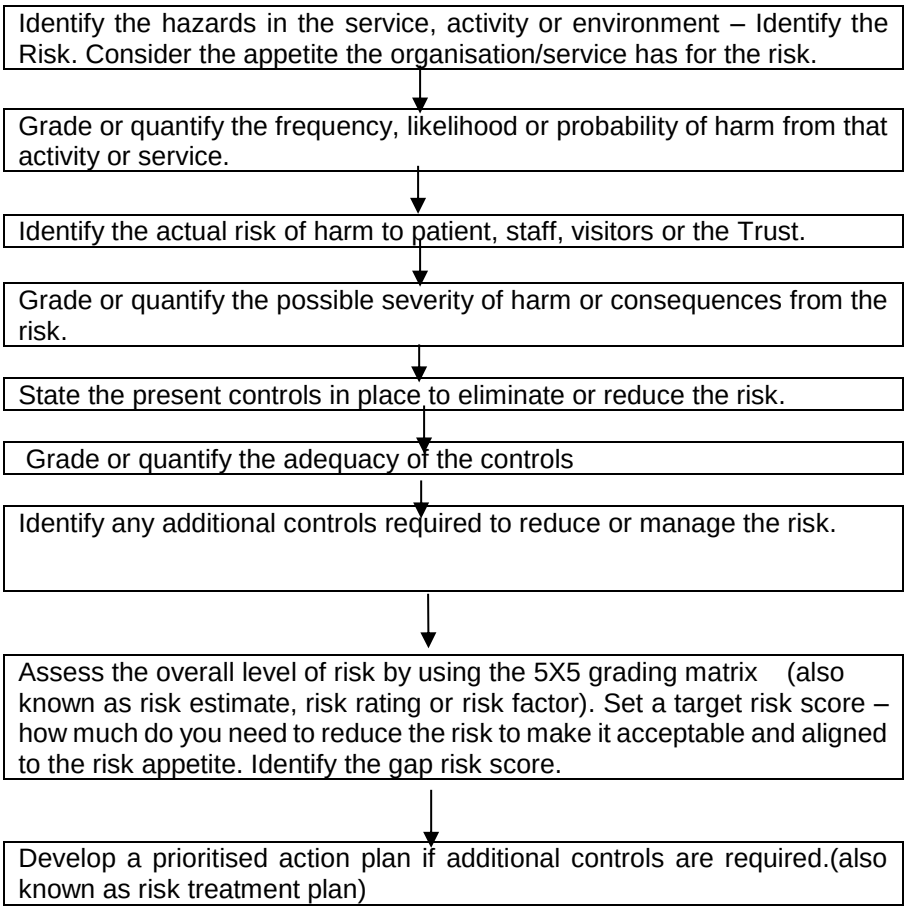
5.3 Risk Assessment Procedure – Process for identifying risk corporately and locally including review of risk registers and assessment

Identifying Risks
The Trust has a number of systems in place which collectively contribute to the identification of risk.
Risks will be identified from a number of sources. This may include: Clinical practice, Health & Safety assessment process, External assessments, Incidents, Medicines and Health Care Products Regulatory Agency notices, CAS Alerts (Central Alerting System), Complaints, Claims, Business Plans, Major Projects, Financial planning, External Audits, Internal Audits, Performance Management, Care Quality Commission, Place Reports etc. Any of the above could be used to inform the risk assessment process and therefore the population of the Trust's Board Assurance framework and /or risk registers. The risk register must include the source of the risk, this will usually be through a description of the risk and hazards showing how the risk has come about. Where multiple sources exist the term 'risk assessment' will be acceptable as will 'multiple'.

Assessing individual risk areas –
To undertake a risk assessment the steps shown in the flowchart are followed (below) Figure 1. This can be undertaken using the Ulysses Safeguard system and clear instructions on how to undertake the assessment are provided through the link on the TIS page. A risk assessment form is included as Appendix 3 to the policy should this be required to support the process.

The general risk assessment tool will assist the Trust and its constituent divisions and directorates by ensuring consistency in carrying out a full risk assessment of their services, developments and working practice, the end result being a series of risk assessments and an action plan incorporating the prioritised actions to be completed. Generic risk assessments may be developed for specific risk areas e.g. Moving and Handling – when this is so these will be outlined in the relevant Trust Policies.

Figure 1: Risk Assessment (Use of the Trust Risk Assessment tool will ensure this process is followed)



Control Adequacy

When undertaking an assessment or re-assessment, it is also necessary to review the adequacy of the controls in place and grade them accordingly. A suggested score sheet appears below:

Adequate	Limited	Poor
Adequate controls in place. Sufficient controls in place Service no longer offered	Limited systems or controls in place Systems have known weakness or are inadequate. Non-adherence to controls or systems in place Action plan will be needed	No controls. Serious weakness in controls Risk exposure ignored. Risk exposure not managed Action plan will be needed

Risk Grading Matrix

All risks in the Trust will be assessed for likelihood and consequence using a 5 x 5 grading matrix shown below. This grading matrix is the common risk management currency of the organisation and all risk activities and mechanisms will migrate to this matrix

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

Target Risk Score
The target risk score – this should be set and identify how much you need to reduce the risk to make it acceptable and aligned to the risk appetite.

Gap Risk Score
The gap risk score is the difference between the current risk score (inclusive of controls) and the target risk score. This enables focus to be applied to those risks where it is possbile to reduce the risk further

Trust Board Risk Target Gap Score	
Gap score ≤0	Risk target achieved
Gap score 1-5	Tolerable
Gap score 6-9	Close monitoring
Gap score 10	Concern
Gap score >10	Serious

Timescales, Prioritisation for Action and implementation of Control
Because it is not possible to address all the required actions immediately, there is a need to develop and prioritise actions to implement the control mechanisms. (Also known as risk treatment plan). The allocation of a time priority depends on the urgency and the time and resources required to implement the action. A timescale needs to be set which reflects when mitigations and controls are expected to take effect and reduce the risk to the target score.

Final prioritisation should be based on all information available and be based on sound judgements. The control mechanisms in place will assist in prioritisation.

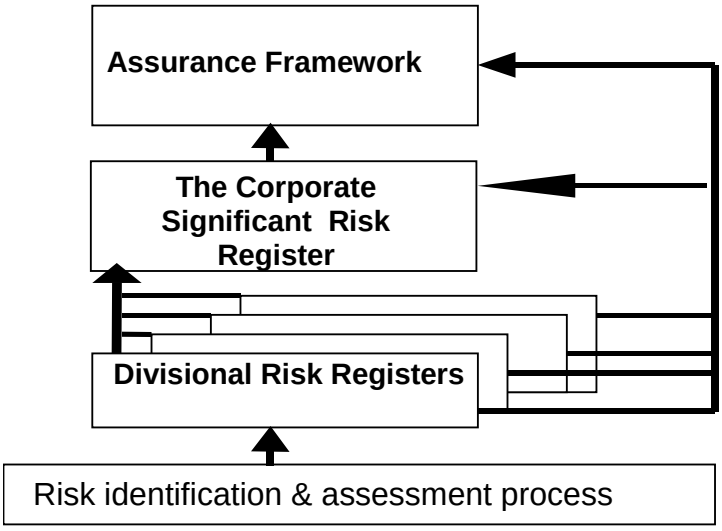
Reference can be made to organisational work streams or plans as methods of actions and control. Whenever possible risk management should be aligned to existing work streams rather than have standalone plans.

Risk Registers
There are two levels of risk registers in the Trust, Local and Corporate (significant risks scoring 15 or over). Our Framework can be summarised as.

Those risks which POTENTIALLY affect Strategic Objectives – appraised by Board against Strategic Objectives

Divisional risks rated 15 (red) and Strategic risks not included in Assurance framework

ALL Significant and Extreme Risks to each Division's objectives and any lower scoring risks to be documented and kept in local registers (local registers can be a compilation of recorded risk assessments)



te registers have a similar format, mirroring the general risk assessment tool and are recorded using the electronic database risk register module Ulysses Safeguard.

In formulating the Registers consideration must be given to all types of risks, i.e. strategic; organisational; clinical; financial; and service delivery. To ensure this occurs, it is essential that there is a robust process for populating the register with identified risks in all divisions, directorates and departments; in addition, there needs to be a process for regular monitoring the mitigation plans and their effectiveness

Movement of risk information onto the significant risk associated, is via the Divisional Governance Groups and escalation to SQOGG. The Associate Director of Integrated Governance and Governance Team, will ensure that the Quality and Governance Committee and Board are kept informed via scheduled reports and updates on the significant risks and BAF. Reports will be provided to each Risk Management Group and Service Quality and Operational Governance Group. Significant or Extreme risks scoring 15 or more are reported to each Trust Board Meeting.

The Trust Assurance Framework will capture all Principal Risks (strategic risks) associated with Corporate objectives.

Clinical Services Divisional Registers are the responsibility of Divisional Directors & Directorate Managers – usually facilitated by the Governance lead or equivalent

For corporate directorates, the Director/ Lead Manager with responsibility for the relevant corporate directorate will determine who will be deemed the appropriate person to act in the capacity and maintain the risk register.

Divisional Directors and Directorate Managers are responsible for ensuring the dynamic management of the divisional risk register and ensuring that any risks of 15-25 are acted upon immediately where possible, and notified to the Associate Director of Integrated Governance via reporting structures. Risk should be escalated to

SQOGG, Risk Management Group, Quality and Governance Committee and Trust Board as appropriate The risks will be identified in the main from undertaking risk assessments within the Divisions but also from any other appropriate source.

Each Divisional Board or Corporate Services Team meeting should receive a governance update including reports of risks and review of those which are being escalated to Divisional risk register scoring 8 and above in accordance with their Terms of refernce. The template for reporting of risks is included as Appendix 2 of this document.

Significant Risk Register – Responsibility of the Associated Director of Integrated Governance and Head of Assurance and Govenance

The Associate Director of Integrated Governance has responsibility for managing the significant risk register supported by the Head of Assurance and Governance. These are identified from risk assessments that have been undertaken by the divisions, directorates, wards and departments of the Trust. The score rating will determine the level of risk and the degree of escalation and detail of monitoring within the documented action plan. Any risk scoring 15 or above will be considered an extreme risk. Any such risk that has been scored and accepted within a division/ corporate directorate will be escalated and submitted to SQOGG for consideration, and moderation prior to inclusion on the Trust Significant Risk Register.

In exceptional cases, the Executive Team can take Executive action for direct inclusion of a reported risk scoring 15 or above for inclusion as a significant risk the process below will be followed after inclusion to ensure that the due process of moderation has been followed.

Acceptable level of risk – Authority of all Managers with regard to managing risk

An acceptable risk is one which the Trust Board or a Divisional Board feel comfortable in facing and which, if the worst happened, would not threaten the individual's / organisation's survival or its capability to meet its objectives. Deciding what is an acceptable risk involves identifying and assessing risks in relation to the impact e.g. reputation, loss of life, financial loss / cost, likelihood of occurrence and/or the level of ease or difficulty required / available to reduce or control the threat that particular risks poses if the individual or the organisation were exposed to it. A risk is deemed acceptable when there are 'adequate' control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm.

As a general principle the Trust will seek to eliminate and control all risk which has a potential to harm its patients, staff, and other stakeholders, which would result in loss of public confidence in the Trust and/or its partner agencies and/or would prevent the Trust from carrying out its functions on behalf of its local residents.

However, the following list identifies areas which would never be deemed to be acceptable: Any act, decision or statement which;

- would result in death, injury or illness except in very specific circumstances involving clinical judgement
- would contravene Trust Standing Orders or Standing Financial Instructions
- would be illegal and/or breach of legislation
- would result in significant loss of Trust assets or resources
- would constitute wilful contravention of Trust policies or procedures

- would fail to observe key targets and objectives

The Turnbull Report requires that Boards be informed of the, "significant risks that face the (organisation's) objectives". Although no specific definition is given as to what constitutes "significant risk", some parameters are given below based on the qualitative risk assessment matrix scores:

- An initial or residual risk rating of between 1 and 8 can be managed at local level. All Managers have authority to directly manage such risks and accept them. If controls are considered necessary take action. Enter onto local risk register or maintain in local risk portfolio.
- An initial or residual risk rated 8 -12 are risks which require further exploration. Risk reduction is required so far as is reasonably practicable. Further risk reduction may not be feasible or cost effective. Where there is a residual risk of 8-12 the responsibility and authority for acceptance of the residual risk lies with the Manager for risks identified within their area of responsibility. Prior to acceptance of a residual risk score of 8-12 the manager must have explored all options for reducing the risk, considered the effectiveness of controls which are already in place and sought the advice and agreement of other senior colleagues. Prior to submission to Divisional Governance Groups or equivalent for a in which these risks are accepted. Key relevant group, solutions and action must have been explored.
- Risk score rated 15-25 are deemed to be significant. Action is required immediately or in the near future so far as is reasonably practicable to reduce/mitigate the risk or the risk needs to be accepted by or Board if it cannot be reasonably reduced further.

Residual Risk scoring 15 – 25 should be reported to either an appropriate Executive Director and the Integrated Governance Unit with an appropriate risk assessment and risk treatment plan. Residual risks between 15- 25 will be monitored and reviewed by the Service Quality and Operational Governance Group. If the Service Quality and Operational Governance Group is assured that the residual risk cannot be reduced, they will then have the responsibility of authorising further action to reduce the risk or agreeing acceptance as a significant risk on behalf of the Trust Board. A template for the risk report risk tables is included as Appendix 2 of this policy.

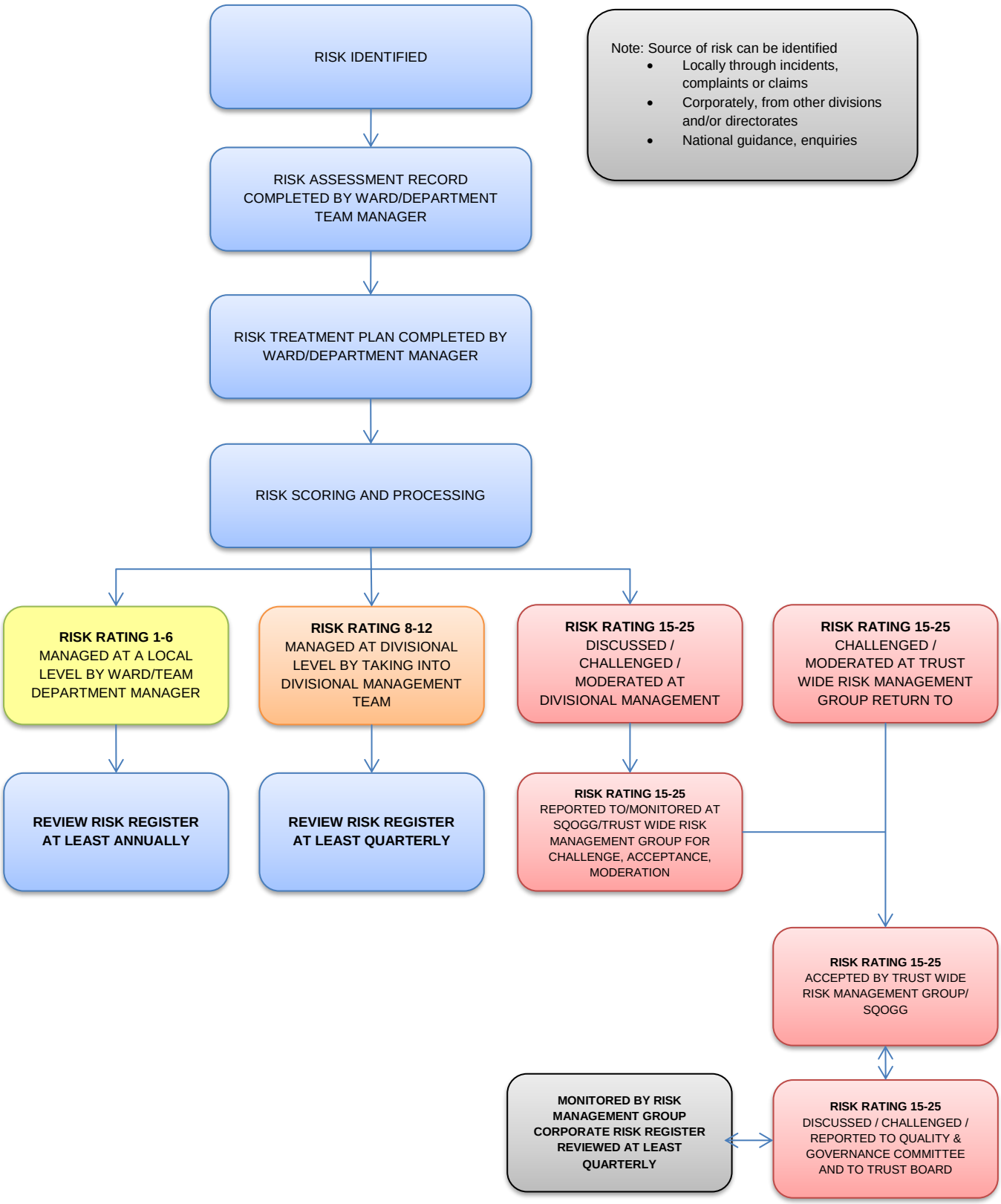
It is recognised that Risk management is a dynamic, iteractive process.

Recording of Acceptable Risk (Management of local Risk)

The table below summarises actions to be taken.

Score	Category of risk	Action	Time Scale for Review
1-3	Very Low	Can be managed via existing control mechanism Take action at local or department level if controls are considered necessary. Enter onto local risk register or maintain a record of the risk score in local records.	Determined by local risk management arrangements/ internal assurance (usually once every financial year)
4-6	Low	Service Quality Leads to develop and implement risk treatment plans. Take action at local or department level if controls are considered necessary. Enter onto local risk register. Or maintain a record of the risk score in local records	Determined by local risk management arrangements / internal assurance (usually once every financial year) Monitoring until residual risk is deemed acceptable
8-12	Moderate	Develop and implement risk treatment plans. Residual risk accepted by Business Manager in conjunction with specialist advisers. – record on Divisional risk register and report outcomes in records of meetings	Quarterly by the Divisional / Departmental Board or equivalent Internal Assurance until residual risk is deemed acceptable
15-25	Significant Extreme	To be considered and taken through the divisional governance processes where applicable and notified to the Integrated Governance Unit who will notify the Executive through the governance structure, depending on circumstances. The risk will be reviewed by the Service Quality and Operational Governance Group who will agree action plans and review in accordance with agreed time scale reporting to Quality and Governance Committee on behalf of the Board.	Monitored by SQOGG and Risk Management Group and reported to the Trust board until residual risk are less than 15. Then will be moved to Divisional / Departmental register. The risk remains the responsibility of the area submitting and managing the risk. Significant risks on the Risk register reviewed at each SQOGG and Risk Management Group and reported to Trust Board at each meeting.

6. RISK REGISTER PROCESS



Rating Risk

The Trust has an established risk assessment process and uses a well-recognised framework to rate or score a risk.

A risk is rated using a matrix of consequence (the impact) versus likelihood (frequency) of the risk occurring. Risk ratings, at all levels of the organisation, are identified on risk registers. See Appendix 1 for guidance on scoring /rating risks and the risk matrix.

Classifications of risk appetite

The Trust's risk appetite is not necessarily static. The Trust Board may want to vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. However, it is not for other parts of the organisation to materially alter the Trust's risk appetite.

RISK Appetite
A matrix to support better risk sensitivity in decision making

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
Risk Levels ➔ Key Elements ⬇	0 **Avoid** Avoidance of risk and uncertainty is a key Organisational Objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward [and VFM]	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards [despite greater inherent risk]	5 **Mature** Confident in setting high levels of risk appetite because of controls, forward scanning and responsive systems are robust
Financial / VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern	Only prepared to accept the possibility of very limited financial loss if essential. VFM is primary concern	Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered [not just cheapest price]. Resources allocated in order to capitalise on opportunities	Investing for the best possible return and accept the possibility of financial loss [with controls in place]. Resources allocated without firm guarantee of return – "investment capital" type approach	Consistently focussed on the best possible return for stakeholders. Resources allocated in "social capital" with confidence that the process is a return in itself
Compliance / Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovation / Quality / Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. only essential systems/technology developments to protect current operations	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to improvements to protection of current operations	Innovations supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved	Innovation pursued and desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by Trust rather than tight control	Innovation the priority – consistently "breaking the mould" and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by Trust rather than tight control is standard practice
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation viewed with concern	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation	Willingness to take decisions that are likely to bring scrutiny of the organisation, but where potential benefits outweigh the risk. New ideas see as potentially enhancing reputation of the organisation	Track record and investment in communication has built confidence by public, press and politicians that the organisation will take the difficult decisions for the right reasons with benefits outweighing the risks

The Trust's Risk Appetite and Risk Tolerance

The Trust's risk appetite is defined as 'the amount and type of risk that the organisation is willing to take in order to meet the strategic objectives.' The table above is the organisational model used to support a common and consistent language to articulate the Trust's position towards the appetite for risks.

The Trust's risk appetite and organisational model considers risks in terms of both opportunities and threats and is not confined to the financial consequences of a risk materialising. The appetite for a risk is impacted on by the capability of the Trust, its performance and reputation and is influenced by the overall objectives set by the Trust, individual programmes of work and the delivery of operational, quality and performance objectives across divisions.

While risk appetite is about the pursuit of risk, risk tolerance is about what the organisation can actually cope with.

The Trust Board acknowledge that that risk is a component of change and improvement, and therefore does not expect or consider the absence of risk as a necessarily positive position. The Trust will, where necessary, tolerate overall levels of risk that are classified as **moderate (12 or lower)** where action is not cost effective or reasonably practicable.

The Trust will not normally accept levels of risk rated high (red) (which are scored 15**-25** using the Trust's risk assessment matrix), unless the Trust's appetite for the risk is also high. The Trust will ensure that plans are put into place to lower the level of risk whenever a high risk has been identified.

A high scoring risk for which the organisation has a low risk appetite should flag that the risk needs serious consideration and more urgent mitigations.

Duties in relation to the Trust's risk appetite

Managers

All managers will ensure that risk registers are maintained for their area of responsibility and that the registers are reviewed on a regular basis. Any risk identified as "high" will be immediately notified to the appropriate Executive Director.

Managers will put in place actions to strengthen controls and reduce the level of risk to **below nine** where this is feasible. Managers must review risk scoring 8 or above on a quarterly basis and significant risks scoring 15 or over on a monthly basis.

Managers must put in place contingency plans when the reduction of risk to an acceptable level is not possible.

Executive Directors

Executive Directors will ensure that mitigation plans and actions are reviewed by appropriate teams or committees at least quarterly and progress noted. The review of actions will form part of the Division's performance management review process.

Monitoring risk against the Trust's risk appetite

The Risk Management Group and SQOGG will review the significant risks on the risk register at every meeting to ensure that identified risks are acceptable within limits of the Trust's risk appetite.

The Trust Board will also review the significant risks at every meeting, and will ensure that its overall portfolio of risks is appropriate, balanced and sustainable.

Learning from risk management
The Trust has systems in place to facilitate learning from risks, this includes discussion and cross divisional learning in relation to risks identified in a Directorate or Division which may apply across other areas. These systems include discussion in relation to risk at Service Quality and Operational Governance Group and Risk Management Group.
The processes for risk management detailed in this policy includes evaluation of risks and learning from the of effectiveness of risk controls and mitigations which prompts a review

7. RISK MANAGEMENT TRAINING

A programme of risk management training is provided for all employees, as outlined within the Trust training needs analysis (see Trust Mandatory and Induction and Training Policy) which includes description of
Risk management training requirements including

- Relevant staff groups
- Frequency of training
- Attendance and follow up of non attendence

All employees currently receive risk management training at corporate induction and mandatory core day
The reporting and monitoring of compliance and the processes the organisation follows should gaps in compliance be identified are managed by the Education, Development and Training Department as described in the Trusts Mandatory Training and Induction Policy.

8. POLICY DEVELOPMENT & CONSULTATION

This policy has been developed by the Head of Assurance and Governance and Associate Director of Integrated Governance in consultation with members of the Risk Management Group. All subsequent policy drafts will be distributed to members of the committees for comments which will be incorporated into final versions where appropriate.

9. IMPLEMENTATION

An updated version of this policy will be placed on the intranet after final ratification.

The policy will be disseminated via the Risk Management Group and through the range of training undertaken by the Integrated Governance Unit, where appropriate.

10. MONITORING

The policy will be monitored by governance processes through Committees and Groups outlined in the policy as having responsibilities for risk management and through their terms of reference. Where monitoring identifies deficiencies or gaps in the implementation or in the policy actions will be taken and improvements made.

11. REVIEW

This policy will be formally reviewed in January 2020, or earlier depending on the results of monitoring or recommendations from approved bodies.

Appendix 1: Risk management at different levels of the organisation and risk scoring

Risk Colour	Remedial Action	Decision to accept risk	Risk register Level
Green (Very low)1-3	Ward Manager	Ward Manager	Ward / Department
Yellow (Low) 4-6	Ward Manager	Ward Manager	Ward / Department
Orange (moderate) 8-12	Departmental or Divisional Manager	Divisional Manager	Ward/Departmental and Divisional
Red (High)15-25	Director	Risk Management Group / SQOGG	Ward/Departmental Divisional Corporate

Determine the level of risk

The trust requires that a risk score is attributed to risks and that this is used to identify priorities and assign resources affectively
The matrix below will enable staff to grade and score risks in a consistent way.

First, select the *Most Likely Consequence* of the hazard. What is the most likely impact of the risk being realised? Is it catastrophic, major, moderate, minor, insignificant?

Table 1 Consequence and likelihood scoring matrix

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

Secondly, identify the likelihood of the realisation of the risk. How likely will be that it happen or happen again?

To calculate the risk rating you should take into account the controls that are in place to manage the risk but not those included as part of any treatment plan until they are implemented.

The risk score is the likelihood score multiplied by the consequence score
This is the residual risk rating score.
In terms of scoring risks, the following grades in the risk rating table below are attached to particular scores within the matrix:-

Table 2 Risk Rating table

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

3. Actions to be taken once the level of risk is determined

Risks falling into the RED boxes;
"High Risks" require immediate action. They must be communicated to the Executive Director/Consultant in charge and the Divisional Management Team, and Integrated Governance Unit as soon as possible. These must be brought to the attention of SQOGG and Risk Management Group for inclusion onto the Corporate Risk Register and onward reporting to the Trust Board.

Risks falling into the ORANGE boxes;
"Moderate Risks" require management attention, they must be reviewed by managers and an action plan drawn up to address them. The Divisional Management Team should be informed of these. These should also be reported to the Governance Leads, Integrated Governance Unit, and the Risk Management Group.

Risks falling into the GREEN / YELLOW boxes;
Represent "low" risks which are defined as 'acceptable risk' but must be investigated and followed up locally by departmental managers.

Inherent in these arrangements is the expectation that the managers with responsibility for the affected area will take the necessary steps to address the associated risk (and the "fall out" of any event which may have occurred), supported by senior managers, Executive Directors and the Integrated Governance Unit in its risk management role.

NB Acceptable risk is defined as those risks/events that occur infrequently and have minimal impact on people, resources or reputation. Such risk can never be entirely removed but should be dealt with and managed locally within existing resources.

Guidance to consequence scoring

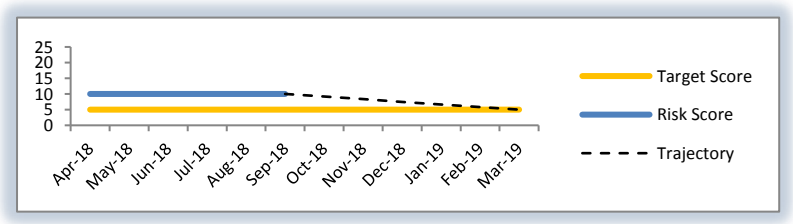
	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Guidance for likelihood scoring

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Appendix 2: Risk report template

<table>
<tr><td rowspan="2">Strategic Primary (Objective)</td><td colspan="2">BAF Ref:</td><td>Date entered on register:</td><td>Risk ID number:</td></tr>
<tr><td rowspan="4">Risk Description:</td><td colspan="2">Assurance Committee</td><td colspan="2">Divisional /Executive Director Lead</td></tr>
<tr><td>Current Risk Score (L x C)</td><td>Risk Direction</td><td>Last received at Assurance Committee:</td></tr>
<tr><td>Target Risk Rating</td><td>Target Gap Score</td><td>Date of next review:</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Graph of Risk over time
 
</td><td colspan="2">Risk Appetite
<table><tr><td>None</td><td></td></tr><tr><td>low</td><td></td></tr><tr><td>Moderate</td><td>✓</td></tr><tr><td>High</td><td></td></tr><tr><td>Significant</td><td></td></tr></table></td><td>Rationale for current score:</td></tr>
<tr><td colspan="2">Date When Target Risk score expected to be achieved</td><td colspan="2">Rational for Risk appetite</td></tr>
<tr><td colspan="2">Controls:</td><td colspan="2">Assurance: (how do we know if the things we are doing are having an impact and can we validate or evidence e.g.: Inspections; Committees; Working Groups; Reports; Monitoring Returns etc?):</td></tr>
<tr><td>Mitigating actions: (what more should we do?)</td><td>Responsible Person</td><td>Timescale</td><td colspan="2">Gaps in assurance and actions not being actioned (what additional assurances should we seek?)</td></tr>
<tr><td colspan="3">Risk source</td><td colspan="2">Anticipated effect of controls (when is a reduction in risk trajectory expected /risk score reduced)</td></tr>
</table>

Appendix 3: Risk Assessment Record

Division/

Directorate……...

Ward/ Department……

Risk Identified:								
Description Of Risk: (i.e. what could go wrong, who may be affected, organisational / financial implications)								
Level of Risk:	Corporate		Non-corporate		*(please tick)*			
Risk Type: *(please tick)*	Clinical		Non-Clinical		Manual Handling (patient)		Manual Handling (inanimate)	
Controls in place: (e.g. consider, equipment, staffing, environment, policy/procedure, training, documentation) **Identify any gaps in control:**								
Effectiveness of controls: *(please tick)*	Adequate				Limited		Poor	
Current Risk Grading: *(indicate appropriate number)*					Severity		Likelihood	
Risk Rating = *(insert score in box)*	High 15-25		Moderate 8-12		Low 4-6		Very Low 1-3	
Name of Assessor(s):								
Signature of Assessor(s):							**Date:**	
Name of Manager:								
Signature of Manager:							**Date:**	

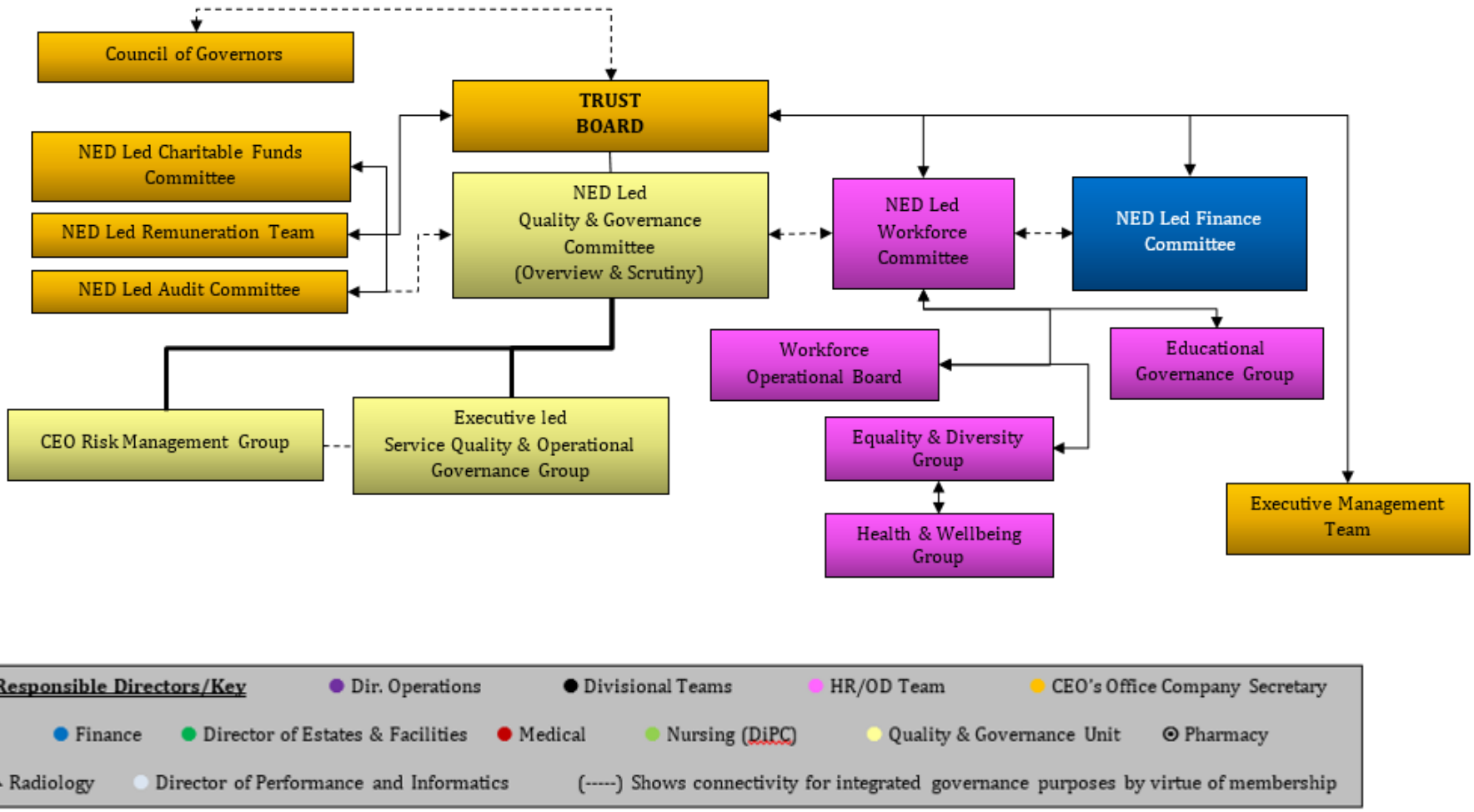
Risk Treatment / Action Plan

Risk Identified:						**Ref:**	
What is being done about the risk? (please tick below)							
Eliminate		**Reduce**		**Transfer** (all or part)		**Accept**	
Actions planned to reduce / prevent risk: (e.g. change in practice, physical systems)							
Proposed Action		**Resource Requirements**		**Responsibilities**	**Timing**	**Target Date for Completion**	
Target Risk Grading: *(indicate appropriate number)*				Severity		Likelihood	
Target Risk Rating = *(insert score in box)*	High 15-25		Moderate 8-12		Low 4-6	Very Low 1-3	
Review Frequency: *(please tick)*	Daily		Quarterly		**Next Review Date:**		
	Weekly		Annually				
	Monthly						
Completed by:					**Date:**		
Date Implemented:							

Risk Assessment Review Record

Name of Risk Assessment:				
Date of Review	Reviewer	Next Review Date	Comments	Signature

Appendix 4: Trust Board Committee Structure



Appendix 5: Equality Impact Assessment Tool

		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	
	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?**	N/A	
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	