Western Health and Social Care Trust

Risk Management Policy

October 2022

Title:	**RISK MANAGEMENT POLICY**			
Ownership:	Medical Director			
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Links to other policies	• Adverse Incident Policy 2021 • Integrated Assurance Framework Document 2021 • Being Open Policy 2021 • Complaints • Claims Management Policy • Control of Substances Hazardous to Health Policy • Emergency Planning Policy • Health and Safety Policy • Moving and Handling Policy • Manual Handling of the Bariatric Patient • Public Interest Disclosure ("Whistleblowing") Policy • Zero Tolerance and Security Policy			

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WESTERN HEALTH AND SOCIAL CARE TRUST

RISK MANAGEMENT POLICY

1.0 INTRODUCTION

The Western Health and Social Care Trust ("The Trust") is committed to providing high quality, safe and accessible patient and client focused health and social care services. This is achieved by promoting a culture of openness and accountability and by effective communication. As outlined within the Trust Corporate Plan we aim to build a shared purpose building on our four themes; a great place to start life, a great place to live well, a great place to grown old and a great place to work, by delivering 'right care, first time'. The Trust recognises that the identification and effective management of risks provide invaluable opportunities to improve patient/client care.

The Board should ensure that there are effective arrangements for governance, risk management and internal controls in place and be able to assess and demonstrate those arrangements through a number of key documents, including the assurance framework and the governance statement. The Trust Risk Management arrangements are aligned to the Assurance Framework and are central to the Board's understanding of key risks that may impact on the achievement of Trust Objectives. The Trust's Risk Management Policy is in line with the regional approach to Risk Management using the ISO31000 Risk Management Standard, which was formally approved by Trust Board in July 2019.

The Trust will strive to place an active awareness of risk and knowledge of how to manage it at the core of its activities. The Trust recognises that it is vital to develop and maintain systems and procedures which identify and minimise risks to patients, clients, visitors, staff and others if it is to achieve its commitment to providing high quality care.

The Trust will work in partnership with the Trade Unions to ensure the implementation of this policy.

2.0 DEFINITIONS

The following definitions are used for the purpose of this Policy:-

Risk - *Risk is the 'effect of uncertainty on objectives'*

It is also expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

Risk management – *Risk Management is the process of systematic identification, reduction and /or elimination of risks*

3.0 AIMS & OBJECTIVES

The aim of the Trust's Risk Management Policy is:

To develop and maintain a clear and effective structure of responsibility and accountability across the Trust, together with clear systems for identifying and controlling risks, so that all Trust employees will play a role in managing risk, leading to measurable improvements in patient/client and staff safety.

This will involve:

- Developing a culture which secures the involvement and participation of all staff in patient/client safety, risk assessment, incident reporting, health & safety, complaints, and management of financial, information and reputational risk;
- Securing the commitment of management at all levels to promote risk management and provide the necessary leadership and direction;
- Ensuring that staff have the right knowledge and skills for the assessment and appropriate management of risk by providing appropriate training;
- Developing and promoting policies and procedures which facilitate positive and effective risk management;
- Monitoring and reviewing risk management performance at all levels of the organisation (i.e. Corporate, Directorate, Sub-Directorate, Ward/Departmental levels) to ensure that corrective action is taken where necessary;

- Using opportunities for learning from e.g. complaints, incidents, litigation, inspections and audit and gaining assurance that appropriate action has been implemented;
- Having in place effective systems of communication to ensure the dissemination of information on risk management matters;
- Complying with national and regional standards and requirements in relation to risk management;
- Developing an Assurance Framework that will provide assurance to the Board on the management of risk.

The policy clarifies the leadership and accountability arrangements for ensuring that appropriate systems are in place throughout the Trust to manage and control risks relating to the achievement of Trust objectives, together with clear systems for identifying and controlling risks, so that all Trust employees understand their role in managing risk, which will lead to measurable improvements in patient/client and staff safety.

4.0 CLINICAL, SOCIAL CARE, FINANCIAL AND ORGANISATIONAL GOVERNANCE

From 1 April 2003, a statutory duty of quality was placed on Health & Social Services (now Health & Social Care) Trusts. Under this duty, a Trust is required "to put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal social services which it provides to individuals and the environment in which it provides them".

Robust risk management systems and clear accountability arrangements will allow the Trust to demonstrate its commitment to providing safe and high quality services and will contribute towards the Trust's aims as set out in the Corporate Plan and ensure the effectiveness of the system of internal governance. The Trust's Organisational Governance Arrangements are outlined within the Integrated Assurance Framework document 2021. Assurance document governance review Trust Board Version August 21.pdf (n-i.nhs.uk)

5.0 RISK MANAGEMENT ACCOUNTABILITY ARRANGEMENTS

Please see the Integrated Assurance Framework document 2021 Assurance document governance review Trust Board Version August 21.pdf (n-i.nhs.uk) for further details regarding roles and responsibilities.

Trust Board - is responsible for ensuring that appropriate risk management and governance structures and arrangements are in place and for receiving assurances that these are operating satisfactorily. It is also responsible for agreeing the risk appetite model and applying the level of appetite against each corporate risk and the associated level of tolerance to achieving the target score.

Chief Executive - is accountable to the **Trust Board** for ensuring that appropriate systems are implemented throughout the organisation to eliminate and control risks to the Trust.

Medical Director - has executive responsibility for ensuring a robust Risk Management system is in place to support the Trust in managing risk, both clinical and non-clinical.

Director of Women & Children's Services - has executive responsibility for the statutory duty quality of care in relation to social services.

All **Directors, Assistant Directors, Divisional Clinical Directors, Clinical Leads, Senior Managers, Facility/Ward Managers and Heads of Department** must ensure that risks within their area of responsibility are managed appropriately. Management of risk is one of their key operational and day-to-day responsibilities. This includes ensuring the risk appetite and tolerance level for each risk is agreed and reviewed as appropriate.

Individual Directors have a responsibility for governance arrangements within their respective Directorates and they have established Directorate Governance Groups to help facilitate this. Governance requirements vary from one Directorate to another depending on the nature of their work and the type of risk involved.

Directors will receive assurance by the information and reports provided at governance meetings including the relevant risk registers and will regularly monitor performance

against risks identified and will consider information and trends on incidents, complaints, claims, inquests and morbidity and mortality reviews to help inform their management of risks.

Directors will have responsibility for specific risks where they are the named responsible director. This involves ensuring the risks are being managed appropriately and that they are adequately reflected against the risk register. As well as risks specific to one directorate, any Trust-wide risk also requires a responsible Director who in such circumstances must ensure a system is in place to link with other directors/directorates relevant to the risk to provide appropriate input to reflect the current management of that risk.

The **Assistant Director, Quality & Safety** has responsibility for ensuring that robust systems for the identification and management of risk are in place and that trends are monitored and reported on.

The **Corporate Risk Manager** is the Trust-wide nominated lead for risk management and has responsibility for providing an assurance to the Assistant Director, Quality and Safety and Directors regarding the risk management systems and processes in place, (including risk registers, incident reporting and management, health and safety and litigation). He/she is charged with responsibility to provide advice to the Directorates, to develop all aspects of risk management and to encourage a Trust-wide risk management culture with the co-ordination of risk identification, analysis and control. He/she has the responsibility for providing and developing risk management training for Directorates. The Corporate Risk Manager also has responsibility for ensuring that the Trust's risk management database (Datix) is maintained and for ensuring that the Corporate Risk Register and Board Assurance Framework is regularly up-dated and produced for appropriate Trust meetings.

Individual staff members have a personal responsibility for maintaining a safe environment, notifying line managers of any identified risk and complying with relevant risk management policies and procedures. In addition staff are accountable to their individual professional bodies and must adhere to their codes of professional conduct. In particular, staff must ensure that any serious risks which have not been addressed appropriately or in a timely basis by the relevant manager are brought to the attention of the appropriate

Director. Staff should refer to the Trust Incident Reporting Policy available on the Trust intranet, see attached link Adverse Incident Policy (n-i.nhs.uk) and when reporting new risks to the 'New Risk Form' at Appendix 5 of this document.

Duty of Candour - All staff, including volunteers, are responsible for reporting any patient/client safety incident to their line manager as soon as possible. Professional bodies also have guidance on reporting concerns. Please refer to Being Open Policy Being Open Policy June 2021.pdf (n-i.nhs.uk) and Whistle Blowing Policy Your right to raise a concern (Whistleblowing) Policy - (HR 18 002) 20 February 2020.pdf (n-i.nhs.uk).

In accordance with Section 21 of the NHS Terms and Conditions of Service Handbook; and the Trust's Policy 'Your Right to Raise a Concern (Whistle-blowing), all employees working within the NHS have a contractual right and duty to raise genuine concerns they have with their employer. Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud. The Policy is available on the Trust intranet at Your right to raise a concern (Whistleblowing) Policy - (HR 18 002) 20 February 2020.pdf (n-i.nhs.uk). The right of Trust staff to "whistleblow" has also been reiterated in a letter to the Strategic Performance and Planning Group (SPPG) staff by the Minister of Health which is available on the intranet at Your right to raise a concern (Whistleblowing) Policy - (HR 18 002) 20 February 2020.pdf (n-i.nhs.uk)

6.0 GOVERNANCE COMMITTEE STRUCTURE

The governance accountability arrangements and committee structure within the Trust are outlined within the Integrated Governance and Assurance Framework document August 2021. Assurance document governance review Trust Board Version August 21.pdf (n-i.nhs.uk)

Audit and Risk Assurance Committee – The Audit and Risk Assurance Committee has oversight of the adequacy and effectiveness of the risk management and assurance framework in the Trust. It does this by review of the Corporate Risk Register and Assurance Framework Document and the Risk Summary Document which are reviewed quarterly by the Audit and Risk Assurance Committee.

Governance Committee (Chaired by a Non-Executive of the Trust) provides assurance to the Trust Board that appropriate governance arrangements are in place and working effectively.

The following Trust Groups report directly to the Governance Committee:-

- **Corporate Governance Sub-committee** provides assurance to the Governance Committee that assurance and risk management arrangements are in place relating to corporate Governance within the Trust.
- **Clinical and Social Care Governance Sub-committee** provides assurance to the Trust Governance Committee that arrangements relating to Clinical and Social Care Governance within the Trust are effective and are contributing real value to the delivery of safe and effective services.
- **Quality & Standards Sub-Committee** oversees the implementation of clinical and social care standards and guidelines throughout the Trust and provides an assurance to the Trust's Governance Committee that appropriate systems are in place to establish and monitor the standards relating to the quality of care provided.
- **Directorate Governance Groups** provide assurance to the Governance Committee on the risk management arrangements within each Directorate.

- **The Governance Sub-Committees** will seek reports and assurances from the Working Groups that report to them on the management of risk within the areas of

work governed by them. The chair of the Sub-Committee will then escalate to the Governance Committee any significant risks reported by the Working Groups.

All reporting Sub-committees will ensure that the specific risks on the Corporate Risk Register related to that forum is a standing item on their agenda for noting. Directorate representatives and Chairs of Working Groups will also be reminded to ensure that any significant risks within their area of responsibility are escalated to as required.

In accordance with National Institute for Clinical Excellence (NICE) Guidance re: The Interventional Procedures Programme (Circular PPMD(NICE)1/07), where a new activity or practice is being considered the Clinical and Social Care Governance Sub Committee is required to review the proposal to ensure that it has been properly assessed for risk prior to approval. Consideration should also be given to including the activity on the Risk Register (see point 7.0 below).

7.0 RISK MANAGEMENT PROCESS

The Trust will ensure that the risks to be managed are identified using a comprehensive, systematic process linked to the organisations Objectives as stated in the Corporate Plan 2019-2021 Corporate Plan 2019 to 2021 26062019 V3.indd (n-i.nhs.uk)and within the Assurance Framework 2021. Assurance document governance review Trust Board Version August 21.pdf (n-i.nhs.uk)

The following are the 4 objectives of the Trust:-

- Improving the quality & experience of care
- Ensuring stability of our services
- Improving the health of our people
- Supporting & empowering staff

Trust Board, is then in a position to identify, the key corporate risks which may prevent the Trust meeting in meeting its objectives.

The Trust is committed to ensuring that risk management arrangements are based on the principles of the ISO 31000:2018 standard for managing risk and recognises that risk management should be an integral part of the organisation's culture.

The Risk Management process has five key components:

1. Risk identification
2. Risk analysis
3. Risk evaluation
4. Risk control (treatment)
5. Risk review

7.1 RISK IDENTIFICATION

Risk identification should be a formal, structured process that considers sources of risk, areas of impact and potential events, their causes and consequences.

Risks must be identified at all levels of the organisation using a variety of means including the risk assessment process, learning from incidents, serious adverse incidents, complaints, claims, inspections, audit, monitoring of performance and financial management systems, regulatory and legislative requirements. Individual Directorates / Wards / Departments / Specialties and Service Areas will be required to identify and prioritise their risks. The range of risks to be identified will be broad and depends on the area or service to be assessed, the key objectives of the Directorate and the risks which can impact to prevent the objectives being met.

Risks and SAIs are tabled at directorate governance forums and directorates should ensure that any new SAI that relates to a risk on the risk register is reflected against that risk. When reviewing new red incidents or SAIs the Rapid Review Group (RRG) will provide further assurance, if a risk is identified, by ensuring that a new risk is raised or where this relates to a current risk that it is updated to inform appropriate actions which are required to manage the risk.

Consideration must also be given to risks which are managed from outside the Trust and are owned elsewhere (e.g. by the Department of Health, SPPG, Contractors or other public service/voluntary organisations) that may impact on objectives. Managers must

ensure that appropriate governance and contractual arrangements are in place to reduce and monitor risks, which are outside of the Trust's direct control.

7.2 RISK ANALYSIS

Risks should be analysed by considering the consequences/severity of the risk and the likelihood/frequency that those consequences may occur. The risk criteria contained within the regionally agreed Risk Impact Assessment Table (Appendix 2) and Risk Matrix (Appendix 3) will provide a guide for analysis. Risk analysis will involve consideration of the sources of risk, their consequences and the likelihood that those consequences will occur (based on quantitative/qualitative data) bearing in mind existing control measures. The outcome will be a prioritised list of risks (extreme, high, medium or low) requiring further action.

7.3 RISK EVALUATION

Risk evaluation involves making a decision about the level of risk and the priority for attention required through the application of the criteria when the particular context was established. This stage of the risk management process determines whether the risks are acceptable or unacceptable.

7.4 RISK TREATMENT / ACCEPTABLE RISK

The purpose of risk treatment (control) is to select and implement options for addressing risk. It is not possible to eliminate all risks from the organisation and therefore the Trust will have to agree that some risks have to be deemed acceptable. This will require some consideration of the principle of reasonable rather than absolute assurance when considering an acceptable level of risk. Acceptable risks are those that reflect the target score in line with the risk appetite. Where this is not the case a level of tolerance must be applied to ensure there is clear prioritisation of those risks requiring more urgent mitigation. All risks will require review with the frequency of review being determined by the level of tolerance applied.

Where control measures fail and lead to a material realisation of risk a deep dive review of the treatment plans should be considered to ensure that the controls and action plan are appropriate to manage the identified risk.

Where it is not possible to completely eliminate risk, all necessary steps will be taken to control the frequency and severity of the risk. The Assistant Director of Quality and Safety and Corporate Risk Manager on the systems for managing risk and senior/specialist managers will provide advice and assistance to managers in identifying appropriate actions. It is essential that the process is kept under regular review. Risks and the effectiveness of control measures need to be monitored to ensure changing circumstances do not alter risk priorities.

7.5 RISK REVIEW

Risks must be reviewed on a regular basis (at least quarterly) to ensure that action plans remain effective and that where the level of risk is increasing, appropriate action is taken to reduce the level of risk and escalate the risk to a higher level within the Trust, as per the process outlined at Appendix 4. Where actions are due the risk must be reviewed to reflect revised targets for implementation. Where actions have been implemented the risk controls should be updated and the risk score reviewed to ensure the risk grading effectively represents the existing risk.

Risk Registers will be a standing item on Trust Committees/Sub-Committees/Working Groups and Directorate/Sub-Directorate governance groups. Discussion regarding risks and action agreed must be recorded within the minutes of each meeting.

8.0 RISK REGISTERS

The Trust will maintain a database of **Corporate, Directorate and Sub-Directorate** level risks. Each risk record will include a description of the risk, current control measures in place to manage the risk, an assessment of the impact and likelihood of realisation of the risk (initial, current and target risk levels) as well as action necessary to treat/remove the risk. The corporate objectives that may be affected, should the risk materialise must also be identified.

The Corporate Risk Manager will have responsibility for ensuring that the database is maintained and used appropriately and will provide training to identify Directorate staff in its use.

The database will enable the Corporate Risk Register and individual Directorate/Sub-Directorate risk registers to be developed, maintained and produced, thus ensuring that significant risks are recorded, action plans are developed and their implementation is monitored.

Raising a risk

The process for identifying risks for inclusion on the Risk Register and recording these on Datix is attached at Appendix 2. Proposed new risks can be recorded on the risk module on DATIXWEB and printed for tabling at the relevant Governance forum for approval. A "new risk form" also is available for those who prefer to submit a paper form for approval at the governance meetings. This is provided at Appendix 3 and is also available in Word format on the Trust intranet at New Risk Form (updated Jan 2021).dotx (n-i.nhs.uk).

Managing a risk

All risks regardless of level must be actively managed to ensure all gaps in control are managed to bring the risk to appetite level as soon as possible. Regular updates should be entered against the risk by the risk lead at least quarterly and more frequently if required by the tolerance level set against achieving the risk appetite for each risk.

Corporate risks are risks, which, due to the high / extreme level of risk involved and/or which cannot be adequately, managed within Directorates, have been recommended by Corporate Management Team and accepted by Governance Committee for inclusion on the Corporate Risk Register. These corporate risks require continual monitoring by the Corporate Management Team (CMT), Governance Committee and Trust Board to ensure all necessary action is being taken to reduce the level of risk to patients, staff, the organisation and other stakeholders. Where a Corporate risk no longer requires Board level management but requires monitoring by them on an annual basis, it can be de-escalated to a relevant sub-committee to be managed. The Chair of the sub-committee must provide a report on the management of that risk annually to Trust Board via CMT.

To facilitate appropriate monitoring the Corporate Risk Register sits within the Board Assurance Framework (see below) to allow presentation of the information required to provide assessment of the ongoing management of the risks along-side an indication of the assurances regarding the effectiveness of that assessment.

The Corporate Risk Register will also be a standing item on the Agenda of the following meetings:-

- Corporate Management Team – for discussion each month and to approve in principle any material changes (see Risk Register Material Changes table below).
- Trust Board – for discussion at each meeting and to approve any material changes.
- Governance Committee - for discussion and noting at each quarterly meeting.
- Governance Sub-committees – for noting and for review of those risks which have been specifically delegated to the Sub-committee to monitor. Directorate representatives and Chairs of Working Groups will also be reminded to ensure that any significant risks within their area of responsibility are escalated to corporate level as required.

The Corporate Risk Register will also be posted on the Trust intranet following each Governance Committee meeting.

Table 1 - Corporate Risk Register Material Changes

CRR – Proposed amendment requiring approval at CMT
New Corporate Risk
Change of responsibility e.g. Lead Director, Directorate
Change to title/description of Risk
Change to Corporate Objective
Current or Target Risk Rating Changed
De-escalation/ closure of Corporate Risk

Risk registers will also be a standing item on Directorate/Sub-Directorate Governance meetings and quarterly updates on key risks will be provided at these meetings. Information on key risks will also be included in Directorate reports to the Governance Committee.

Each risk on the database should be reviewed and up-dated **at least quarterly** to reflect the position regarding its current risk rating and implementation/progression of action plans. Staff at Directorate and Sub-Directorate level have been given access to the database to enable this requirement to be met.

Consideration must be given to corporate risks which are cross-Directorate in nature. Such risks will be categorised as “Trust-wide” and an appropriate Director must be nominated to take the lead in its management. A sub-committee (or other forum within the Assurance Framework) may be nominated to manage such risks if appropriate and relevant Directorates must ensure they have a system and nominated officer to link to the risk lead to provide updates on the risk from their area as necessary.

9.0 RISK APPETITE STATEMENT

The risk appetite statement clarifies the Trust Board’s expectations in relation to the category of risks they expect the Trust’s management to identify and the level of such risk that is acceptable.

Trust Board will agree a statement against each category of Risk which sets out their Risk Appetite and quantifies the level of tolerance it is prepared to accept. Risk Appetite statements must be used to derive acceptable Target Scores for Risks.

The Statement is based on the premise that the lower the risk appetite, the less the board is willing to accept in the terms of the risk and consequently the higher the levels of control that must be put in place to manage the risk.

The higher the appetite for the risk, the more the board is willing to accept in terms of the risk and consequently the Board will accept the business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls.

Risk appetite is therefore set at one of the following levels:

Table 2: Risk Appetite

Risk Appetite	What this means:
No Appetite	We are not prepared to accept uncertainty that outcomes can be prevented for this type of risk.
Low appetite	We accept a low level of uncertainty that outcomes can be prevented but expect that risks are managed to a level that may not substantially impede the ability to achieve objectives.
Moderate Appetite	We accept a moderate level of uncertainty but expect that risks are managed to a level that may only delay or disrupt achievement of objectives, but will not stop progress towards objectives.
High Appetite	We accept a high level of uncertainty and expect that risks may only be managed to a level that may significantly impede the ability to achieve objectives.

Risk Category, Sub-category and Appetite

When we refer to risk appetite we are expressing the Trust's level of willingness to accept a particular outcome if the risk is realised (based on the likelihood and consequence of this outcome happening) after consideration of all possible actions in managing the risk. Whilst acknowledging the wide range of possible outcomes, risk appetite is applied to a broad range of categories and subcategories of outcome to ensure as far as possible a consistent approach to help prioritise decision making in managing the risk register effectively.

To help in applying a risk appetite level each risk must be assigned to a Category and sub-category related to the risk outcome. Table 3 illustrates the categories and sub-categories and applicable appetite level and score for each. Each risk's target score must therefore be set within the appropriate appetite score range against that sub-category.

Many risks may have more than one outcome but when selecting the outcome category and subcategory it should be the one that is of most obvious concern to Trust Board (or whatever appropriate management forum if not a Corporate risk) that should be selected. This will also likely be the outcome at which most significant mitigation will be targeted against through the risk action plan.

Table 3 - Risk Categorisation, Appetite and Scoring

Category	Sub Category	Appetite	Maximum acceptable score
Financial	Value of Money & sustainability (including cost saving)	Low	5
	Standing Financial Instructions & Financial Control	Low	5
	Fraud & Negligent Conduct	Low	5
	Innovation (e.g. new ways of working, new products, new and realigned services)	Moderate	12
Quality of Care	Patient safety (e.g. patient harm, learning lessons)	Low	5
	Effectiveness (e.g. outcomes, delays, cancellations or targets and performance)	Moderate	8
	Service user and carer experience (e.g. complaints, audit)	Moderate	8
Health & Safety	Service user, staff, visitor harm	Moderate	8
	Compliance with laws and regulations	Low	5
ICT & Physical Infrastructure	Security (e.g. Access and permissions to systems and networks)	Low	5
	Control of assets (e.g. purchase, movement and disposal of ICT equip)	Low	5
	Business continuity (e.g. cyber attack)	Low	5
	Data (e.g. Integrity, availability, confidentiality)	Low	5
	Innovation (e.g. new ICT systems)	Moderate	12
Resource & People	Staff recruitment (e.g. compliance with regulations)	Low	5
	Staff in work (e.g. AfC implementation, professional development, compliance with policies)	Low	5
	Staff retention (e.g. attractiveness of Trust as an employer)	Low	5
	Innovation (e.g. new models of staffing, international recruitment)	Moderate	12
Regulation & Compliance	Statutory Regulation and requirements (e.g. ICO, GMC,NMC,ICO)	Low	5
	National guidance and best practice (e.g. NICE)	Moderate	12

Risk Tolerance

Once the risk appetite is applied to a risk, Trust Board (or relevant forum for non-corporate risks) will set and at least annually review a level of tolerance to not achieving the appetite level. In doing so consideration should be given to the following:

- Current controls
- The gaps in controls preventing the appetite score from being reached
- Any actions unable to be taken

Tolerance should be set to indicate a higher tolerance or lower tolerance to remaining above the risk appetite level as follows:-

- Tolerance (1) Higher - Acceptance of ongoing actions and limitations to reduce the level of risk to the target scores. The progress against risk appetite will be reviewed at least annually (at the annual Risk Workshop)

- Tolerance (2) Lower - Require actions to reduce/eliminate the risk more urgently. This will include a requirement that actions are taken to reach the appetite score by a date as specified by Trust Board.

The Corporate Risk summary report will indicate the level of tolerance against appetite and include what actions are required to manage the risk as a result of the tolerance level indicated.

Categories of Risk

Financial – Risks that may impact on income, expenditure, procurement, business continuity, value for money and protection of assets.

Quality of Care - Risks that may impact on the safety of patients (i.e. resulting in harm), effectiveness (e.g. clinical audit, outcomes, delays, cancellations, operational performance), experience for patients and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems).

Health & Safety – Risks related to the assessments of hazards under the associated Health and Safety Policy. Records of hazards and their assessment form a part of the day to day activities of the Trust and will be available to all staff members.

ICT & Physical infrastructure - Risks that may impact on IT security (e.g. access and permissions); controls of assets (e.g. purchasing, movement and disposal of equipment); business continuity (e.g. cyber-attack, network maintenance); data (e.g. integrity of data, availability, confidentiality); innovation infrastructure (maintenance and security); and systems and resources and their ability to support the Trust in pursuit of its objectives.

Resource & People – Risks that may impact on staff recruitment, staff in work, staff retention, security and welfare of people.

Regulation & Compliance - Risks that may impact on legal/regulatory requirements (e.g. Information Commissioner, CQC, Health & Safety (H&S), Professional Standards, external certifications); and national guidance and best practice (e.g. National Institute for health and Care Excellence).

Managers should consider the Trust's risk appetite by answering the following questions when developing Action Plans for new risks, or escalating existing risks to corporate level:

1. Does the proposed Action Plan actively manage this risk to ensure that the level of risk can be reduced to the target level?

2. Does the proposed Action Plan take account of any opportunities that could be exploited whilst managing this risk?

3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?

4. How will the proposed actions be monitored to ensure they are completed within identified timescales?

5. At what point should the decision regarding the management of this risk be escalated to a higher level?

The "new risk" form at Appendix 5 incorporates these questions.

10.0 BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) document is a HSC requirement. The BAF is more than a risk register. It is designed to provide evidence through the provision of assurance to the Board and the Board Committees in relation to achieving its vision and values providing a structure for the evidence to support the Annual Governance statement

within the Annual accounts. It seeks sources of assurance from within the governance framework. It also serves to inform the Board on corporate risks threatening the delivery of the objectives associated with the Trust strategic priorities. Thus providing a clear, concise structure for reporting key information to the Board. This provides assurance at all stages of the reporting process and allows for early identification of gaps in the process. Providing reliable assurance within these reporting arrangements will deliver confidence to the Board of Directors that the systems and processes supporting delivery of the Trust's objectives and management of risks are robust and the system of internal control is effective.

For Corporate Risks the BAF document sets out the strategic objectives, identifies risks in relation to each strategic objective and the controls to mitigate these risks. The list of the assurances on the effectiveness of these controls are also included. As such, gaps in controls and assurances can be identified and acted upon. The BAF document is then used as a tool for further discussion in relation to the levels of assurance received and required at the Trust Board and sub Committee Level. The role of the BAF is to provide evidence and structure to support effective management of risk within the organisation, to assist and support the Annual Governance Statement.

11.0 ASSURANCE

The Assurance Process is designed to provide evidence that HSC bodies are doing their reasonable best to manage key risk areas so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds.

The Trust Board can only properly fulfil its responsibilities when it has a full grasp of the principal (Corporate Risks) facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of reasonable rather than absolute assurance and is linked to the organisations appetite for risk.

The Board Assurance Framework is a record of the systematic process for achieving assurance and requires the Organisation to follow the 5 Steps to Risk Assurance.

The first step in preparing the assurance framework is for the Board to identify the Organisations Objectives. The next step involves the identification of principle (i.e. corporate) risks, which are defined as those that threaten the achievement of the Organisation's principal objectives. The third stage is for the organisation to ensure that there are key controls in place to manage the principal risks and these are documented on the Corporate Risk Register. It is also important to consider what the gaps in controls are and the action required to improve the controls. The fourth step is considering the evidence of assurance which will confirm the effectiveness of the key controls. This should also include a record of where there is a lack of assurance, either positive or negative, about the effectiveness of one or more of the key controls and note the actions required to obtain further evidence. The fifth and final step is the recorded Board Assurance Framework document (BAF) which is provided to the Board or its Committees to consider and assess how the Organisation is meeting objectives or mitigating risks.

The Department of Heath have determined that assurance will be provided using the following governance and accountability tools:
Board Governance Self-Assessment Tool
Assurance Framework
Management Statement/Financial Memorandum.

The Business Service Organisation's (BSO) Internal Audit Department and RQIA will provide the Western Trust with independent assurance against these requirements. Deficiencies identified will be reported to the Audit and Risk Assurance Committee and the relevant Governance Sub-committee, together with action plans aimed at addressing these. Progress against action plans will be reported to Governance Committee.

Assurance mapping

In facilitating assurance against Corporate Risks all corporate risks should have assurances aligned against the 3 lines of assurance model (see below) as applicable. Each assurance listed should be aligned to the controls they are providing assurance on. There should also be an assessment of control effectiveness (i.e. the outcome/conclusion of the assurance process).

Table 4: 3 Lines of Assurance Model

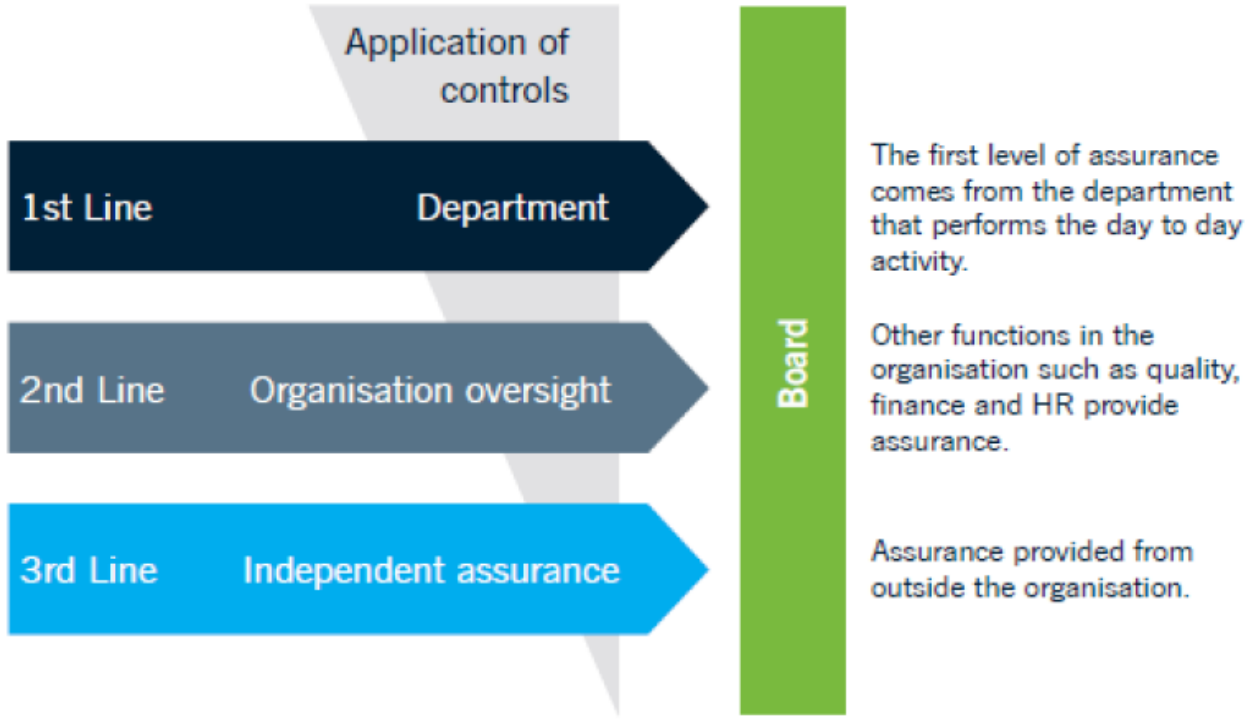


Illustration included in the NHS Board Assurance: A Toolkit for health sector organisations 2015.

12.0 GOVERNANCE STATEMENT

The assurance provided by the above arrangements enables the Chief Executive to sign the mid-year and end of year "Governance Statement" which confirms that the Trust has in place, and is constantly reviewing, a comprehensive risk management and control framework that is built on sound risk management practice. The Chief Internal Auditor also provides assurances to the Audit Committee and the Governance Committee that there is sufficient evidence to support statements on internal control and governance.

13.0 POLICY REVIEW

The Chairs of the Reporting Sub-committees will be required to assure the Governance Committee that the Policy remains relevant to the business of the organisation. The Policy will be reviewed every three years, or sooner if necessary.

14.0 OTHER ASSOCIATED POLICIES AND PROCEDURES

The following policies and procedures are relevant to the Risk Management Policy:

- Complaints - Complaints and Compliments Policy.pdf (n-i.nhs.uk)
- Claims Management Policy - Claims Management Policy 2017
- Control of Substances Hazardous to Health Policy
  COSHH Policy (n-i.nhs.uk)
- Emergency Planning Policy - Emergency Planning Policy (n-i.nhs.uk)
- Health and Safety Policy - Health and Safety Policy
- Adverse Incidents Policy - Adverse Incident Policy (n-i.nhs.uk)
- Manual Handling Policy - Moving & Handling Policy
- Manual Handling of the Bariatric Patient - Moving & Handling of the Bariatric Patient Policy
- Public Interest Disclosure ("Whistleblowing") Policy - Your right to raise a concern (Whistleblowing) Policy - (HR 18 002) 20 February 2020.pdf (n-i.nhs.uk)
- Zero Tolerance and Security Policy - Zero Tolerance and Security Policy
- The above list is not exhaustive.

15.0 EQUALITY & HUMAN RIGHTS STATEMENT

The Trust's equality and human rights statutory obligations have been considered during the development of this policy.

Signed: _____ (Chairman)

Date: _____ 20_____

	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				Appendix 1
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Appendix 2

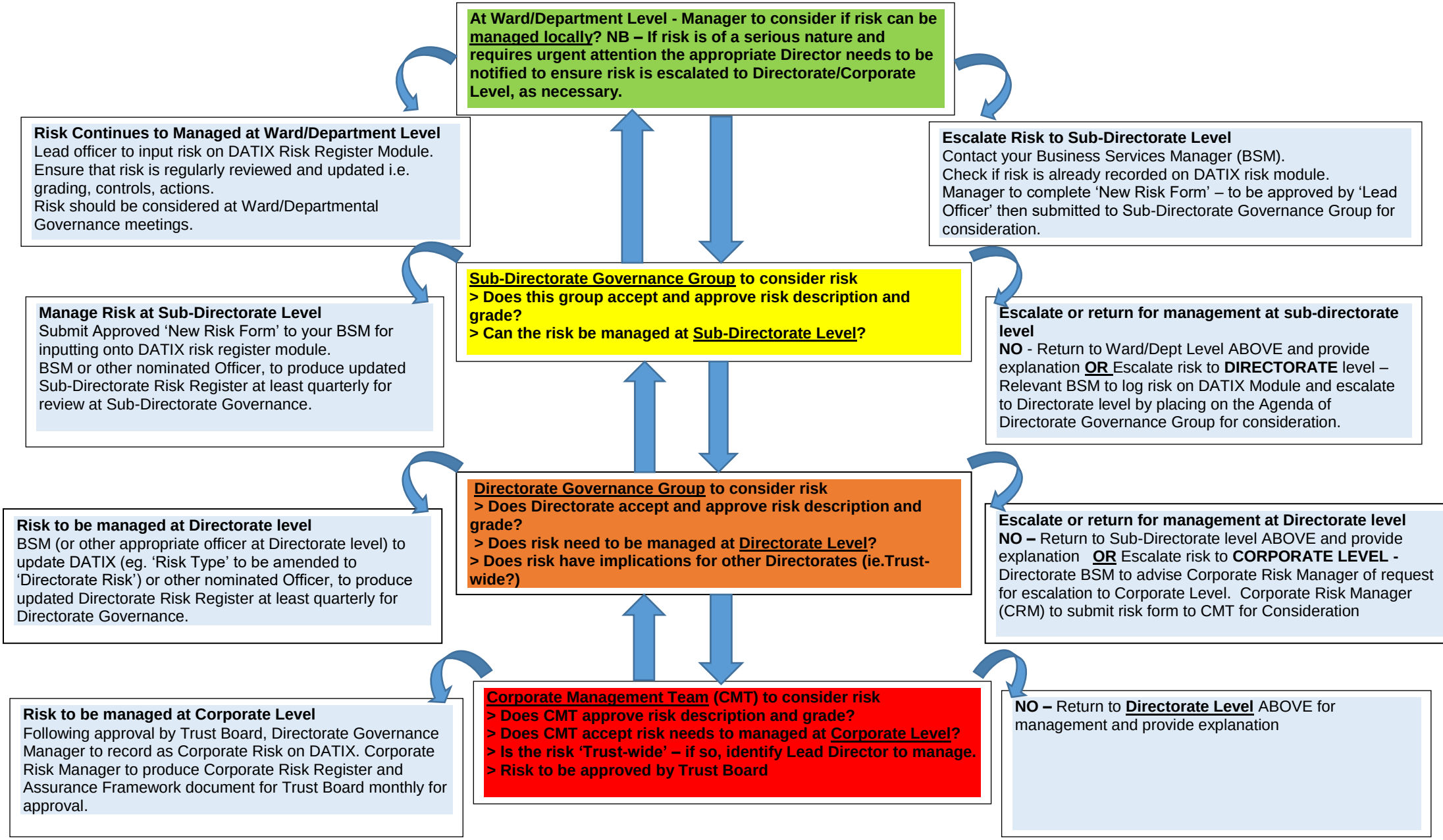
HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016 & August 2018)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Governance Process for Risk Management

Appendix 3



1. Log Risk on DATIX Web Risk Module

- Title
- Description (Cause, Event, Outcome)
- Grading
- Controls (at least key performance indicators to measure the effectiveness of controls)
- Gaps in Controls
- Assurance (3 lines of Assurance please see table 4)
- Gaps in Assurance
- Action Plan – to address to gaps
- Agree due dates for actions (regularly review dates)
- Communicate to all staff

2. Obtain Appropriate Approval

- **Ward/Department level Risk** – Risk submitted for approval at Ward/departmental governance forum.
- **Sub- directorate risk** – Risk submitted for approval at Sub-directorate governance forum
- **Directorate Risk** – Risk submitted for approval at Directorate Governance meeting
- **Corporate Risk** – Risk submitted for approval of escalation to Directorate Governance Meeting. If approved risk should be submitted to Corporate Risk Manager to submit for consideration at CMT. Following CMT the risk will be submitted for approval at Trust Board. If approved at Trust Board the risk will added to the Corporate Risk Register. All material changes to corporate risks must be approved by Trust Board (via CMT). Corporate Risk Register to be considered by CMT each month before submission to Trust Board for approval. Audit and Risk Assurance Committee will review risks quarterly. Governance Committee will be advised of any amendments.

3. Manage/Assess Risk

- Evaluate risk at least quarterly (Is the grading appropriate? Should the risk be escalated/de-escalated?).
- Provide updates on work ongoing to manage the risk (should be provided at least quarterly)
- Measure effectiveness of controls via key performance indicators and include in update
- Review the progress of actions and due dates
- Present updates at appropriate governance meeting

Appendix 5

New Risk Form

Please complete this form if you have identified a risk which needs to be considered for inclusion on the Trust's Risk Register database (Datix). Appendix 3 of the Trust's Risk Management Policy sets out the process that must be followed. The Policy is available on the intranet, web-link: New Risk Form (updated Jan 2021).dotx (n-i.nhs.uk)

The information requested below is required for completion of fields within Datix. Sections marked with an asterisk (*) are mandatory and must be completed. The completed form should then be considered at the appropriate Sub-Directorate/Divisional/Department Governance meeting.

No	Datix Field Name	Data to be included in this Field		
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**			
2.	**Facility** **(only necessary if risk relates to one specific facility)**			
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**			
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**			
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**			
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**			
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**		Corporate	
			Directorate	
			Sub- Directorate/Divisional	
			Ward Level	
8.	**Risk Category*** Please tick most appropriate category:	• Finance and Efficiency • Health and Safety • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation& Compliance (Statutory, Professional, Quality Legislation)		

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	Improving the Health of our People	
	C02	Supporting and Empowering Staff	
	C03	Ensuring the Stability of our Services	
	C04	Improving the Quality and Experience of Care	
10.	**Key Performance Indicators to show how the risk is being managed (Please list 3-4) *** **(e.g. number of incidents, compliance with H&S – number of Risk assessments returned etc)**		
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**		
12.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**		
13.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters and structure to include cause, event and effect		
14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)		
15.	**Please list all identified gaps in Controls.***	.	
16.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).		
17.	**Please list all identified gaps in Assurances.**		
18.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**		
	Impact/Consequence /Severity		**Likelihood**
	Insignificant/none		Rare
	Minor		Unlikely
	Moderate		Possible
	Major		Likely
	Catastrophic		Very Likely/ Almost Certain
19.	**Target/Acceptable level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).**		
	Impact/Consequence /Severity		**Likelihood**
	Insignificant/none		Rare
	Minor		Unlikely
	Moderate		Possible
	Major		Likely
	Catastrophic		Very Likely/ Almost Certain

NB: Datix will automatically calculate the level of risk (i.e. Red/Extreme, Amber/High, Yellow/Medium, Low/Green).

20. Action Plan to reduce Level of Risk

When developing an action plan to reduce the level of risk to the target level, Managers should take the Trust's Risk Appetite Statement into consideration, as set out in the Risk Management Policy, as follows:-

"The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits."

Managers must consider the following questions when developing an action plan to manage the identified risk:-

Question	Response
6. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	
7. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	
8. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	
9. How will the proposed actions be monitored to ensure they are completed within identified timescales?	
10. At what point should the decision regarding the management of this risk be escalated to a higher level?	

Please set out below the key actions that will be taken to reduce the level of risk (e.g. develop business case, service redesign, develop policy/procedures, provide training, recruitment of staff, etc):-

Action Required	Start Date	Due Date	Lead Officer

Once the new risk has been approved, these key actions should be recorded within the "Actions" section of Datix.
Once each action has been completed, the date of completion should be recorded.
Each completed action should then be listed within the "Controls" section of Datix.

If you require advice with regard to completion of this form, or on the use of Datix Risk Register module, please contact the Corporate Risk Manager on extension 214129.

Meeting where risk was approved: **Date of Meeting:**

For use by BSO/BSM only	**Risk ID No:** (automatically generated by Datix)