Royal Devon University Healthcare NHS Foundation Trust

Risk Management

Reference Number: RDF1493-23
Date of Response: 18/05/2023

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

1- Your organization's current risk management policy (or nearest equivalent, e.g., risk evaluation, risk reduction, risk assessment Policy, etc.)

2- The organization's current risk management procedures (or nearest equivalent, e.g., risk assessment procedures, risk evaluation procedures, risk control, etc.).

3- Risk Evaluation and Risk Control Guidance provided to employees (or any other related guidance that exists)

4- Any procedure or guidance or related document existing about how to decide if a risk needs to be reduced or not.

5- Any procedure or guidance or related document existing about how to evaluate if your organization is obliged by the regulations to reduce the identified risk to a lower level or not. In this case, if you use a specific tool like "cost-benefit analysis" or any other tools, it would be truly appreciated to provide those documents as well.

6- Any procedure, guidance, formula, guideline, instruction, direction, prescription, method, or process through which your organization decides if your organization is going to implement a measure to reduce risk, or, you will not implement more risk reduction measures; and in case of not implementing more risk reduction measure, how you justify that risks are reduced to a level As Low As Reasonably Practicable"

Please see attached Trust Risk Policy in answer to all the above questions.

Royal Devon University Healthcare NHS Foundation Trust

Risk Management Policy

Post holder responsible for Procedural Document	Chief Nursing Officer
Author of Policy/	Trust Risk Manager, Eastern Services
Division/ Department responsible for Procedural Document	Corporate Nursing
Contact details	
Date of original document	01.08.2019 NDHT 01.08.2011 RD&E
Impact Assessment performed	Yes
Ratifying body and date ratified	Safety & Risk Committee 07/12/2022
Review date	01/04/2025
Expiry date	01/10/2025
Date document becomes live	01/04/2023

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards – **Regulation 12: Safe Care and treatment** **Regulation 17: Good Governance**		Infection Control	
Other *(please specify)*:	**ISO 31000: Risk management** **Management of Health and Safety at Work Regulations 1999**		
Note: This document has been assessed for any equality, diversity or human rights implications			

		Status: Draft	
Version	Date	Author	Reason
V1.0	07/07/2022	Trust Risk Manager, Eastern Services	Merger of two existing Risk Management Policies for Northern and Eastern Services for the newly formed organisation on 01/04/2022
V1.1	23/09/2022	Trust Risk Manager, Eastern Services	Draft updated from items raised within consultation period
V1.2	13/10/2022	Trust Risk Manager, Eastern Services	Draft version updated following 1st review by Task and Finish group
V1.3	20/10/2022	Trust Risk Manager, Eastern Services	Draft version updated from 2nd Task and Finish group meeting
V1.4	02/03/2023	Trust Risk Manager, Eastern Services	Draft version updated from Safety and Risk Committee meeting
V1.5	11/05/2023	Trust Risk Manager, Eastern Services	Policy revised following April Safety and Risk Committee CRR discussions
V1.6	16/05/2023	Trust Risk Manager	Policy final Carolyn gave approval as vice chair of S&RC on 11/5/23

Associated Trust Policies/ Procedural documents:	Business Continuity Management Policy Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets Policy Control of Substances Hazardous to Health (COSHH) Policy and Spillage Procedure Datix Risk Register Module Standard Operating Procedure Display Screen Equipment (DSE) Policy and Procedure Emergency Preparedness, Resilience and Response Policy Health and Safety Policy Incident management Policy Introduction of New Clinical Procedures Policy Lone Working Policy Management of Organisational Change Policy Moving and Handling Policy and Procedure (including Bariatrics) National Best Practice Clinical Guidance Implementation Policy New and Expectant Mothers at Work Policy and Procedure Risk Assessment: Standard Operating Procedure Work at Heights Policy
Key Words	*Risk, Risk Assessment, Risk Management, Quality Impact Assessment, Risk Management Framework, Risk Appetite, Risk Tolerance*
In consultation with and date: • Chief Nursing Officer – 14.09.22 • Chief Medical Officer – 14.09.22 • Chief Operating Officer – 14.09.22 • Chief People Officer – 14.09.22	

- Chief Finance Officer – 14.09.22
- Risk Management Lead, Northern Services - 14.09.22
- Director of Governance and Assistant Director of Governance – 14.09.22
- Medical Directors, Directors of Nursing, Directors of Operations (Northern and Eastern Services) – 14.09.22
- Divisional Directors, Associate Medical Directors, Associate Directors of Nursing (Northern and Eastern Services) – 14.09.22
- Associate Directors for Patient Safety and Quality, Northern and Eastern Services – 14.09.22
- Divisional Governance Managers, Eastern Services – 14.09.22
- Head of Health and Safety – 14.09.22
- Chief Information Officer – 16.09.22
- *External* - Regional Counter Fraud specialist – 16.09.22
- Task and Finish group – Meeting 1 (Chief Nursing Officer, Director of Governance, Associate Directors of Safety and Quality (Northern and Eastern Services), Trust Risk Manager, Eastern Services – 13.10.22
- Task and Finish group – Meeting 2 (Chief Nursing Officer, Director of Governance, Associate Director of Safety and Quality (Northern Services), Trust Risk Manager, Eastern Services – 20.10.22

Contact for Review:	Trust Risk Managers, Northern and Eastern Services
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	Carolyn Mills, Chief Nursing Officer – 11.05.23

CONTENTS

KEY POINTS OF THIS POLICY:

The policy applies Trust-wide to all staff and students including contractors and agency staff.

Please refer to Section 2 for the key points of the Risk Management Policy.

1 INTRODUCTION

1.1 The Trust is faced with a number of factors that may impact upon its ability to meet its objectives. The effect of uncertainty on those objectives is known as risk.

1.2 Risk management can be defined as the identification, assessment, and prioritisation of risks, followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events – please refer to **figure 1**. Risks should also be reviewed at regular intervals to ensure they continue to be appropriately mitigated.

Figure 1: Risk Management

1.3 It is widely recognised that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces adverse outcomes, and can result in benefit from what is often referred to as the 'upside of risk'.

1.4 The Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 describes the Trust's responsibilities and the importance of assessing and managing risk in order to prevent people from receiving unsafe care or harm. Monitored by the Care Quality Commission (CQC), the Trust accepts its duties under Regulation 17: Good Governance and Regulation 12: Safe Care and Treatment, and the need to ensure risks to people are assessed and their safety monitored and managed so they are supported to stay safe.

1.5 Under the Management of Health and Safety at Work Regulations 1999, the Trust is duty bound to:

- Identify what could cause injury or illness in the Trust (hazards)

- Decide how likely it is that someone/something could be harmed and how seriously (the risk)
- Take action to eliminate the hazard or, if that isn't possible, control the risk (mitigation)

1.6 All staff have the right to work in a healthy and safe workplace, and the people using services are entitled to care and support that is safe and takes their needs, human rights and dignity into account.

1.7 The Health and Safety Executive (HSE) supports sensible risk assessment in care settings in recognition that managing these different needs can sometimes present unique and complex situations which can, if not effectively managed, result in serious harm to employees, people using care services, and others.

2 PURPOSE

2.1 The purpose of the policy is to define the framework and systems the Trust will use to identify, manage and eliminate or reduce to a reasonable level risks that threaten the Trust's ability to meet its objectives and achievement of its values.

2.2 This policy defines the Trust's approach to risk management which is to ensure that risks are added to an appropriate risk register (Departmental, Divisional, Corporate Risk Register) and managed by the most appropriate Committee/Group to monitor the delivery of actions to mitigate the risk down to the lowest level (target score). The Trust's Performance Assurance Framework (PAF) will be the gate keeper in directing risks to the most appropriate Committee/Group.

2.3 The policy sets out:

- The framework that supports the maintenance and development of a risk-aware culture where the right people do the right thing at the right time;
- The outline of the processes to be used for the management of all Trust risks;
- Definitions of risk types;
- Escalation processes to ensure oversight of risks from ward to the Board of Directors;
- The roles of all staff in relation to risk identification, management and review.

3 DEFINITIONS

3.1 **Assurance:** In governance terms provides certainty through evidence and brings confidence that systems are working. There is triangulated evidence that what needs to happen is actually happening. Observation of evidence in practice or review of reliable sources of information, which is often independent.

3.2 **Consequence:** The outcome or potential outcome of an event, sometimes referred to as 'impact' or 'severity'.

3.3 **Control:** A measure that is already in place to mitigate a risk.

3.4 **Datix:** The Trust's incident reporting and risk management system which is the electronic repository for recording and dynamically managing risks that have been escalated, approved at the relevant divisional and Trust risk governance framework

3.5 **Governance: "**A framework for assurance, decision-making, accountability, and optimal use of resources, which provides a safe and supportive environment for delivery of high-quality care to patients, service users, and citizens." (HQIP 2021)

3.6 **Hazard:** something with the potential to cause harm (e.g. bleach) or the potential for not meeting an objective (e.g. finance).

3.7 **Incidents/issues**: Things **that have happened**, were not planned and require management action, must be reported as appropriate and where required in line with the Incident Reporting Policy.

3.8 **Inherent risk:** is an assessed level of raw or untreated risk; that is, the natural level of risk inherent in a process or activity without doing anything to reduce the likelihood or mitigate the severity of a mishap, or the amount of risk before the application of the risk reduction effects of controls.

3.9 **Internal Controls:** Are Trust policies, procedures, practices, behaviour's or organisational structures to manage risks and achieve objectives.

3.10 **Likelihood:** The probability that the consequence will actually happen.

3.11 **Operational Risks:** Are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc.

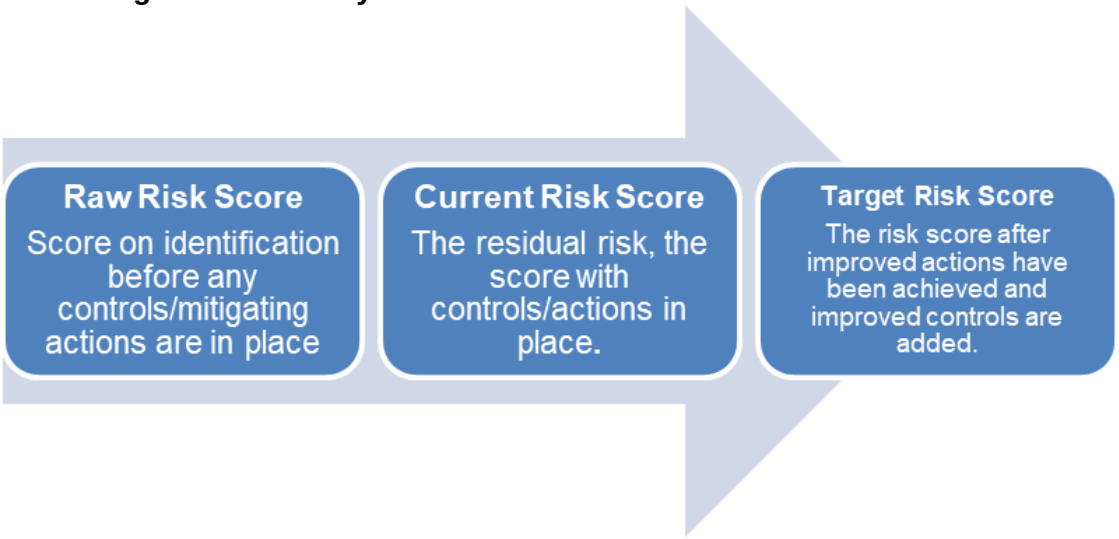
3.11.1 The Trust is obliged to have a formal fraud risk assessment completed in line with the "Government Counter Fraud Profession Fraud Risk Assessment Methodology" (GCFP). Notwithstanding this, the fraud risks identified must then be assessed and managed in accordance with the Trust's own risk management policy and processes. This may mean that the risks identified on the Trust's risk registers will be more generalised than set out GCFP version however, this better reflects the Trust's approach to risk management.

3.12 **Project Risks:** Are risks relating specifically to the delivery of a particular project. They should run alongside project 'issue' logs (issues being events that are currently occurring).

3.13 **Quality Impact Assessment (QIA):** Explores the effects a particular decision may have on quality (patient safety/patient experience and clinical effectiveness), both the positive and negative impacts in order to support decision making.

3.14 **Raw, Current, and Target Risk Scores:** A Risk Score (RS) is applied to the three elements of the risk assessment as demonstrated in **figure 2** below. The current risk score is key to determining how a live risk will be managed.

Figure 2: Summary of risk score vs. level of control



3.15 **Residual Risk:** the amount of risk that remains after all the risks have been mitigated to their lowest level.

3.16 **Risk and Effect:** the likelihood and consequence of harm that **might occur** or not achieving objectives. The consequence or 'how bad' the risk being assessed is must be measured. In this context, consequence is defined as: the outcome or the potential outcome of an event. It is important to note that there may be more than one consequence of a single event.

3.17 **Risk Appetite:** All risk is managed to "as low as reasonably practicable" (ALARP). However, ISO 31000 states risk appetite is the amount and type of risk that an organisation is prepared to seek, accept or tolerate in pursuit of its objectives.

3.18 **Risk Analysis:** the process to comprehend the nature of risk and to determine the level of risk. This is the part where an understanding of the risks is developed. Causes are examined, consequences defined and the likelihood of various scenarios considered, taking account of the effectiveness of any controls that are already in place. This is an important step in providing a basis for risk-informed decision making.

3.19 **Risk Assessor:** the individual or team that conducts the risk assessment.

3.20 **Risk Assessment:** the systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or consequence).

3.21 **Risk Grading Matrix:** the process of comparing the results of risk analysis with risk criteria to determine whether the risk and/or its magnitude are acceptable or tolerable. The risks that have been identified and analysed can now be compared with the risk criteria developed earlier, ideally in the design of the framework. With this as the basis, the organisation can make rational decisions as to the tolerability of the risks and the need for further risk treatment. Risks are scored using a risk scoring or grading matrix as part of this process. The grading matrix can be located in appendix 2.

3.22 **Risk identification:** the process of finding, recognising and describing risks, it is the part where the organisation's objectives should be considered in the light of any and all

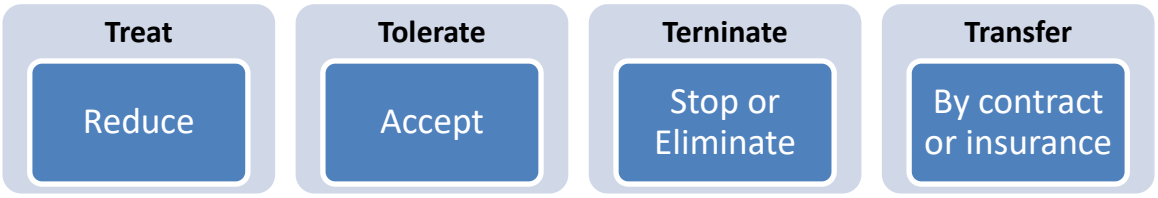
events or situations that could affect their achievement, whether positive or negative.

3.23 **Risk Owner:** the individual responsible for ensuring the risk is adequately managed/mitigating actions are completed within the stated timescales.

3.24 **Risk Tolerance (or capacity):** the boundaries of risk taking outside of which the organisation is not prepared to venture in pursuit of its objectives (directly relates to risk appetite)

3.25 **Risk treatment:** the options available to manage the risk, decision making of action plans to implementation of new controls

Figure 3: Risk Management Options



3.26 **Risk Registers:** the management tool for risk assessments and their associated actions within the Trust's. Risk Registers are available at different organisational levels across the Trust and are organised as shown in **figure 4**:

Figure 4: Organisation of the Risk Registers

Register	Current Risk Score	Level of Risk
Department	1-6	Low
Divisional	8-12	Medium
	15 -25 Linked to a corporate risk and/or the specific mitigations managed at Divisional level	High
Corporate	15 -25 Managed at a corporate/Executive Director level	High

3.27 **Strategic Risks:** are those that represent a threat to achieving the Trust's strategic objectives. These could include risks that are beyond the Trust's ability to completely control/mitigate e.g. national and system challenges. Strategic risks are held on the Board Assurance Framework (BAF) and are owned and managed by the Board of Directors.

3.28 **Strategic Objectives (Trust Strategy):** are set by the Board of Directors in the annual planning process, they specify the standards, outcomes, achievements and targets for various areas of the Trust's operations.

4 DUTIES AND RESPONSIBILITIES

4.1 Board of Directors

Executive and Non-Executive Directors have a collective responsibility as a Board of Directors to ensure that the risk management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's achieving its objectives.

The Board of Directors is responsible for annually reviewing and documenting their risk appetite in a Risk Appetite Statement which articulates the risks the Board is willing or unwilling to take in specific areas in order to achieve the Trust's strategic objectives. In setting out its appetite for risk within a Risk Appetite Statement, the Board of Directors defines its strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds.

The Board of Directors reviews the Board Assurance Framework quarterly alongside the update on performance against the Trusts Strategic objectives.

4.2 Executive Directors

Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in the Risk Management Policy and the Terms of Reference for the Safety and Risk Committee which is chaired by the Chief Executive Officer/Accountable Officer.

4.2.1 Chief Executive Officer (CEO)

The Chief Executive Officer as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business.

The CEO is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the Board of Directors acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

4.2.2 Chief Medical Officer

The Chief Medical Officer holds joint responsibility for clinical governance and patient safety with the Chief Nursing Officer. This includes; lead responsibility for clinical performance of the medical workforce: clinical audit: clinical effectiveness: medical innovation: research governance: medical education: mortality and information governance (SIRO – section 4.3).

The Chief Medical Officer also holds joint responsibility with the Chief Nursing Officer for the review and approval of all Quality Impact Assessments (QIAs) for the Trust according to the scheme of delegation and the QIA process; escalating to the Trust Delivery Group and Governance Committee any schemes brought to their attention which they have not supported and/or have been amended because of the identified actual/potential adverse quality impact.

4.2.3 Chief Nursing Officer

The Chief Nursing Officer holds joint responsibility for clinical governance and patient safety with the Chief Medical Officer. This includes: lead responsibility for the operational management and performance of the

nursing, midwifery and allied healthcare profession workforce: nursing practice and standards: risk management: the delivery of the Trust's patient safety and quality initiatives: patient safety incident management: patient experience: safeguarding and infection control.

The Chief Nursing Officer also holds joint responsibility with the Chief Medical Officer for the review and approval of all Quality Impact Assessments (QIAs) for the Trust according to the scheme of delegation and the QIA process; escalating to the Trust Delivery Group and Governance Committee any schemes brought to their attention which they have not supported and/or have been amended because of the identified actual/potential adverse quality impact.

4.2.4 **Chief Operating Officer**

The Chief Operating Officer is accountable for the overall management of operational risks and for the operational management of Divisional teams and EPPR.

4.2.5 **Chief People Officer**

The Chief People Officer has delegated responsibility from the Chief Executive Officer for the operationalisation of the Trust's Health and Safety Policy which includes the identification and control of health and safety risks under the Management of Health and Safety at Work Regulations 1999. The Chief People Officer is also responsible for the identification and control of risks related to people functions/workforce and non-medical education.

4.2.6 **Chief Finance Officer**

The Chief Finance Officer is responsible for the management of financial governance, including advising on financial/business risk, audit and assurance.

4.3 **Senior Information Risk Officer (SIRO)**

The SIRO is responsible for:

- Ensuring that identified information security risks are followed up and incidents managed;
- Ownership of the Information Risk Policy and associated risk management strategy and processes;
- Providing leadership and guidance to Trust information asset owners;
- Ownership of the risk assessment process for information and cyber security risk;
- Review of an annual information risk assessment to support and inform the Statement of Internal Control.

4.4 **Caldicott Guardian**

The Caldicott Guardian is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly and risks in relation to protecting the confidentiality of people's health and care information are managed in line with the Trust's risk management systems and processes.

4.5 **Trust Directors: Medical, Nursing, and Operations**

The Trust Directors are accountable for oversight and ensuring appropriate

management of risks on divisional risk registers/divisional risks that sit on the Corporate Risk Register; and receive risk exception reports from divisions at each Performance & Assurance Framework meeting.

The Trust Directors are responsible for:

- ensuring governance of the QIA approach and that QIA processes are in place and adhered to.
- ensuring that PID/QIA documents are completed for all relevant schemes and that the standard of completion is what they would expect of a robustly worked up scheme with an adequate risk assessment.

4.6 **Director of Governance**

The Director of Governance is responsible for:

- ensuring that the Board of Directors is cognisant of its duties, its governance; and for coordinating the annual cycle of Board of Directors business to ensure these duties are incorporated on the Board's agenda;
- the co-ordination of the Trust's Corporate Risk Register and The Trust's Board Assurance Framework; to ensure that the Board of Directors are sighted on the key risks facing the Trust's delivery of its strategic objectives;
- providing expert support and advice on the assessment of risks within the non-clinical divisions and others areas as required

4.7 **Risk Managers,**

The Risk Managers are responsible for:

- Developing, implementing and monitoring compliance with the risk management policy;
- Facilitating the development of a risk aware culture within the Trust;
- Compiling risk information and preparation of reports for the Trust Directors and Board of Directors;
- Responsibility for providing expert support and advice on the assessment of risks within the clinical divisions and others areas as required;
- Overseeing the monitoring of the clinical Divisional Risk Registers in partnership with divisional senior management teams.

4.8 **Head of Health and Safety**

The Head of Health and Safety is the legally competent person for health and safety in the Trust and is accountable to the Chief People Officer who has delegated responsibility from the Chief Executive for Health and Safety across the Trust. They are responsible for ensuring that the Trust complies with its legal duties relating to Health and Safety risk management.

The role of the competent person is to provide advice and guidance on Health and Safety law, processes, systems and procedures throughout the Trust.

The Head of Health and Safety is also responsible for the monitoring of the local Departmental Risk Registers via the schedule of Health and Safety Inspections.

4.9 **Divisional Directors, Associate Medical Directors and Associate Directors of Nursing**

The Divisional Directors, Associate Medical Directors and Associate Directors of Nursing are accountable to the Trust Directors and responsible for working

together to ensure that risk management is embedded within the divisions' processes, that the divisions' services operate within the law and escalate concerns/barriers as necessary.

They are responsible for the management of risks on the Divisional Risk Registers, managing risks through the divisional governance and business processes in accordance with this policy and supporting documents.

Divisional Directors will also present a quarterly overview of the risks contained within their divisions to the Safety and Risk Committee for scrutiny and assurances.

The Divisional Directors, Associate Medical Directors and Associate Directors of Nursing are responsible for ensuring governance of the QIA approach and QIA processes are in place and adhered to. They have responsibility to ensure that PID/QIA documents are completed for all relevant schemes and that the standard of completion is what they would expect of a robustly worked up scheme with an adequate risk assessment.

Divisions are required to report progress of mitigating actions in respect of their key risks in performance reviews with Executive/Trust directors, ensuring resource is allocated within their division to assess and manage their risks. Divisions are responsible for escalation of risks for the Corporate Risk Register to the Trust directors supporting the Divisions Senior Management teams to articulate the risk to the Safety and Risk Committee.

4.10 **Divisional Governance Managers (Eastern Services)**

Divisional Governance Managers are part of the Divisional Senior Management Team; responsible for ensuring compliance with risk management systems and processes, working with managers to ensure that a risk aware culture is embedded within their Divisional governance processes; that their Division's services operate within the law and escalating concerns / barriers with the relevant Trust expert for the subject matter.

4.11 **Divisional Governance Co-ordinators (Northern Services)**

Divisional Governance coordinators support Divisional teams to embed formalised governance processes and structures relating to risk management. In conjunction with the Risk Lead for Northern Services, they ensure the robust monitoring and timely review of risks at the divisional level. Divisional Governance Co-ordinators support divisional teams to follow appropriate processes when risks are identified. This includes supporting and advising on the completion of risk assessments.

4.12 **Risk Owners**

Each risk owner is responsible for ensuring: risk registers relating to their area of responsibility are managed in accordance with this policy and related procedures; risks are reviewed regularly, updated and progress added prior to governance groups or performance reviews or when there are any changes which impact on the risk; implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected.

4.13 **Managers**

Managers are responsible for:

- Ensuring all risks within their services are assessed in liaison with appropriate

subject matter experts. Any proposed changes or developments to any service should be subject to local risk management scrutiny.

- Ensuring that relevant staff are provided with suitable and sufficient information, instruction, training and / or guidance on risk management.
- Ensuring that their staff have visibility and ready access to all risk assessments relevant to their work activities. This will be achieved by a monthly listing of risk assessments held as live on the Department Risk Register being displayed on local comm cell boards or equivalent.
- Working with their staff and the above individuals to ensure that risk assessment is embedded within their services, that their services operate within the law and discussing concerns / barriers with the relevant Trust expert for the subject being assessed, escalating as necessary.
- Compliance with control measures should be monitored by Managers to ensure their effectiveness.
- Ensure that risk assessments of 8 - 12 are escalated to the Divisional Risk Register via the divisional governance processes.
- Monitoring to completion all actions in relation to risks

4.14 **Health and Safety Risk Assessors**

Health and Safety Risk Assessors are responsible for ensuring that all identified health and safety risks in their areas are appropriately risk assessed, that such risk assessments are reviewed according to an agreed timescale, that control measures are appropriately maintained

4.15 **All Staff (including Honorary Contract holders, locum, agency staff and contractors)**

Notwithstanding the identification of the above key personnel, the Trust recognises that organisational risk management is the responsibility of all members of staff. Every member of staff (including clinicians, temporary staff, contractors and volunteers) are responsible for ensuring that their own actions contribute to the wellbeing of patients, staff, visitors and the Trust.

4.15.1 All staff are required to attend and follow individual essential training requirements and not to use equipment, adopt practices or processes which deviate from mandatory or statutory requirements and procedures for the purposes of health and safety. They are expected to locate, observe and comply with all relevant policies and procedures that have been made available within the Trust.

4.15.2 All staff must contribute to the identification, management, reporting and assessment of risks and to take positive action to manage them appropriately. This is an essential part of managing risks locally and is a statutory requirement.

4.15.3 In addition, staff have a responsibility for taking steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Whistleblowing/How to Raise a Concern Policy.

4.15.4 Staff can access the complete up to date detail of all local risk assessments relating to their work activities by requesting a download from their line manager or in the event of a dispute their Divisional Governance Manager / Coordinator.

4.16 **Audit Committee**

The Audit Committee is a sub-committee of the Board of Directors. In the risk management capacity, its remit is to offer independent assurance to the Board of Directors that the actions detailed in this policy are adhered to and that the Trust has effective systems of internal control in relation to risk management and governance

4.17 **Governance Committee**

The Governance Committee is a sub-committee of the Board of Directors and is responsible for:

- Receiving assurance twice a year from the S&RC that it has received, reviewed and scrutinised the risks on the Corporate Risk Register;
- Receiving quarterly reports from the Trust Delivery Group on new and existing Trust wide schemes/projects that have been subject to a QIA, to ensure risk planning is robust and the impact on quality and performance is being regularly and thoroughly assessed with any potential negative impact mitigated;
- Signing off QIA's that have been reviewed by the Chief Medical Officer and Chief Nursing Officer according to the QIA process; and reviewing QIA's that have not been approved.

4.18 **Safety and Risk Committee**

The Safety and Risk Committee is responsible for:

- Oversight and governance of organisational risk at a divisional and Trust level;
- Scrutiny of all new risks scoring 15 or above on a case by case basis and approval on to either the Corporate Risk Register or the relevant Divisional Risk Register via the Trust Evaluating/Scoring Risk Matrix (Appendix 2). The following criteria will act as potential triggers for entry on to the Corporate Risk Register:
    - The mitigating actions are at corporate level (as opposed to site or divisional level) as outlined in **Figure 4**;
    - The risk/actions require Executive Director leadership as per **Figure 6**;
    - The risk is a Trust wide issue affecting both Eastern and Northern Services;
    - The risk relates to a statutory requirement
- Monitoring and maintaining an overview of all live risks on the Corporate Risk Register and scrutinising divisional risks through a quarterly report provided by Divisional Directors;
- Providing a summary report to the Governance Committee bimonthly.

4.19 **Trust wide Specialist Groups/Committees**

Trust wide Specialist Groups/Committees within the Trust's Governance Structure (Appendix 10) are responsible for providing oversight and scrutiny of risks related to their area of work.
For example:

- The People, Workforce Planning and Wellbeing Committee will review workforce risks;
- The Safeguarding Committee will review Safeguarding risks;
- The Infection Prevention and Decontamination Assurance Group will review infection control risks

4.20 **Trust Delivery Group**

Trust Delivery Group is responsible for ensuring overall governance of the QIA approach, aligned to operational planning processes, and that the QIA process is undertaken on all new and proposed CIP's, ICP's and investments; escalating any associated financial risks in accordance with this policy.

4.21 **Performance Assurance Framework (PAF)**

The Divisional Performance Review meetings are responsible for receiving an extract from the respective Division's Risk Register listing medium and high risks, and to understand newly identified risks within the Division. The Divisional Performance Review meeting will serve as a forum from which to direct the Division to engage and discuss newly identified and articulated risks with relevant committees and groups within the Trust's governance and performance system, prior to consideration of the risk as appropriate at the Safety & Risk Committee, and the risk's potential inclusion on the Corporate Risk Register.

The Divisional Performance Review meetings will be responsible for identifying and agreeing during the course of their discussions any newly identified risks for which preparation of a formal risk assessment by the Division is considered necessary, and to be briefed on any proposed revisions to scorings of risks held on the Corporate Risk Register.

4.22 **Divisional Governance Groups**

The Divisional Governance Groups (DGGs) are responsible for ensuring effective divisional governance and risk management systems and processes (including the maintenance of a Divisional Risk Register) are in place.

The DGGs review and monitor the Divisional Risk Registers to gain assurance that:

- Appropriate actions have been identified to integrate and control the risks identified.
- The risks are being regularly reviewed (in line with identified review frequency) and managed by the risk owner and relevant stakeholders.
- Any issues or exceptions have a planned response to manage them.
- Risks with a score of 15 or above are presented to the S&RC for consideration for inclusion onto the CRR or held on the Divisional Risk Register.

4.23 **Specialty/ Corporate Service Governance Groups**

The Specialty/ Corporate Service Governance Groups (SGGs) are responsible for managing risks held on the relevant Divisional Risks and Department Risk registers.

Similar to the DGGs, the SGGs will review relevant new or updated Divisional Risks and their Department Risk Register at a frequency identified in their Terms of Reference to gain assurance that:

- Appropriate actions have been identified to integrate and control the risks identified.
- The risks are being regularly reviewed (in line with identified frequency) and managed by the risk owner and relevant stakeholders.
- Any issues or exceptions have a planned response to manage them.
- The SGGs escalate to the relevant DGG any issue associated with the management of risks held on the Divisional and/or Department Risk Register.

5 RISK MANAGEMENT FRAMEWORK

5.1 Risk management is an integral part of good governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial.

Figure 5: Risk Management Framework

5.2 The management of risk underpins the achievement of the Trust's objectives. The Trust believes that effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in the business planning process where a more competitive and successful edge and public accountability in delivering health services is required. Risk management is the responsibility of all staff from 'Ward to Board'

5.3 Risk management is a fundamental part of both the operational and strategic thinking of every part of service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks. Risk management processes involve the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals to reduce the incidence and impact of the risks they face.

5.4 The Trust considers risk management to be an essential element of the entire management process and not a separate entity.

6 RISK MANAGEMENT PROCESS

6.1 Attributes of effective risk management

- **Proportionate -** The effort spent managing an individual risk should be proportionate to the level of risk faced.
- **Aligned -** The identification and assessment of risk should be in the context of, and aligned to, the achievement of the organisation's objectives.
- **Comprehensive -** The controls and actions put in place to manage risk need to be detailed and specific enough that they fully achieve the desired level of mitigation.

- **Embedded -** Risk management should be imbedded into normal working practices, this requires risk to be integrated into business and operational planning cycles.
- **Dynamic** - Risks can change so controls put in place need to be continually monitored to ensure they are up to date.

See appendix 1 for further detail regarding an overview of the Royal Devon Risk Assessment process.

6.2 **Establishing the context** - Risks have no relevance on their own – they only have meaning in relation to the objectives of the organisation and its stakeholders. Understanding the various environments in which the organisation functions is necessary in order to assess what risks there may be, as well as what effect they could have.

6.3 **Recording Risk -** Risks are recorded on Datix, the Trust's electronic Risk Management System, supporting risk action plans are completed as part of the risk report (appendix 5) presented to the relevant risk governance process for approval in line with this policy. The risk report and its content is uploaded to Datix once approved. The risk reporting process is demonstrated in appendix 3.

6.3.1 Risk associated with the care needs of an individual patient will be held as part of the electronic patient record.

6.3.2 All employee work activities must be risk assessed where reasonably practicable and meet legislative requirements. A list of tasks/activities which are covered by separate policies and procedures and have their own specific Health and Safety Risk Assessment can be found in the Health and Safety Policy.

6.4 **Monitor and review -** The process is continuous from re-establishing the context in line with service changes to regular re-assessment as actions plans are completed. The frequency of review should be proportionate to the level of risk and the volume and timeframe of the additional actions required. The desired review frequency of each risk is therefore identified by the risk assessment team/risk owner. A summary of each **formal review** is an important aspect of ensuring transparency of action being taken.

6.5 **Cross-divisional and Trust-wide risks-** To ensure appropriate oversight and scrutiny, all risks must reside on a risk register (Corporate/Divisional/Departmental). Divisional ownership of a risk will usually be dictated by the division to which the individual risk owner belongs. Where a risk is identified in a division that may also be a risk to another division, it is attendant on the owner of the risk to notify the other Division and/or escalate the risk if it meets the threshold for entry onto the Corporate Risk Register.

6.5.1 Datix permits a risk to be held on one risk register with multiple locations and/or services added to the risk. This allows multiple parties to have access, view and work in the risk.

6.6 **Linked Risks –** Datix permits risks to be linked to other risks held on different registers for example a risk held on the Corporate Risk Register maybe be linked to others held at a Divisional level. Risks can also be linked to relevant incidents and complaints, either manually or automatically via the Datix monitoring system.

6.7 **Closure of risks -** Where risks have been sufficiently mitigated and reached their target scores they may be closed through the relevant Committee. This could be due to the root cause being eliminated, or the controls being embedded into business as usual and forming part of the Trust's systems of internal control. Risks should follow the same process for approval to be closed as they do for escalation, and form part of the monthly risk exception report received by the divisional governance groups.

6.8 **Risk reporting arrangements**
Risk Registers are monitored and maintained according to the level of risk they hold – please refer to **Figure 6.**

Figure 6: Oversight and monitoring of the Risk Registers

6.9 **Operational Support**

In addition to the oversight and monitoring described in section 6; day to day operational support, advice and guidance is provide for each of the registers through a range of activities set out in appendix 6. These mechanisms support early detection of issues in achieving the risk action plan and support or prompt corrective intervention.

7 RISK APPETITE AND TOLERANCE

7.1 The terms risk appetite and risk tolerance are often used interchangeably. Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can actually cope with and thresholds at which it is willing to 'accept' a specific risk.

7.2 The Board of Directors defines the Trust's risk appetite and tolerance through the annual risk statement.

7.3 The Trust supports staff to manage risk at the lowest and most appropriate level in the organisation. Risks should only be escalated when action is required outside the control of the current owner. The Risk escalation and reporting process is demonstrated in appendix 4.

8 BOARD ASSURANCE FRAMEWORK (BAF)

8.1 The Board of Directors is responsible for the Board Assurance Framework (BAF) which sets out the risks which could prevent the Trust from achieving its strategic objectives. In addition to this the Board of Directors receive twice yearly assurance reports from the Governance Committee regarding the risks on the Corporate Risk Register.

8.2 Please refer to appendix 7 for further detail regarding core information included within the BAF.

9 QUALITY IMPACT ASSESSMENT (QIA)

9.1 The QIA process (appendix 8) supports quality governance through assessing the impact of the on new and proposed plans/investments/treatment pathways, cost improvement programmes (CIP's), and internal cost pressures (ICP's) processes on quality by: analysing the type of impact (both positive and negative); the likelihood of impact; the level of impact and the corresponding plans for managing any identified risks with the ultimate aim of enabling informed and appropriate decision-making on service changes.

9.2 Throughout the QIA process there are three key areas of quality indicators that need to be considered, although other indicators that may be relevant should also be considered. They are:

- Safety
- Clinical Effectiveness
- Patient Experience

9.3 The impact on equality and diversity also needs to be assessed during the QIA process via the quality impact assessment template (appendix 9) where as a result of the proposed change; people could be treated differently in terms of race, religion, disability, gender, sexual orientation, pregnancy, gender reassignment, civil partnerships or age. This supports the Trust in meeting its obligations under the Equality Act 2010 to undertake equality impact assessments.

9.4 Evidence to support these decisions should be clearly documented as per national guidance *(Monitor - Delivering sustainable cost improvement programmes – January 2012)*

9.5 Savings schemes - For each savings scheme in the CIP plan which meets the criteria set out within this process: **an inherent risk score over 12; a financial value over £100k or the removal of a post involved in direct patient contact, regardless of the financial value**, a project initiation document (PID) and/or just a QIA will be developed depending on the scheme. The PID/QIA sets out the benefits and objectives of the scheme, assesses the potential risks to quality from the scheme and sets out mitigation actions that will be put in place where their proposed change has the potential to affect one group less favourably than another on the basis of the 9 protected characteristics as defined in the Equality Act 2010. It should be noted that Commissioners and other external bodies may request to see PID/QIA documents.

9.5.1 All costing and savings need to be calculated and agreed before the scheme

matures & progresses beyond divisional governance. Costings on PID/QIA must match those presented on the Divisional CIP template.

9.5.2 It is acceptable to produce one PID/QIA to cover a number of schemes if these schemes are similar in nature as long as it is clearly stated on the PID/QIA which schemes are covered.

9.5.3 For schemes originated within Trust wide workstreams, a PID/QIA must still be developed, unless the scheme is covered by the exceptions as detailed in appendix 8. Where a PID/QIA is required it will be jointly developed by workstream & relevant divisional/corporate teams. Approval of the PID/QIA is via the same route as set out for Division initiated scheme

9.6 **Investment proposals -** The purpose of completing a QIA to support investment proposals is to ensure that for each of the proposals where the decision is made not to invest and consequently not to proceed, there is a clear risk assessment of the impact, including oversight of how any associated risk is mitigated and monitored.

9.6.1 For each investment proposal, the QIA sets out detail pertaining to the investment proposal and assesses the potential risks associated with a decision not to invest or not to proceed with this investment proposal. It also includes the mitigating actions that are in place or will be put in place to manage the risk within the Trust/division and the process for ongoing review of the management of any outlined risk, with divisional or Board oversight depending on the level of risk assessed.

9.6.2 QIAs are completed at the same time bids for investment proposals are submitted, which means QIAs are available for proposals where investment was approved and where it was not approved. These are subject to executive review through the annual operating planning process or outside of these timescales as required.

9.6.3 No Investment will be approved without evidence of a completed QIA.

10 INCIDENT INVESTIGATION

10.1 The introduction of the statutory requirement to develop an annual Patient Safety Incident Response Plan (PSIRP) requires greater interface between risk and incidents. Within the planning process incident data will inform identification of principle risks; and the insight from our risks will support identifying priorities for Patient Safety Investigation. Incident investigation will remain in line with the current Trust-wide processes; subject to any changes required as a result of the implementation of the Patient Safety Incident Response Framework (PSIRF).

11 TRAINING

11.1 The delivery of effective training is crucial to the success of the risk management agenda. There are differing levels of safeguarding training dependent on roles and responsibilities:

11.1.1 **Health and Safety Risk Assessor Training**
Prepare staff to be able to undertake the role of Health and Safety risk assessor on behalf of the Trust.
Provide staff with suitable and sufficient information and training to be able to complete risk

assessment forms for a variety of activities.

11.1.2 **Risk Management Level 1**
Outline roles and responsibilities with the identification, management, reporting and assessment of risks

11.1.3 **Risk Management Level 2**
Examine the basics of risk management architecture, strategy and protocols.
Outline the roles and responsibilities in risk management

11.1.4 **Board Risk Management Induction**
Inform new board members of the Trusts Governance Performance System, and its associated policies and procedures
Explanation of the fundamentals of the Corporate Risk Register (CRR), its structure and reporting
Overview of the BAF, its purpose, structure and function.

12 ARCHIVING ARRANGEMENTS

12.1 The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

13 PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY/ STRATEGY

13.1 To evidence compliance with this policy, the following elements will be monitored:

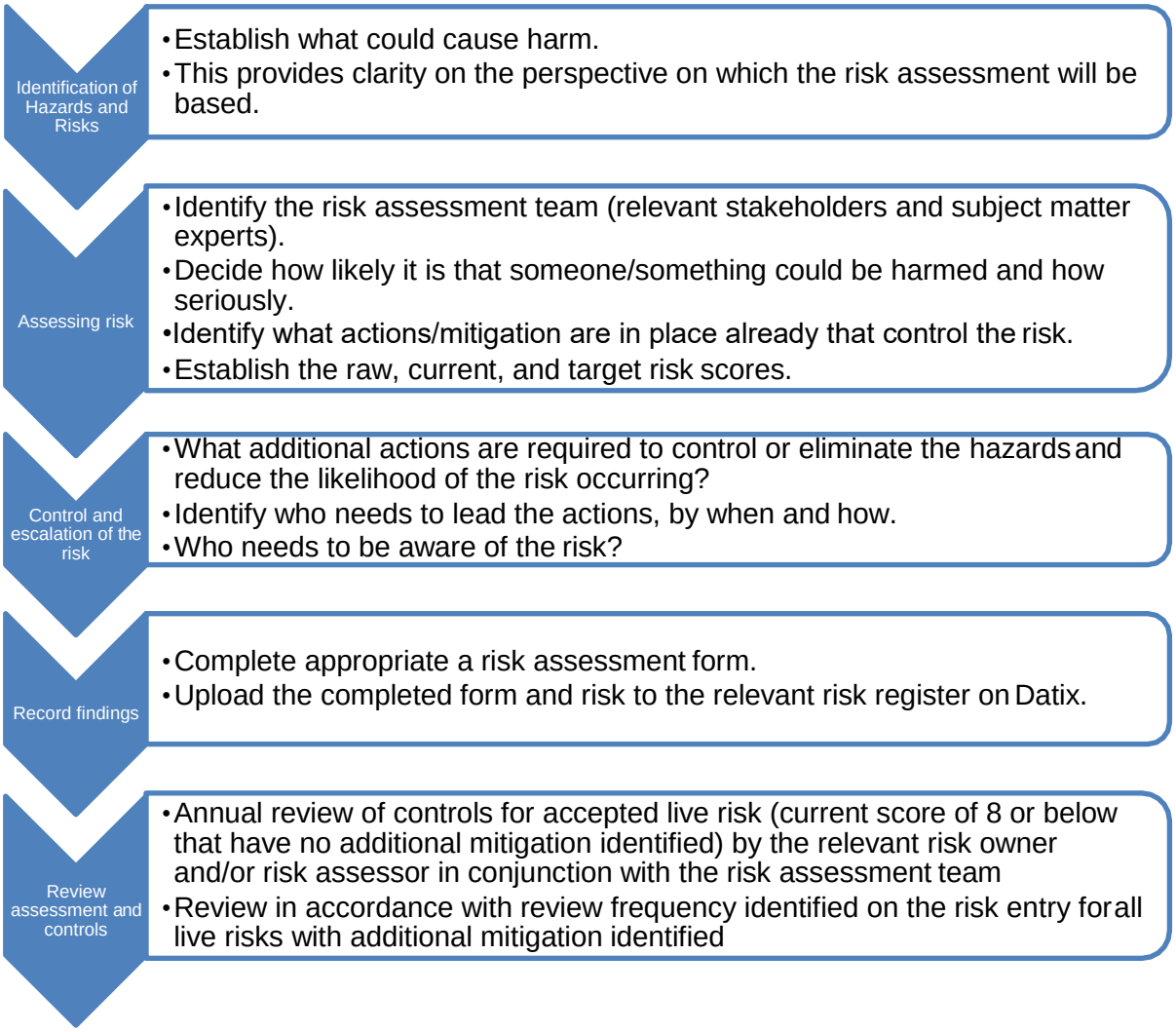
What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Risks are being effectively managed at each level of risk register	The Governance Committee will receive a summary of all risks on the Corporate Risk Register. The efficacy of the risks held on the Divisional risk registers will form part of the annual internal audit process.	The Director of Governance/ Assistant Director of Governance will report to the Governance Committee on a frequency determined by the GC. The internal audit report will be presented to the Governance Committee.
The Health and Safety risks are suitable and sufficient for their related work activities	Health and Safety inspections undertaken with support from Staffside Health and Safety Representatives	Head of Health and Safety will provide a report of Health and Safety inspections which will include the monitoring of Health and Safety risks to the Health and Safety group which meets 10 times per year and escalates any issues to the Safety and Risk Committee

Fire Risk Assessments (FRA) meet the main statutory requirements of the Fire Safety Order	Fire Safety Officers	The Fire Safety officers provide a quarterly report to the Fire Safety group which includes the monitoring of FRA and escalates any issues to the Safety and Risk Committee via the Health and Safety Group.

14 REFERENCES

14.1.1 HQIP Good Governance Handbook
14.1.2 Good Governance Institute : What Good Governance Looks Like
14.1.3 Risk-Appetite-for-NHS-Organisations.pdf (good-governance.org.uk)
14.1.4 ISO31000: Risk Management
14.1.5 Risk framework - NHS Digital
14.1.6 NHS England » An operational risk management strategy for trusts
14.1.7 Risk management - NHS Resolution
14.1.8 NHS England » Well-led framework
14.1.9 CQC Well Led KLOES
14.1.10 GGI-Board-Guidance-on-risk-appetite-2020
14.1.11 Good Practice Quality Impact Assessment – NHS Providers

APPENDIX 1: OVERVIEW OF THE RISK ASSESSMENT PROCESS



APPENDIX 2: EVALUATING/SCORING RISK MATRIX

Risks are scored using a risk scoring or grading matrix. The Trust has adopted a 5x5 matrix with the risk scores taking account of the Impact and likelihood of a risk occurring. The scoring of risk is a 3-step process.

Step 1 – Evaluating the impact or of a risk occurring if no plans exist to control, mitigate or reduce the impact of a risk occurring. The impact (consequence) score has five descriptors or severity levels. The examples given in table 1 are not exhaustive, and consequences should reflect the nature, needs, and activity being assessed.

Table 1: Consequence (C) Score and severity level

Domains	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
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 y Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff 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 breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in stat. duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims (based on total Trust budget)	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	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
Information Governance	No personal data lost	Limited demographic data Less than 10 people	Celebrity /VIP involved. Basic demographic data Limited clinical information 10-50 people	Sensitive personal data, high level of stress / financial loss, 51 – 100 people	Highly sensitive personal data, multiple occurrences of loss, 100 + people

Step 2 – Evaluating the likelihood (how often) (table 2 below) a risk may occur before and once plans and controls to mitigate (reduce/remove) a risk have been put in place. The table below gives the descriptions of the likelihood of a risk occurring.

Frequency (how many times will the adverse consequence being assessed actually be realised?)
or
Probability (what is the chance the adverse consequence will occur in a given reference period?).

Frequency is not always the best way to score certain risks, especially those associated with the success of time-limited or one-off projects such as a new IT system that is being delivered as part of a three-year programme or business objectives.

For these kinds of risks, the likelihood score cannot be based on how often the consequence will materialise. Instead, it must be based on the probability that it will occur at all in a given time period. In other words, a three-year IT project cannot be expected to fail 'once a month', and the likelihood score will need to be assessed on the probability of adverse consequences occurring within the project's time frame.
With regard to achieving a national target, the risk of missing the target will be based on the time left during which the target is measured. A Trust might have assessed the probability of missing a key target as being quite high at the beginning of the year, but nine months later, if all the control measures have been effective, there is a much-reduced probability of the target not being met.

This is why specific 'probability' scores were developed for projects and business objectives. Likelihood scores based on probability have been developed from project risk assessment tools from across industry. The vast majority of these agree that any project which is more likely to fail than succeed (that is, the chance of failing is greater than 50 per cent) should be assigned a score of 5.

Table 2: Likelihood (L) scores (broad, time-framed and probability descriptors of frequency)

Descriptor	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
Frequency How often might it/does it happen	This will probably never happen/recur **(< once per year)**	Do not expect it to happen/ recur but it is possible it may do so **(one per year)**	Might happen or recur occasionally **(Monthly)**	Will probably happen/recur but it is not a persisting issue **(Weekly)**	Will undoubtedly happen/recur, possibly frequently **(Daily)**
Probability >50 per cent Will it happen or not?	<0.1 per cent 0.1–1 per cent	<0.1 per cent 0.1–1 per cent	1–10 per cent 10–50 per cent	1–10 per cent 10–50 per cent	>50 per cent

Step 3 – Use table 3 to calculate the risk score. You must then multiply the consequence score with the likelihood score.

CONSEQUENCE score x LIKELIHOOD score = RISK score

Table 3: Risk scoring (RS) = consequence x likelihood (C x L)

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

By multiplying the Consequence and Likelihood scores together a total risk score will be created. The score will then determine the level of risk.

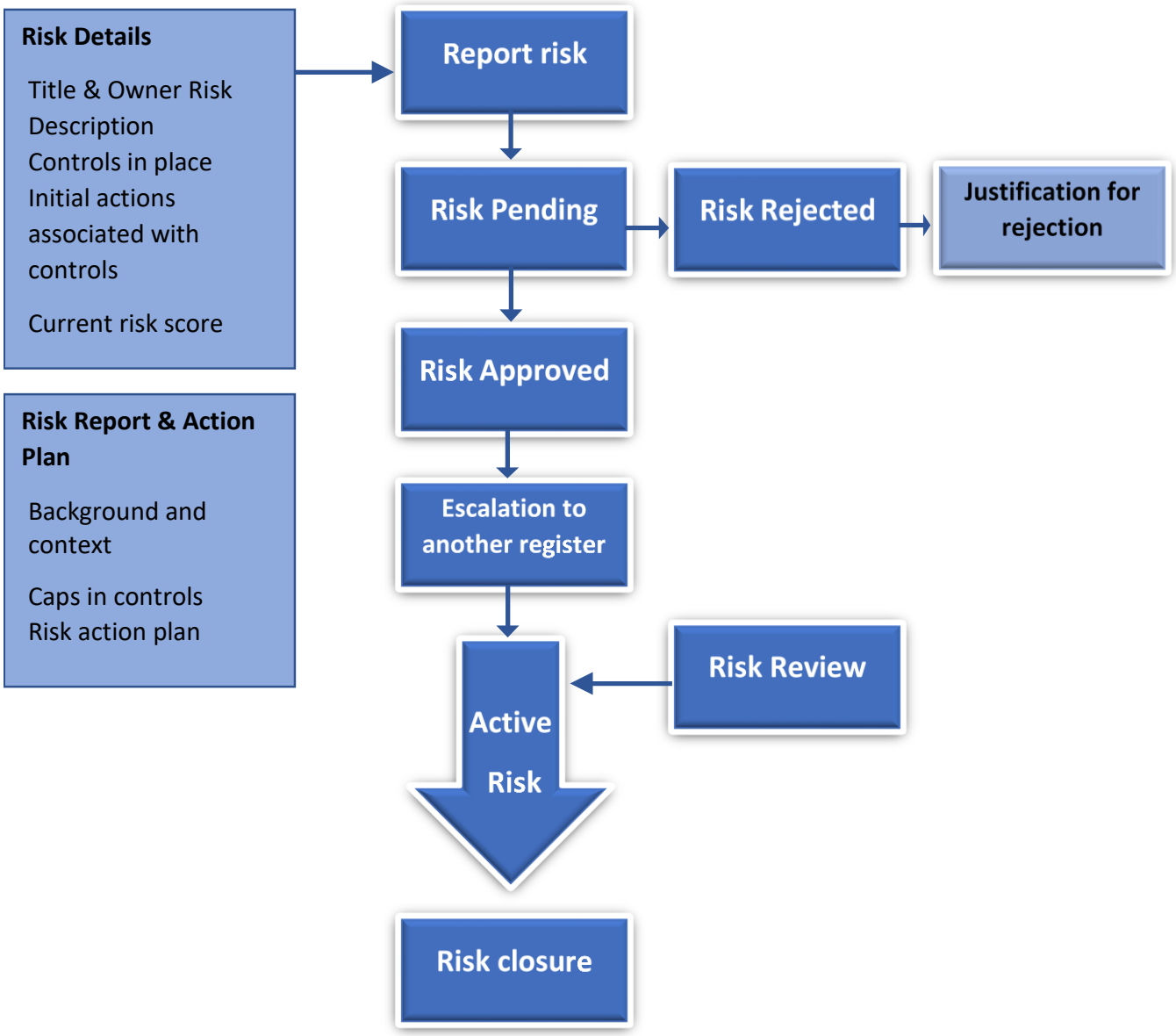
Fire Risk Assessment (FRA)
When completing an FRA, look at the likelihood of fire occurring x consequence scored **as if a fire did occur**, as the severity therefore may be high but the likelihood is low.

Deliberate fires also have to be addressed. Therefore, there may be a point where the likelihood is reduced to ALARP, but the severity still scores high due to the possible outcome. For example, a deliberately set fire in a plastic wheelie bin in the hospital street scores 12 on the Trust risk scoring (Table 3), but on the FRA scores 2 for the likelihood and 5 for the severity, giving it a score of 10 on the fire risk value matrix (Table 4).

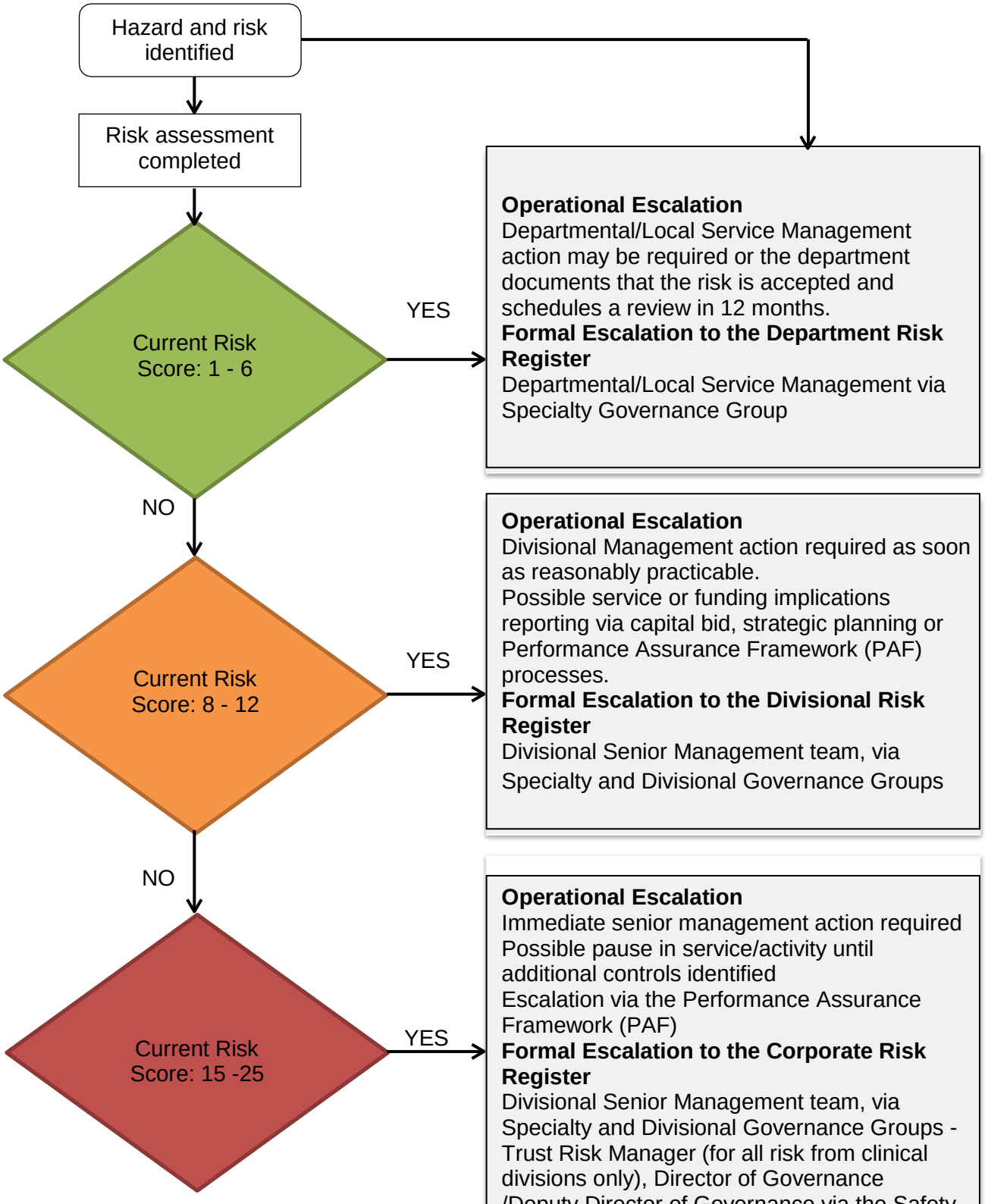
Table 4: Fire Risk Value Matrix

Likelihood (L)	Value	Severity of Outcome(s)
Negligible	1	Negligible
Low	2	Slight damage to property Minor injury to occupants, first aid required
Moderate	3	Moderate damage to property Partial evacuation required Injury to occupants, medical attention required
High	4	Large scale damage to property Complete evacuation required Occupants require hospitalisation
Extreme	5	Major loss of property Major loss of life

APPENDIX 3: REPORTING AND RECORDING RISK



APPENDIX 4: ESCALATION OF RISK



APPENDIX 5: RISK REPORT AND ACTION PLAN

<Title of Risk>Risk Report

Date: <Date of meeting>

Presented to: <Meeting/group/committee>

Prepared by: <Name, title>

Presented by: <Name, title>

1. RISK STATEMENT

1.1 Because of……There is a risk that …….., which will result in…….

2. BACKGROUND AND CONTEXT

2.1 A brief summary of why the risk a is required and the detail behind it. This section should be clear to those that do not work in the environment, for example, with no jargon or abbreviations

3. GAPS IN CONTROLS

3.1 Summary of further controls that need to be implemented

Royal Devon University Healthcare NHS Foundation Trust

RISK ACTION PLAN

Risk Owner responsible for Action Plan:					
Current Risk Score	**Consequence <xx>**	**Likelihood <xx>**	**Risk Score <xx>**	**Highest Risk Domain**	**<xxxxx>**
Target Risk Score	**Consequence <xx>**	**Likelihood <xx>**	**Risk Score <xx>**	**Risk ID**	**<xxxxx>**

Item	**Recommendations** Proposal of course of action required to remove the gap in control	**Action Required** Description of action required to achieve the control	**Lead Responsible for completing action**	**Date to be completed**	**Assurance** What evidence will bring confidence that the action is being achieved
1					
2					
3					
4					
5					
6					

APPENDIX 6: OPERATIONAL SUPPORT

Risk registers - Operational Support

Corporate Risk Register	Divisional Risk Register	Department Risk Register
• Corporate Risk Surgeries	• Divisional Governance Comm Cells • Management meetings • Stakeholder meetings • Speciality/Local Service Risk Surgeries • Divisional Risk Surgeries	• Department/Local Comm Cells • Team meetings • Local service meetings • Health and Safety Team inspections

Risk Surgeries

Risk surgeries have an important role in supporting the maintenance of risk registers to ensure that they accurately reflect the nature of the risk held at each level and the actions being taken to mitigate it. Figure 13 reflects the nature of each of the risk surgeries held.

Surgery Type		Attended by	Function
Corporate (Every 2 months)		Director of Governance / Deputy Director of Governance Risk Owner	• Review of risks on the CRR ensuring that appropriate actions are in place to manage and mitigate the risk, review score and escalate any changes in the risk to the S&RC.

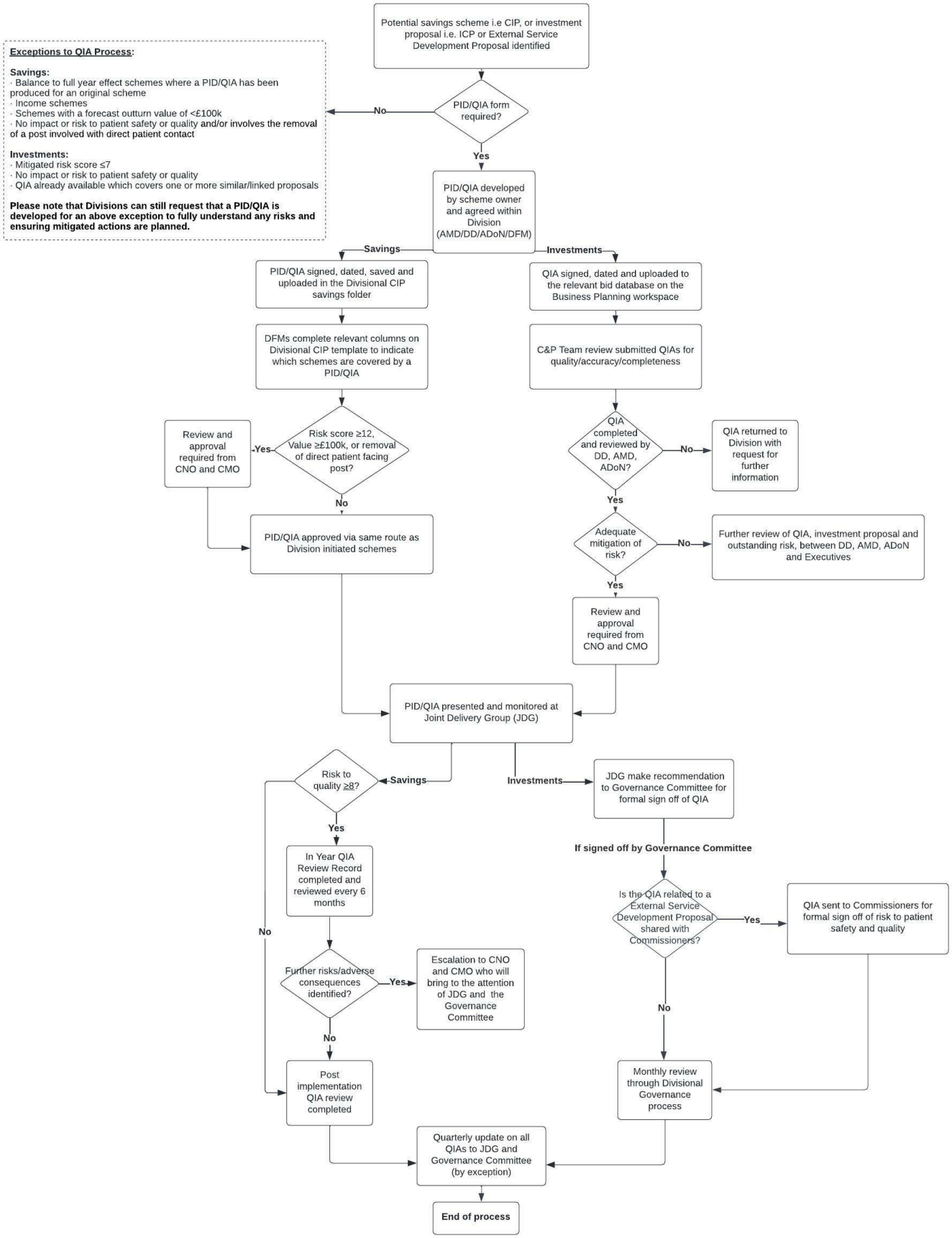
Divisional (Every 2 months)		Clinical Divisions: Trust Risk Manager Clinical Divisional Governance Manager Corporate Divisions: Director/Deputy Director of Governance Corporate Divisional Governance Manager Risk Owner and/or Divisional management lead	• Review risks being developed or newly entered to the Divisional Risk Register • Review and advise on long standing risks or issues identified by the Governance Manager or management team • Support the development of risk to be escalation to the Corporate Risk Register
Specialty/Local Service (Every 2 months)		Divisional Governance Manager Risk Owner	• Support the development of risk for escalation to the Department/Divisional Risk Register • Support the Risk Owner with the review of risk and updates on Datix • Escalate issues to the Divisional governance comm cell

APPENDIX 7: CORE INFORMATION CONTAINED IN THE BAF

Element	Explanation
Strategic objectives	The Board requires assurance that: risks to the fulfilment of its strategic objectives are under control; fundamental standards of care are in place; the necessary resources (workforce, physical resources and finance) and relationships are being maintained; and that licence and regulatory obligations are complied with. The Board is expected to make a number of assurance statements to accompany plans and reports, and at other times during the year, which focus on these critical operational impacts.
Principal risks	These are the major risks which arise by virtue of the Trust undertaking the particular activity associated with delivery of its strategic objectives, and which must be managed in order to achieve that objective. They are inherent risks and are considered before making any judgment on the strength of the mitigations ('controls') in place. The purpose of the BAF is to understand the controls in place to mitigate such risks, to plan the gathering of evidence as to the quality of those controls, to evaluate the results and act on any weaknesses in controls identified. It is not to manage live risks, which is undertaken through corporate and divisional risk registers.
Controls	These are the policies, procedures and activities undertaken to reduce the likelihood of inherent risks arising, or for early detection and action should they do so. Controls can be: • Directive – setting a framework within which the activities can take place (e.g. a policy) • Preventive – helping to prevent risks from arising (e.g. scrutiny and authorisation of transactions before committing to them) • Detective – controls designed to identify if errors are occurring and to trigger action (e.g. monitoring checks) • Contingency plans – controls which allow an organisation to respond effectively to risks arising and manage their impact.
Sources of assurance	These are the activities which are undertaken to provide evidence as to the strength or quality of controls. Some of these will be led by management, including self-assessment and monitoring checks; others will be undertaken by semi-independent monitoring functions. Others will be fully independent; for example, internal audits. Metrics are a further source of assurance, particularly where they are objectively verifiable and derived from systematic data collection rather than based on self-assessment. It is important to consider the frequency, independence, remit and evidence-base when evaluating whether there are sufficient sources of assurance available to provide robust and timely evidence as to the health of controls.

Gaps in controls	The results of assurance checks may identify that controls in place are not operating as laid down, or are not covering all elements of the risks which they are designed to address. Such gaps can also come to light as a result of live risks captured to the risk register or from management self-evaluation. Any such gaps, or weaknesses, in controls are captured and should have a corresponding action in the Risk Mitigation Plan.
Gaps in assurance	When capturing sources of assurance, and through ongoing evaluation, it may become apparent that there are no, insufficient, or untimely activities planned to obtain evidence on the health of specific controls. Again, such gaps need to be captured and should result in a corresponding action in the Risk Mitigation Plan.
Assurance outcomes	The results of assurance checks and key metrics. Adverse outcomes point to gaps in controls and gaps in assurance and should result in corresponding actions in the Risk Mitigation Plan.
Risk Mitigation Plan	This should capture, at a high-level, the actions being taken to address any gaps in controls or assurance.

APPENDIX 8: QUALITY IMPACT ASSESSMENT PROCESS



APPENDIX 9: QUALITY IMPACT ASSESSMENT TEMPLATE

Part A: Quality Impact Assessment Details

This tool provides a template for carrying out a quality impact assessment on a new or existing project, programme, savings scheme. It is intended to support quality governance by assessing the impact of Savings schemes and service change on quality. It is also intended to support the Trust in meeting its obligations under the Equality Act (2010), to undertake race, disability and gender impact assessments.	Scheme / project / programme title	Title		
	Project Director/Sponsor	Name		
	Author	Name		
	Date completed	Date	Version	
Approvals	Clinical Director approval	Name	Date	
	Chief Nursing Officer approval **Required for medium/high rated QIA only*	Name	Date	
	Chief Medical Officer approval **Required for medium/high rated QIA only*	Name	Date	

Summary of Scheme / project / programme	Insert summary details of scheme, project or programme

Part B: Quality Impact Assessment

		Current Risk			**Risk mitigation and monitoring arrangements**	**Residual Risk**			**Quality Metrics**
Impact Area	**Summary of impact**	Impact	Likelihood	Risk score		Impact	Likelihood	Risk score	
Patient safety				0				0	
Clinical Effectiveness				0				0	
Service user experience				0				0	

Equality and Diversity				0				0	
Non Clinical/ Operational Impact				0				0	
Summary Rating	Highest rating = summary score			0				0	

If Current Summary rating is 9 (medium) or higher for any impact area, Part C must be completed

Part C: Risk Assessment Screening

Is the Scheme / project / programme identified as mitigation to an existing risk held on a risk register?	**YES**	Complete the risk details in the table below to complete this form. You do not need to complete Part D
	NO	Go to Part D to complete this form.

Risk Details

Risk ID	Risk Title	Risk Register	Date Risk Opened	Action ID
		Cor/Div/Dept	Xx/xx/xxxx	

Part D: Full Quality Impact Assessment

Quality areas	Positive Impact	Negative impact	Current Risk			Risk mitigation and monitoring arrangements	Residual Risk			Quality Metrics
			Impact	**Likelihood**	**Risk score**		**Impact**	**Likelihood**	**Risk score**	
Patient Safety										
Overall Impact Summary score (highest)					0				0	
Impact on serious incidents, their reporting and learning					0				0	
Impact on violence and aggression experienced by service users and staff					0				0	
Impact on effective use of risk assessment in clinical practice					0				0	
Impact on safeguarding vulnerable adults and children					0				0	
Please add more areas as applicable					0				0	

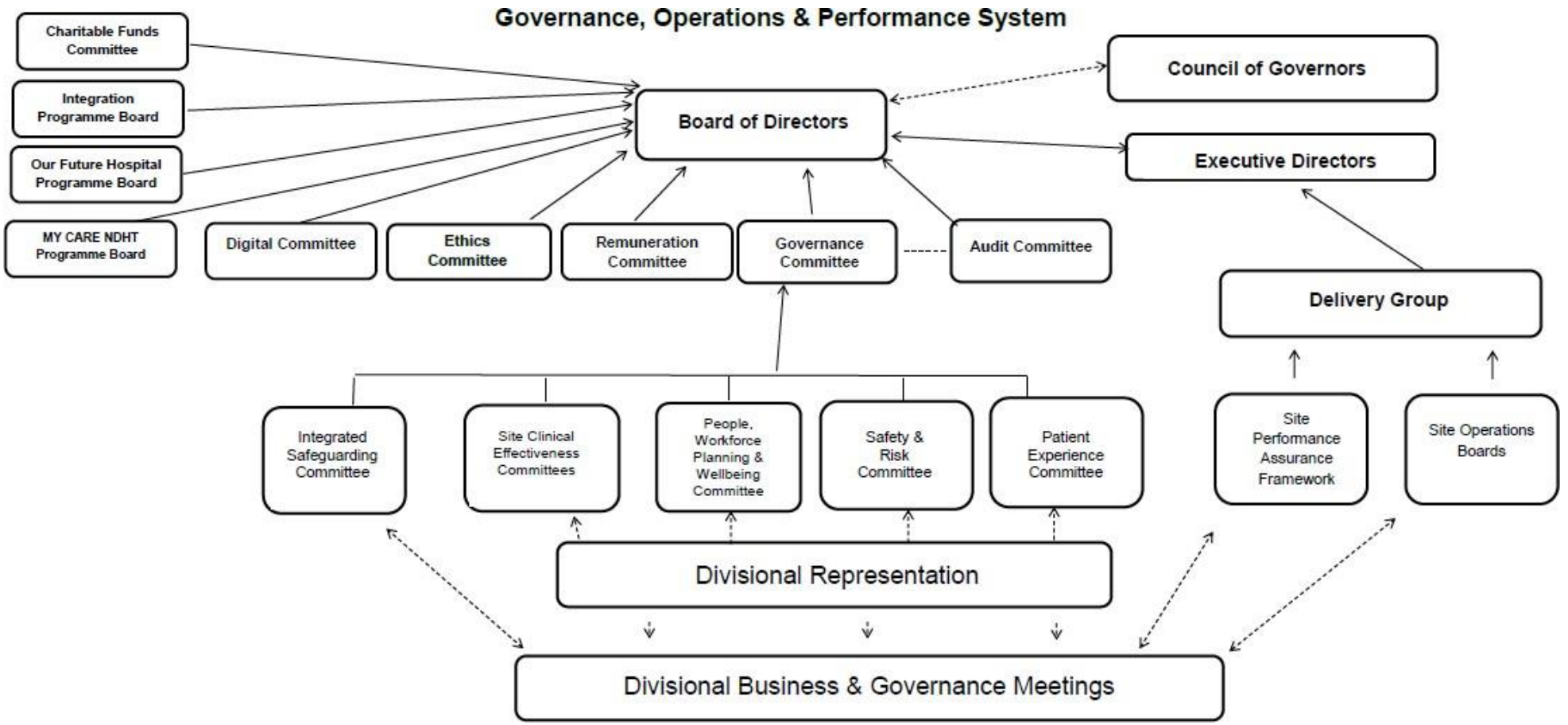
Quality areas	Positive Impact	Negative impact	Current Risk			Risk mitigation and monitoring arrangements	Residual Risk			Quality Metrics
			Impact	**Likelihood**	**Risk score**		**Impact**	**Likelihood**	**Risk score**	
Clinical Effectiveness										
Overall Impact Summary score (highest)					0				0	
Impact on readmission					0				0	
Impact on access to crisis and home treatment					0				0	
Impact on provision of NICE compliant treatment					0				0	
Impact on effectiveness of support in the community					0				0	
Impact on carers					0				0	
Please add more areas as applicable					0				0	

Quality areas	Positive Impact	Negative impact	Current Risk			Risk mitigation and monitoring arrangements	Residual Risk			Quality Metrics
			Impact	Likelihood	Risk score		Impact	Likelihood	Risk score	
Service user experience										
Overall Impact Summary score (highest)					0				0	
Impact on dignity and respect					0				0	
Impact on service user satisfaction					0				0	
Impact on service user choice					0				0	
Impact on straightforward and timely access to care and treatment					0				0	
Impact on complaints					0				0	
Impact on waiting times					0				0	
Please add more areas as applicable					0				0	

Quality areas	Positive Impact	Negative impact	Current Risk			Risk mitigation and monitoring arrangements	Residual Risk			Quality Metrics
			Impact	**Likelihood**	**Risk score**		**Impact**	**Likelihood**	**Risk score**	
Equality & Diversity										
Overall Impact Summary score (highest)					0				0	
Impact on eliminating discrimination					0				0	
Impact on eliminating harassment					0				0	
Impact on promoting good community relations /positive attitudes					0				0	
Impact on encouraging participation					0				0	
Any other impact on equality or diversity?					0				0	
Please add more areas as applicable					0				0	

Quality areas	Positive Impact	Negative impact	Current Risk			Risk mitigation and monitoring arrangements	Residual Risk			Quality Metrics
			Impact	**Likelihood**	**Risk score**		**Impact**	**Likelihood**	**Risk score**	
Non Clinical/Operational Impact										
Overall Impact Summary score (highest)					0				0	
Impact on staff satisfaction					0				0	
Impact on staff turnover					0				0	
Impact on staff absentee levels					0				0	
Impact on bank and agency staff levels					0				0	
Public perception of the Trust or its services					0				0	
Please add more areas as applicable					0				0	

APPENDIX 10: GOVERNANCE, OPERATIONS & PERFORMANCE SYSTEM STRUCTURE



APPENDIX 11: COMMUNICATION PLAN

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All staff and/or others who have to work in accordance with a risk assessment.
The key changes if a revised policy/strategy	This policy replaces previous RD&E and NDHT Risk Management Policies in order to provide clarity to the Trust wide risk management process and supports the optimal utilisation of Datix iCloud management software, and the overall management of risk.
The key objectives	The key objectives of the Risk Management Policy are: • The framework that supports the maintenance and development of a risk-aware culture where the right people do the right thing at the right time; • The outline of the processes to be used for the management of all Trust risks; • Definitions of risk types; • Escalation processes to ensure oversight of risks from ward to the Board of Directors; • The roles of all staff in relation to risk identification, management and review.
How new staff will be made aware of the policy and manager action	At the local induction process, staff training, and local governance systems and processes i.e. DGGs, risk surgeries
Specific Issues to be raised with staff	Staff should be made aware of the Risk Management Policy.
Training available to staff	A training programme is currently under development in line with the changes made within this policy
Any other requirements	Nil

Issues following Equality Impact Assessment (if any)	No negative impact
Location of hard / electronic copy of the document etc.	The original of this Policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely

APPENDIX 12: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Risk Management Policy
Division/Directorate and service area	Corporate Nursing
Name, job title and contact details of person completing the assessment	Lisa Richards, Trust Risk Manager, Eastern Services
Date completed:	29/09/2022

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

The aims of this policy are to:

- Ensure the management of risk is consistent with, and supports the achievement of the Trust's strategic and corporate objectives;
- Provide a safe high quality service to patients;
- Initiate action to prevent or reduce the adverse effects of risk;
- Minimise the human costs of risks, i.e. to protect patients, visitors and staff from risks where reasonably practicable;
- Meet statutory and legal obligations;
- Link into the assurance framework of the Trust;
- Link into the clinical governance framework of the Trust;
- Improve compliance with the on-going requirements of NHS governance;
- Minimise the financial and other negative consequences of losses and claims, for example, poor publicity, loss of reputation;
- Minimise the risks associated with new developments, activities, and business.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☐ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☐	☒
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Not applicable

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- ***Fairness –*** *how have you made sure it treat everyone justly?*
- ***Respect –*** *how have you made sure it respects everyone as a person?*
- ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?*
- ***Dignity –*** *have you made sure it treats everyone with dignity?*
- ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

No human rights implications

7. **If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact** please note this below and how this will be monitored/addressed.

"Protected characteristic":	
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	