Risk Management Strategy

Category:	Strategy
Summary:	The purpose of this document is to set out a clear strategy for the Trust's vision in relation to the management of risk, detailing the system and processes in place and highlighting roles and responsibilities.
Equality Impact Assessment undertaken:	September 2015
Valid From:	September 2015
Date of Next Review:	September 2018
Approval Date/ Via:	10 September 2015, Trust Management Executive
Distribution:	Trust-wide
Related Documents:	Assurance Strategy, Quality Strategy. Risk Management Handbook. Being Open Policy; Claims Policy; Policy for the Management of Conflict/Tackling Violence against Staff; Conflict Management Procedure; Complaints Policy; Health and Safety Policy; Incident Reporting and Investigation Policy; Management of Central Alerting System (CAS) standard operating procedure; Infection Control Policy; Slips, Trips and Falls Clinical Prevention Procedure, Slips, Trips and Falls Prevention Procedure (staff, contractors, visitors and others), COSHH policy; Stress Management Policy; Procedure for the Prevention & Management of Occupational Stress; Security and crime prevention policy; Dealing with bullying and harassment at work policy; Manual Handling Policy; Statutory and Mandatory Training Policy, Risk Register Review Standard Operating Procedure.
Lead Director	Director of Assurance
Author(s):	Deputy Director of Assurance, Assurance Manager
This Document replaces:	Risk Management Strategy (Version 4 – August 2012)

Contents

Introduction

1. Risk is an inherent part of the delivery of healthcare. This risk management strategy outlines the Trust's approach to risk management throughout the organisation.

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

3. This Board approved strategy for managing risk identifies the accountability arrangements the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

4. Successful risk management involves:

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

Aim

5. The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:

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

Scope

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

7. The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

8. The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.

9. Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

Risk Statement

10. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

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

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

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

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

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

16. All Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

17. Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally

18. There will be active and frequent communication between staff, stakeholders and partners.

Risk appetite statement

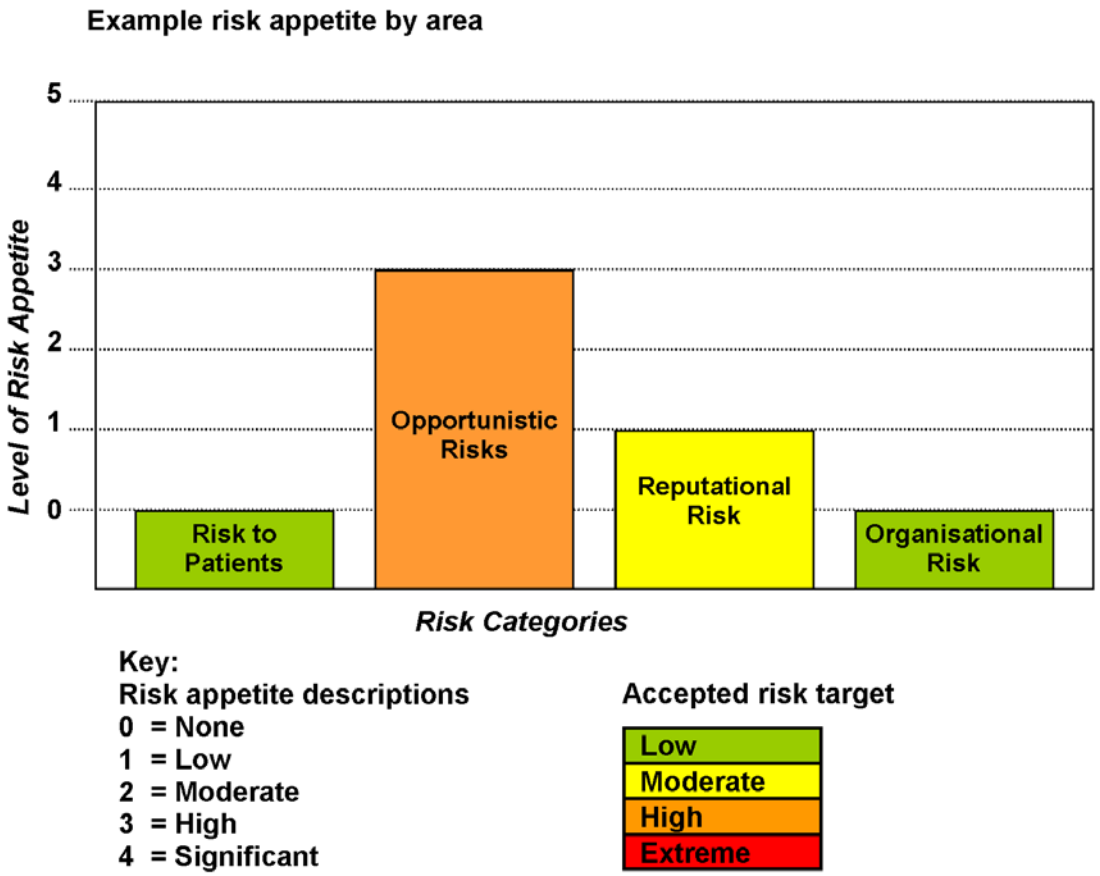
19. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

    - The nature of the risks to be assumed;
    - The amount of risk to be taken on;
    - The desired balance of risk versus reward;

20. On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

    - Risk to patients
    - Organisational risk
    - Reputational risk
    - Opportunistic risk

    These categories of risk are more fully explained in Appendix 1.



21. The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

22. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

23. Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Board to determine the organisational capacity to control risk. The review will consider:

- Risk leadership
- People
- Risk policy and strategy
- Partnerships
- Risk management process
- Risk handling
- Outcomes

24. Tolerances for each management level of the risk management framework are defined for staff in the Risk Management Handbook.

25. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

Definitions of Risk and Risk Management

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

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

Principles of successful Risk Management

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

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

Responsibilities and accountabilities for risk management

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

30. Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks. To support the governance and escalation process, Appendix 3 sets out the specific risk management responsibilities of the following staff/staff groups:

- Chief Executive
- Director of Assurance
- Director of Finance
- Medical Director
- Chief Nurse
- Executive Directors
- Head of Corporate Governance
- Deputy Director of Assurance
- Divisional Directors
- Clinical Directors
- Senior Managers and Senior Staff
- All staff
- Staff side representatives

Risk Management Process

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

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

33. Risks are clarified and managed in the following key stages:

- Clarifying objectives
- Identifying risks that relate to objectives
- Defining and recording risks
- Completion of the risk register
- Identifying mitigating actions
- Recording the Likelihood and Consequence of risks
- Escalation, de-escalation and archiving of risks as appropriate

Stage 1: Clarifying objectives

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

35. In order to clarify:

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

Stage 2: Identifying risks to objectives

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

37. Where appropriate, working collaboratively with colleagues with consideration of the following suggested questions. This enables stakeholders to more accurately identify risk:

- What are the risks which may prevent the delivery of your objectives?
- What risks have an impact on the delivery of high quality, safe care?
- What could happen or What could go wrong?
- How and why could this happen?
- What must we do to enable continued success in achieving objectives?
- Who else might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

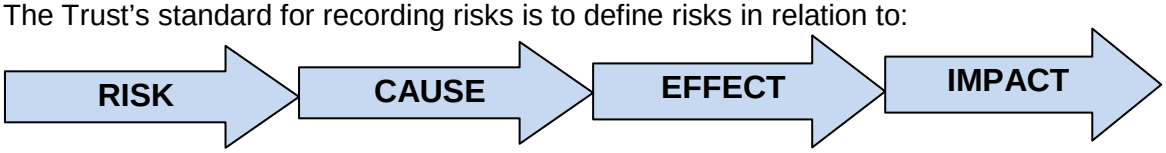
Stage 3: Describing Risk and Assigning Controls

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

39. When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk that….. This is caused by ….. and would result in…. leading to an impact upon……"

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



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

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

Objective: To ensure safe staffing levels
Risk: • Risk of failure to maintain safe staffing levels
Cause: • High staff sickness rate • Difficulties in recruiting clinical staff • Inability to release clinical staff for mandatory training
Effect: • Staff not receiving compulsory training in resuscitation or blood safety
Impact: • Increased safety risk to patients

Table 1: Example Risk

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

43. Key controls must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

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

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted
- **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party

- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity
- **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit

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

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

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

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

Stage 4: Completing the Risk Register

48. Trust Risk Registers are web based and stored electronically. All staff with permissions to access risk registers are able to see risks for the whole organisation. It is a transparent system to enable users to share learning.

49. The process for completing risk registers

- Assign an **owner** to the risk
- List the **key controls** (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact
- If it is a severe risk (red or orange) then consider what the contingency action plan is, i.e. what will you do should the risk happen (see escalation)
- Rate the **likelihood** of the risk materialising
- Rate the **consequence** of the risk happening

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

- **Risk Identification** (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk. Risks without a risk ID will be omitted from any report. It is therefore crucial to include an ID for each risk and control.
- **Risk Owner** is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the Action Owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many Action Owners. The Risk Owner must know, or be informed, that they are the owner, and accept this.
- **Source** of how or where the risk was identified. This could include:
    - Business planning
    - Clinical audit

- Complaints/PALS
- External Audit
- External Review
- Incident
- Internal Audit
- Legislation
- Litigation
- NICE guidance
- Regulatory standard
- Risk Assessment
- Risk Register (existing)

- **Proximity** – this indicates when the risk is likely to materialise or anticipated timescale. There are three categories:
  - Within three months
  - Between three and twelve months
  - Twelve months or longer
- **Previous Risk Rating** and **Current Risk Rating** - these columns are mirror images of each other. Each time the register is reviewed or updated the risk register should move the current rating into the previous column and recalculate the current rating. This is so the history and progress of a risk can be reviewed. The Trust's guidance on the matrix and advice on scoring in contained in Appendix 4
- **Trend** shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by an appropriate arrow.
- **Review Date** should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.
- **Risk Target** is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to. When deciding the risk target, consider the following:
  - What risk rating should an individual risk be managed down to in an ideal world?
  - What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
  - Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?
  - What are the defined tolerance and escalation thresholds for the level of risk? (see the Risk Management Handbook for detailed guidance)

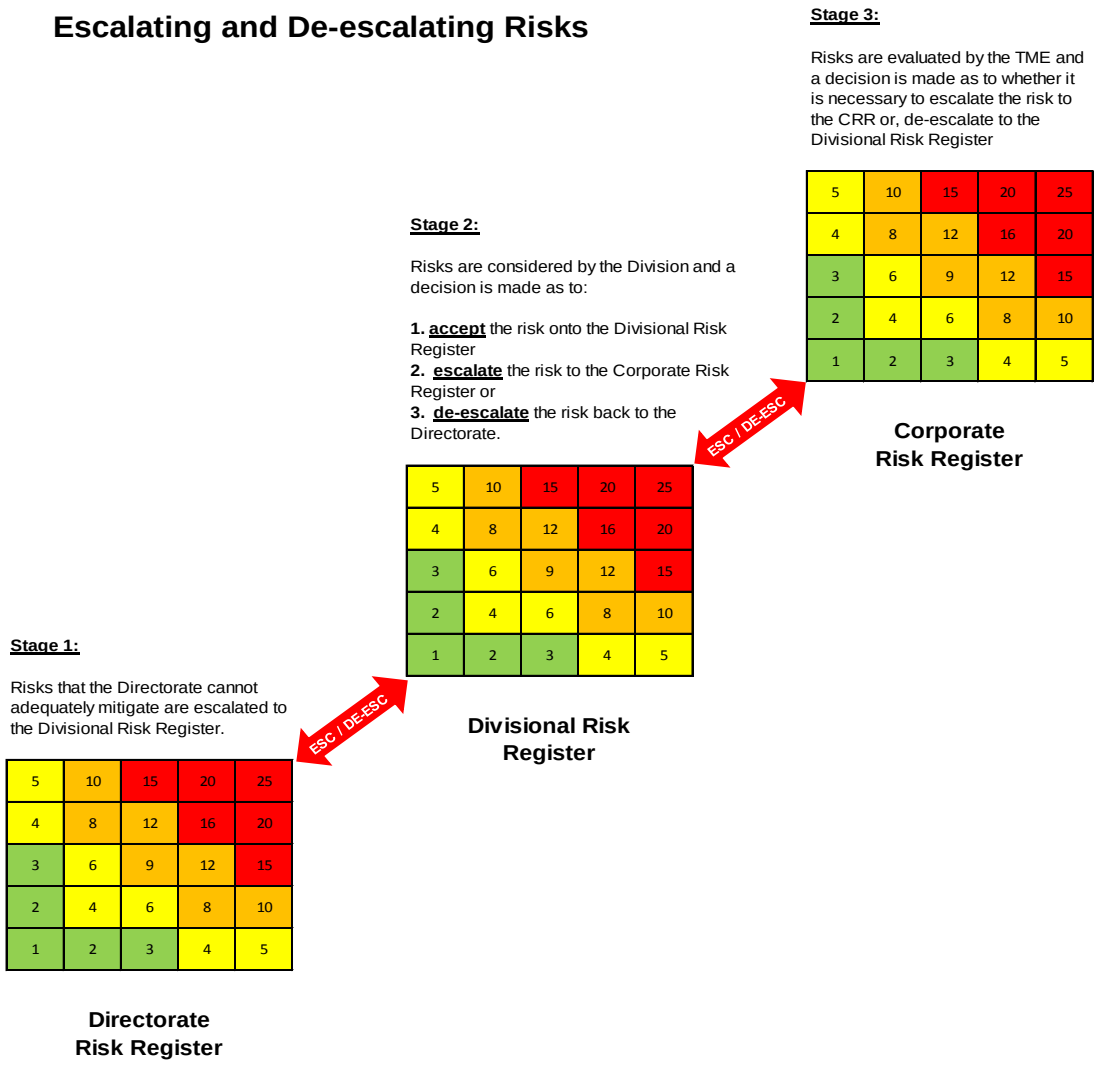
51. Having considered the above, assign the risk target a colour that best represents what it is possible and practical to manage it down to using the existing risk matrix. If the risk target is:

- RED represents a very high tolerance of the risk, i.e. willing to tolerate a risk rated with either a very high likelihood or consequence (or both).
- AMBER – represents a reasonably high tolerance to the threat occurring i.e. more open to the threat occurring, often if there are operational or resourcing constraints.
- YELLOW – prepared to tolerate and accept a little more threat but are prepared to be more 'scared' as more risk is accepted, but still cautious.
- GREEN – averse to the risk as if the risk materialises this cannot be tolerated

Stage 5: Escalation and De-escalation of Risks

52. The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Directorate risk register to a Divisional register, or from the Divisional risk register to the Corporate Risk Register reviewed by the Trust Management Executive, Finance and Performance, Audit, and Quality Committees, and finally the Board.

53. Risks will be escalated or de-escalated within the defined tolerances and authority to act for each level. Further guidance is contained in the Risk Management Handbook.



54. The risk owner should discuss and seek approval from their manager who in turn should consult the risk register owner before risk escalation to the next level.

55. A risk will then be reviewed and either accepted at the next level and agreed at the relevant risk forum, or rejected and returned to the management team to review and rescore, or for further action.

56. Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e. a risk rated 25 (red, or extreme) at Divisional level will be re-evaluated and may not be rated at 25 at Trust level.

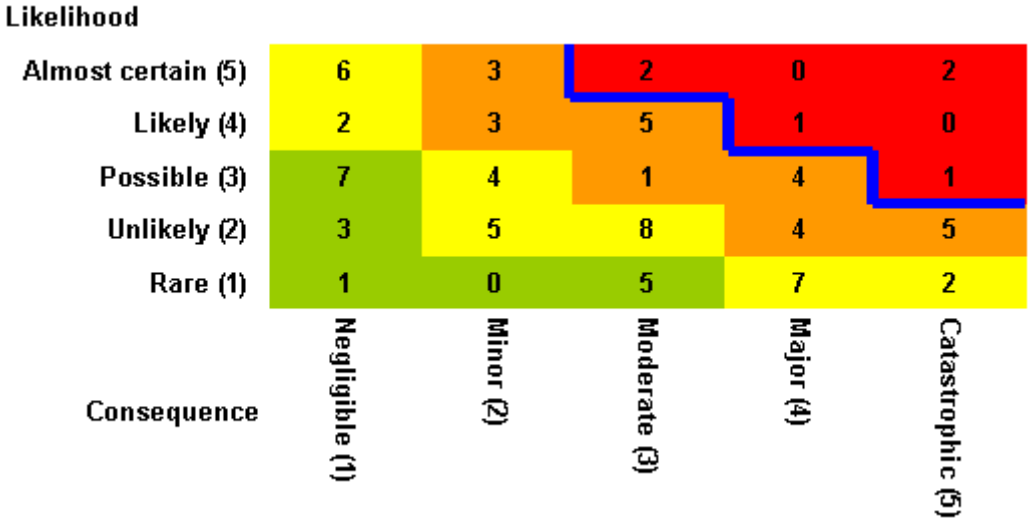
57. Once an escalated risk has reached the accepted target for the risk, following mitigating actions or a change in the nature of the risk, it will be de-escalated. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

58. It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

59. Risk registers at Divisional level are also reviewed to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. This will aid in identifying lower risk issues which may be common across many areas. Registers will also be reviewed to identify high impact but low frequency risks which may pose a threat. These will be included in the Corporate Risk Register reports for review.

Risk Profile

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



Example risk profile diagram

Project and Programme Risk

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

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

- If a programme, through the escalation of risks from projects within the programme
- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with this project or programme
- By operational areas affected by the project or programme

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

- Identify the owners of a programme and individual projects within the programme
- Identify any additional benefits of adopting risk management within this project or programme
- Identify the nature and level of risk acceptable within the programme and associated projects
- Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level
- Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects
- Identify how inter-project dependencies will be monitored and managed
- Clarify relationships with associated strategies, policies, and guidelines.

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

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

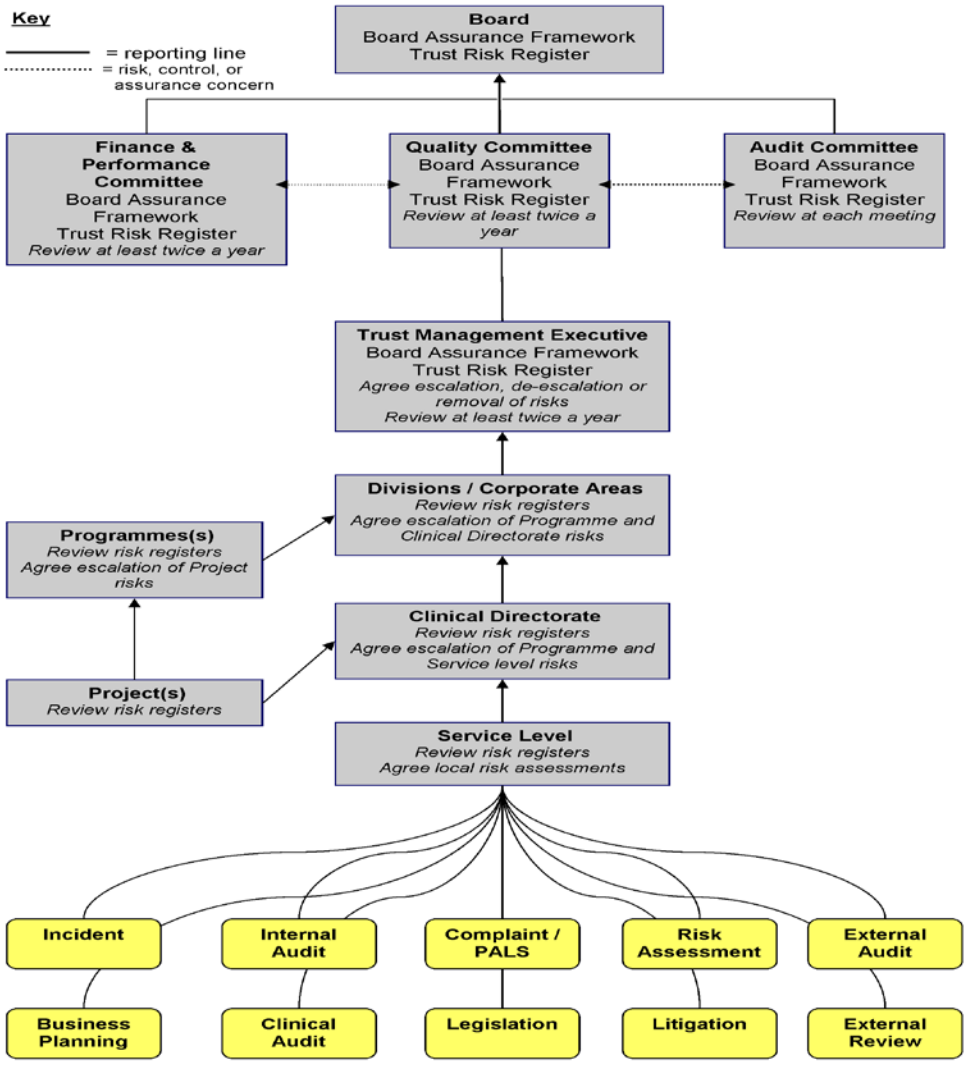
Governance Structure

65. The Trust's governance structure identifies the relevant Committees and their relationship to the Board. Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by the following Committees and further detailed in Appendix 5:

- Board of Directors
- Trust Management Executive (TME)
- Audit Committee
- Finance and Performance Committee
- Quality Committee

66. Additionally the Audit Committee and other Board subcommittees (Finance and Performance, Quality) exist to provide assurance of the robustness of risk processes and to support the Board of Directors.

67. Each Division, Clinical Directorate, and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.



Reporting structure and sources of risk

68. Risks are correspondingly monitored at operational level (Ward, Clinic and Service) through the following team meetings and forums:

- Divisional or Corporate Management,
- Clinical Directorate Management, and
- Directorate and Divisional Management Teams

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

- The **Board Assurance Framework** (BAF) sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the Board agenda.
- The **Corporate Risk Register** is a high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
- The **Annual Governance Statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

Horizon Scanning

70. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

71. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

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

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health publications
- Local demographics
- Seeking stakeholders views

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

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

Training

75. Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

76. Training required to fulfil this strategy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Statutory and Mandatory Training Policy. This information can be accessed on the Learning and Development pages on the Trust intranet.

77. Specific training will be provided in respect of high level awareness of risk management for the Board. Risk Awareness Sessions are included as part of the Board's Development Programme.

78. Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register.

79. The specific training required by staff group is outlined in Appendix 6 along with description of how the training is managed.

Monitoring Compliance

80. The Risk Management Strategy is subject to Annual Review.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency of Monitoring	Group of Committee
Risk Management Strategy	Review	Assurance Team	Annual	TME Audit Committee
AGS	Internal / External Audit	Assurance Team	Annual	Audit Committee
Risk Management Process	Internal Audit	Assurance Team / Divisions	Annual	Audit Committee

Review

81. This strategy will be reviewed every three years or sooner if circumstances dictate.

82. All documents in existence prior to the issue of this policy will remain in effect until such time as they are reviewed, replaced or cancelled.

References

83. The references relating to this strategy are:

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

- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)

Equality Impact Assessment

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

Document History

Date of Revision	Version number	Reason for review or update
July 2012	V3	Approved Document
August 2015	V4.4	Revised Document

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Appendix 1: Categories of Risks

Risks to patients

1. The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

Organisational risks

2. The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

3. The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.

4. A range of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

Reputational risk

5. The Board of Directors models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

Opportunistic risks

6. The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Integrated Business Plan, whilst respecting and abiding by its statutory obligations.

7. Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure safety and quality is maintained.

Appendix 2: Definitions

For the purposes of this strategy, the following key terms are in use:

- Assurance – External evidence that risks are being effectively managed
- Control(s) – Actions in place to manage the risk in order to reduce the likelihood and / or consequence of that risk
- Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.
- Inherent Risk – the level of risk before any control activities are applied.
- Impact – The potential consequence if the adverse effect occurs as a result of the hazard
- Likelihood - the chance or possibility of something happening.
- Residual Risk - The current risk 'left over' after controls, actions or contingency plans have been put in place
- Risk – The chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.
- Risk Appetite – the level of risk considered the Trust is prepared to accept, tolerate or be exposed to at any point in time
- Risk Capacity - Maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available
- Risk Management - 'all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress'.
- Risk Maturity – the overall quality of the risk management framework
- Risk Owner – the individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated
- Risk Profile – the overall exposure of the organisation to risks (or a given level of the organisation).
- Risk Rating – the total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix
- Risk Register – the tool for recording identified risks and monitoring actions and plans against them.
- Risk Tolerance - the boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 3: Roles and Responsibilities

Title	Responsibilities
Chief Executive	The Chief Executive is the responsible officer for the Oxford University Hospitals NHS Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management
Director of Assurance	The Director of Assurance has delegated authority for the risk management framework, and is the Executive lead for maintaining the Board Assurance Framework and its supporting processes.
Director of Finance	The Director of Finance has responsibility for financial governance and associated financial risk.
Medical Director	The Medical Director has responsibility for clinical governance and clinical risk, including incident management, and has joint responsibility with the Chief Nurse for quality.
Chief Nurse	The Chief Nurse has responsibility for patient safety and patient experience, and joint responsibility with the Medical Director for quality.
Executive Directors	The Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates. Executive Directors also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.
Head of Corporate Governance	The Head of Corporate Governance is accountable to the Director of Assurance for the overall performance of corporate governance functions, including monitoring the system of internal control; including the system and supporting processes for risk registers and maintenance of the Board Assurance Framework.
Deputy Director of Assurance	The Deputy Director of Assurance is responsible for the assurance of the system of internal control to ensure effective management of risk.
Divisional Directors	The Divisional Directors are accountable for ensuring that appropriate and effective risk management processes are in place within the Divisions, and that all staff are aware of

Title	Responsibilities
	the risks within their work environment, together with their personal responsibilities. The Divisional Directors must ensure that risks are identified, assessed, and acted upon. They must ensure that where appropriate captured on local risk registers, ensuring that risks are reviewed by an appropriate divisional group at least quarterly as part of performance monitoring, to consider and plan actions being taken. They must ensure appropriate escalation of risks from services or directorates to divisional level within the defined tolerances. Divisional Directors have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this strategy and related documentation. The Divisional Directors are responsible for ensuring that staffs receive the relevant elements of risk management training and that non-attendance is followed up.
Clinical Directors	The Clinical Directors are responsible for ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk register; and ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.
Senior Managers and Senior Staff	Senior Managers take the lead on risk management and set the example through visible leadership of their staff. They do this by: • Taking personal responsibility for managing risk. • Sending a message to staff that they can be confident that escalated risks will be acted upon. • Ensuring risks are updated regularly and acted upon • Identifying and managing risks that cut across delivery areas. • Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach. • Communicating downwards what the top risks are, and doing so in plain English • Escalating risks from the front line. • Linking risk to discussions on Finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.

Title	Responsibilities
	• Ensuring staff are suitably trained in risk management. • Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve. • Ensuring that people are not blamed for identifying and escalating risks, and fostering a culture which encourages them to take responsibility in helping to manage them. • Ensuring that risk management is included in appraisals and development plans where appropriate. Senior staff are expected to be aware of and adhere to the risk management best practice to: • Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front line colleagues • Identify risk owners with the seniority to influence and be accountable should the risk materialise • Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do • Identify the actions needed to reduce the risk and assign action owners • Is there an opportunity to benefit from the risk or the work done to mitigate against the risk materialising? • Record risks on a risk register • Check frequently on action progress, especially for high severity risks • Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so • Implement a process to escalate the most severe risks, and use it
All staff	All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow the Raising Concerns Policy incorporating guidance on both whistle blowing and raising concerns.

Title	Responsibilities
Staff side representatives	Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.
Chief Executive	The Chief Executive is the responsible officer for the Oxford University Hospitals NHS Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management

Appendix 4: Risk matrix and risk scoring guidance

Calculate the consequence and likelihood rating using the scales below.

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

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

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

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

Consequence x Likelihood = Overall risk rating

3 x 5 = 15

Moderate x Almost certain = Extreme Risk

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

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

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

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

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

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

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

Consequence Table

	Consequence 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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Human resources/ organisational development /staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches 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

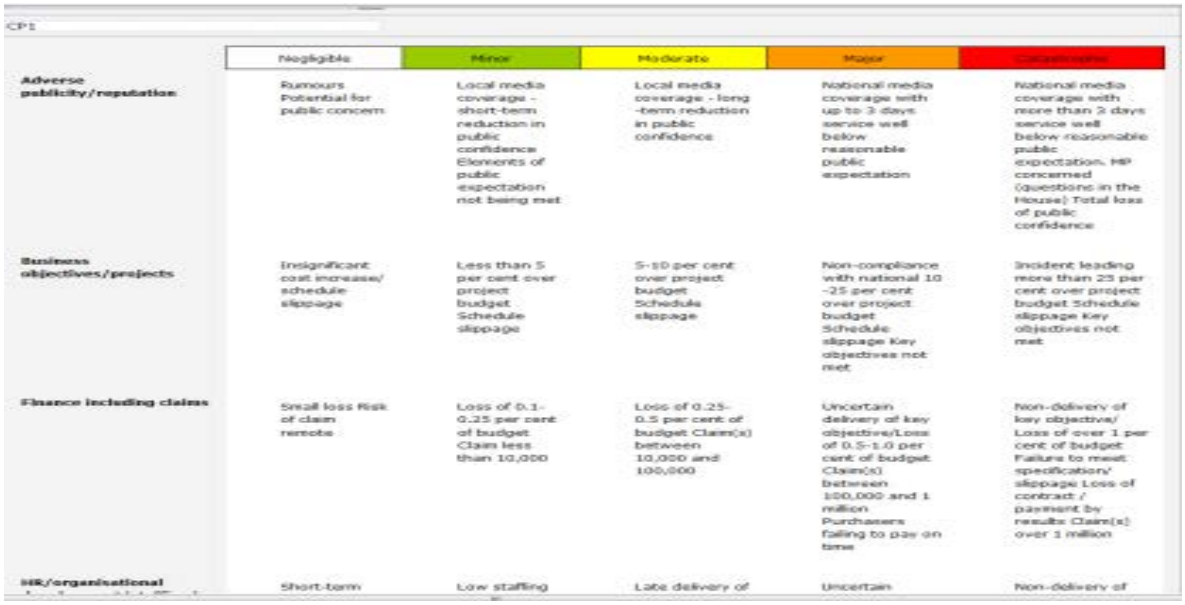
	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £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

Setting the Initial Risk Score from the Add Risk Section of HA

The *initial risk* is the level of risk *without any controls* in place and is set when adding a *new risk.*

Consequence:

1. Choose a category to select the consequence of the risk (8 categories):
    - Adverse publicity
    - Business objectives
    - Finance including claims
    - HR organizational
    - Impact on safety of patients
    - Quality / complaints / audit
    - Service / Business interruption
    - Statutory duty / inspections



	Negligible	Minor	Moderate	Major	Catastrophic
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 up to 3 days service well below reasonable public expectation	National media coverage with more than 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	Less than 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 more than 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 over 1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) over 1 million
HR/organisational	Short-term	Low staffing	Late delivery of	Uncertain	Non-delivery of

2. Choose the level - using the words as a guide to make a judgment–
    - negligible
    - minor,
    - moderate,
    - major or
    - catastrophic.

Likelihood:

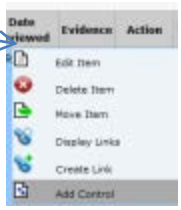
Select the Likelihood of that risk occurring if no controls (mitigating factors) were in place by checking the 

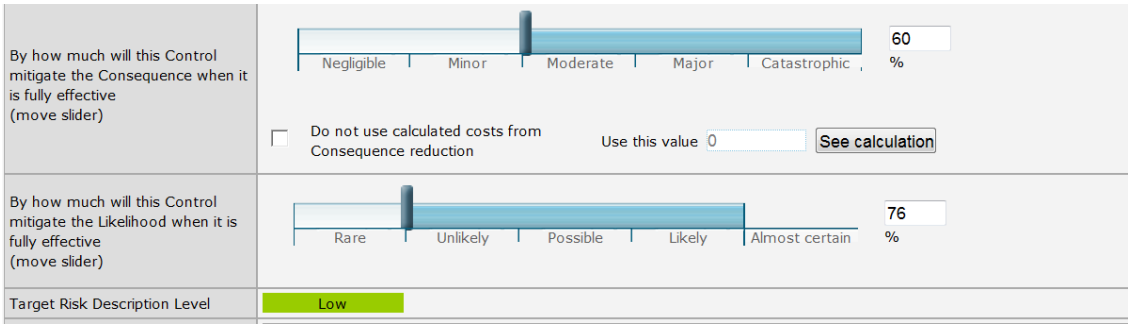
box

- Rare
- Unlikely
- Possible
- Likely
- Almost certain

Setting Target and Residual Risk in the Add Controls Section of HA

From the add controls section of HA, set the target risk by moving 2 sliding scales which represent consequence and likelihood to show how much the risk will reduce when all controls are in place

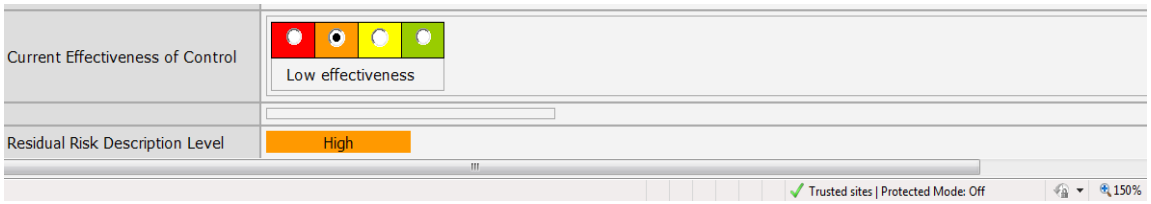




Residual Risk (current)

To calculate the residual risk, complete the check box below to select how effective the current controls are at reducing the risk.

- Red – very low effectiveness
- Amber – Low effectiveness
- Yellow – Moderately effective
- Green – Highly effective



Appendix 5: Committees and Governance Structures

Title	Responsibilities
Board	The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust.
Trust Management Executive	The Trust Management Executive (TME) in its role as the Executive decision making committee of the Trust maintains oversight of operational risk. Risk is monitored through the Corporate Risk Register (CRR) and Board Assurance Framework (BAF). The TME are also responsible for agreeing resourced treatment plans and ensuring their delivery.
Audit Committee	The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk: • To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. • To review the Trust strategic risk register at each meeting or as the Board determines. • To monitor and review the Board Assurance Framework, and ensure its presentation to the Trust Board at intervals that the Board determines. • To assess the overall effectiveness of risk management and the system of internal control. • To challenge on the effectiveness of controls, or approach to specific risks.
Finance and Performance Committee	The Finance and Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.
Quality Committee	The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care;

Title	Responsibilities
	governance systems including risks for clinical, corporate, workforce, information and research & development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.
Clinical and Corporate Divisions and Directorates	All Clinical and Corporate Divisions and Directorates will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.
Divisional forums	The Divisional forums have the responsibility, through the Divisional Directors, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. The Divisions will develop, populate and review their risks, drawing on risk processes within the services, to ensure that Service, Directorate and Divisional Risk Registers are kept up to date through regular review.
Directorate meetings	Directorate meetings will review the risk registers and contribute to the development of the Directorate and Divisional Risk Registers and ensure risk registers are in place and operating within the defined tolerances and escalation processes.
Directorate and Divisional management teams	Directorate and Divisional management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

Appendix 6: Trust training for the management of risk

Staff groups	Training need	Frequency	Format
Executive and non Executive Directors of the Board	Board Risk Awareness training	Annual	Workshop session as part of Board Development Programme
Trust senior managers	General Risk Awareness Training Risk assessment training Risk register training Management of risk for senior managers	Every 5 years Every 5 years Every 5 years Every 5 years	Powerpoint presentation/workshop Powerpoint presentation/workshop Powerpoint presentation/workshop
All new staff	Risk awareness training and an understanding of the role of risk management in the organisation	Once only Completed as part of induction	Powerpoint presentation/workshop
Existing staff	Ad hoc bespoke training Risk assessment training	As required Ad hoc /as required	Variable according to need- powerpoint/workshop
Staff involved in risk management	Individually addressed according to individual needs	Dependent on individual needs	As required

The Board development session will be booked and attendance noted by the Head of Corporate Governance. Any non-attendance will be followed up circulation of presentation and briefing materials and a 1:1 session provided by the Director of Assurance or nominated deputy.

All other mandatory training will be booked and managed in accordance with the Trust training needs analysis as outlined in the Guide to Statutory, Mandatory and Essential Training.