Great Western Hospitals NHS Foundation Trust

TRUST-WIDE POLICY DOCUMENT

RISK MANAGEMENT POLICY

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Division or Department	Corporate – Quality
Lead Author(s):	Risk & Legal Facilitator

Version 4.0

Great Western Hospitals NHS Foundation Trust

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RISK MANAGEMENT POLICY

Further information about this document:

Document summary	The aim of this policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.
Author(s)	Risk & Legal Facilitator
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To be read in conjunction with	**Stage 2 Full Equality Impact Assessment**
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.	

Version Control:

Version History:	
4.0	Complete Review and Rewrite

Contents

1 PURPOSE AND RATIONALE

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

Risks provide us with threats and opportunities, which can impact the achievement of objectives. Risk is defined events that 'might happen' as the effect or result of uncertainty on objectives. Risk management includes identifying, assessing, and responding to risks. Good risk management awareness and practice at all levels is a critical factor for success.

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

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

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

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

The aim of this Risk Management Policy is to provide a supportive risk management framework that ensures:

- Integration of risk management into activities throughout the Trust
- Chances of adverse incidents, risks and complaints are minimised by effective risk identification, treatment and management
- A risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed
- Risk management is an integral part of GWH culture and encourages learning from incidents
- Informs prioritisation of investment and is aligned to business planning

This is the predominant risk management policy in the Trust. The Maternity Services Risk Management Strategy (Ref 1) has been developed to supplement the Trust Risk Management Policy; however, this remains subservient to the Trust-wide Risk Management Policy.

3 SCOPE

This document applies to all staff employed by Great Western Hospitals NHS Foundation Trust (whether on a permanent, temporary or honorary contract) who are involved in writing, reviewing or the management of Policy documents.

4 DEFINITIONS

The following terms and acronyms are used within the document:

CQC	Care Quality Commission
EIA	Equality Impact Assessment
GWH	Great Western Hospital
ID	Identification

NHS	National Health Service
NPSA	National Patient Safety Agency

5 DUTIES

5.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

5.2 Executive Leads

Executive Leads are directly accountable to the Board for effective risk management within their areas of responsibility. They are required to ensure that risks are identified promptly and managed effectively in accordance with this Strategy and any associated documents, policies and procedures.

5.3 Divisional Triumvirate and Corporate Department Leads

Divisional Triumvirates and Corporate Departments will:

- Scrutinise risks scoring 12+ within their Division at least monthly (the review, together with any action taken, must be minuted);
- Holds departmental managers to account for managing their risks;
- Reports areas of concern to the Trust Management Committee .
- Ensure that appropriate and effective risk management processes are in place within designated areas and scope of responsibility and that all employees are made aware of the risks within their work environment and of their personal responsibilities;
- Implement and monitor any identified risk management control measures within their designated area and scope of responsibility ensuring that they are appropriate and adequate;
- Ensure that risks are captured onto division/specific-area risk ; and
- Ensure that a local group (usually the monthly division/specific-area meetings) review the Division/specific-area risks

Executive Directors are responsible for ensuring the Risk Owner reviews the risk regularly and has effective controls and mitigations in place. They are also responsible for ensuring the risk is scored appropriately and are responsible for approving or rejecting them onto the Corporate Risk Register.

5.4 Service Leads

The Service Lead has responsibility to ensure risks are being managed within their services. They will be responsible for management of risks scoring 1 – 10 within their services and responsible for the escalation of risks scoring 12+ to the Divisional Risk Registers.

The Company Secretary is responsible for the coordination of the Trust Board's Board Assurance Framework to ensure proactive management and to ensure the Board remains sighted on the key risks facing the Trust.

5.5 Departments and Teams

Departments and Teams will review their risks to ensure their management and will report any areas of concern to the Service Leads.

5.6 Risk Owners

The risk owner is the responsible point of contact for an identified risk, who co-ordinates efforts to mitigate and manage the risk with various individuals who may also own parts of the risk. The responsibilities of the risk owner are to ensure that:

- Risks are identified, assessed, managed and monitored
- Risks are clearly articulated within the Risk Management Tool
- Controls and actions are in place to mitigate the risk in line with the risk appetite

5.7 All Employees

All employees are required to comply with all relevant legislation and regulation, attend training where appropriate and maintain their own professional competencies, ensuring they are familiar with, and comply with, Trust policies, procedures, and other documents.

All employees have a responsibility to ensure any risks that they identify are flagged to their line manager in the first instance. Employees must be aware of risk management procedures and be willing to report incidents and risk management issues.

5.8 Risk and Compliance Team

The Risk and Compliance Team are responsible for:

- Supporting Divisions in compiling division risk dashboards.
- Providing support and training on the Risk Management Tool.
- Producing Divisional Risk Dashboards using data from the Risk Management Tool system on a monthly basis to support the review of risk at Divisional Governance Meetings.
- Supporting the Deputy Chief Nurse with compiling a 15+ Risk Dashboard and report; and
- Providing administrative support and training on the Risk Management Tool.
- Provide support to department in the monthly production of the template which enables them to produce and report on their area risks.
- Weekly oversight huddle to monitor quality of risk.

5.9 Company Secretary

The Company Secretary is responsible for the coordination of the Board Assurance Framework to ensure proactive management and to ensure the Board remains sighted on the principal risks facing the Trust.

5.10 Trust Board

The Trust Board is responsible for risk management throughout the Trust. It delegates some responsibility to the Trust Management Committee and the Audit, Risk and Assurance Committee and receives assurance from those committees on the effectiveness of the risk management strategy. To discharge its responsibilities it will:

- Ratify the Trust's Risk Management Policy every three years;
- Review the 15+ Risks at least quarterly;
- Review the Board Assurance Framework on a quarterly basis;
- Delegate responsibility for taking assurance on the management of 15+ risks in relation to the relevant Board sub-committees.
- Delegate responsibility for taking assurance on the risk management processes to the Audit, Risk and Assurance Committee.

5.11 Board Committees

The Board Committees have responsibility for seeking assurance relating to work within their remit.

The Quality & Safety Committee is particularly concerned with quality and safety matters and ensuring risk mitigation in these areas, whereas the Finance Investment & Digital Committee is engaged in regular reviews of risk outcomes of financial performance and the estates and digital infrastructure. The Performance, Population & Place Committee is concerned with operational performance and partnership working risks and the People & Culture Committee focusing on workforce risk. The Mental Health Governance Committee

is concerned with areas relating to mental health, safeguarding and learning disabilities.
Each of these committees has delegated oversight and scrutiny of those relevant strategic risks on the Board Assurance Framework and the relevant risks on the Corporate Risk Register which have been assigned to them by the Board. The committees will undertake the following roles in relation to the Board Assurance Framework;

- Seek assurance on a quarterly basis that the strategic risks under the Strategic Objective(s) aligned to the remit of the Committee are effectively managed and mitigated.
- Consider the scoring of those strategic risks based upon the assurance received.
- Report any gaps in assurances or deterioration on strategic risks scores to the Board by exception.

5.12 Audit, Risk & Assurance Committee

The role of the Audit, Risk and Assurance Committee is to oversee the implementation of the Risk Management Policy and to take assurances that the processes supporting the Risk Management Policy are effective in mitigating risk. It does not have operational responsibility for individual risks, but will take assurances from the Trust Management Committee that risks are being managed. Its specific responsibilities are:

- To review the management of 15+ Risks at least twice a year;
- To review Divisional Risk management and governance processes at least once a year;
- To review the Board Assurance Framework quarterly.

The Audit, Risk and Assurance Committee will also receive assurances from the Board Committees to supplement the overall assessment of risk and the effectiveness of the risk management process within the Trust.

5.13 Trust Management Committee

The Trust Management Committee has operational responsibility to ensure risks are being managed. It has specific responsibility to:

- Scrutinise and challenge the 15+ Risks on a quarterly basis;
- Consider risks for escalation to the Board Assurance Framework and where identified recommend these for inclusion to the Board;
- Scrutinise and challenge the Board Assurance Framework on a quarterly basis year;
- Scrutinise and challenge each Divisions Risks once a year;
- Hold Associate Medical Directors and Divisional Directors to account using the Risk Report on how risks are managed within their Division, directing action where appropriate.

5.14 Risk Group

The Risk Group has responsibility to provide oversight, challenge and scrutiny to the management of risks on the Trust's risk register reporting to the Trust Management Committee and Audit, Risk & Assurance Committee.

6 PROCESS

6.1 Risk Management Framework

Stage 1 – Determine priorities and horizon scanning
The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify

positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change. This is part of the annual Business Planning Process.

By undertaking a continuous, systematic and participatory approach to horizon scanning the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Divisions and Corporate services will highlight any issues on the horizon through the risk register and when presenting their risk reports to the Risk Group (as per the Risk Group programme); the Board will undertake at least one formal horizon scanning session per year when undertaking the annual Board Assurance Framework refresh. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Stage 2 – Risk identification
Risk is identified in many ways; we identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust. (2.1.2)

Stage 3 – Risk assessment
Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure (2.1.3)

Stage 4 – Risk response (risk treatment)
For each risk, controls are established, documented and understood. Controls are implemented to avoid, modify, transfer or accept risk; or to seek risk (take opportunity). Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk, and expressed its appetite in the form of 'tolerable' risk ratings in the Board Assurance Framework. So as to prevent inconsistencies from being introduced which may destabilise and reduce the effectiveness of the risk management framework, any fundamental changes to the way in which risks are described will require the approval of the Risk Group. (2.1.4)

6.2 Risk Management Process

Risk management is a systematic and cyclical process, in which risks are identified, assessed, managed, monitored and reviewed. It is applicable at all level throughout the Trust – Board, Divisional, Department, team and individual.

This process enables the Trust to monitor and address the strategic risks that would prevent the organisational achieving its strategic objectives. It sets out controls (or ways the risk is being mitigated), and the sources of assurance that those controls are effective, as well as setting out action plans for those risks that require action to bring them within the risk appetite where possible.

6.2.1 Risk Management Process

Trust should strive to identify, evaluate and manage changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation. Proactive risk identification can also identify positive areas for the Trust to develop its business and services, taking opportunities when they arise. The risks identified and managed throughout the Trust can be grouped by either:

Strategic Risks
Corporate Risks
Operational Risks
Programme and Project Risk Log
Organisational Risks

Strategic risks are the Principal Risks that populate the Board Assurance Framework (BAF). These are defined by the Board of Directors and managed through the work of Lead Committees and Lead Directors.

Corporate Risks consist of those risks that score 15 and above and cover both clinical and corporate services. These risks can affect multiple areas (rather than being confined to a single division). These risks will be assigned to an appropriate lead, who will co-ordinate the risk response for the Trust. They are recorded and maintained on Datix as part of the Corporate risk register.

Operational risks are defined at service level and vary dependent upon the specific activities that take place within each service. They are also recorded and maintained on Datix as part of the organisational risk register.

Programme and Project risk logs are risks that are identified at project management level, and are defines as those which impact directly on the success or failure of a particular project being undertaken.

Organisational risks are risks that affect GWH fulfilling its contractual, statutory, and regulatory objectives to provide safe and effective care. Risks falling into this category are those that have an organisation-level impact. The risk themes for these risks align to the Risk Appetite and are as follows:

- Quality Outcomes
- Legal, regulatory, compliance
- Workforce
- Continuous Quality Improvement/Innovation
- Operational
- Commercial
- Reputation
- System Working
- Finance
- Estates
- Digital Technology / Data

All Organisational risks are owned by the department or service that has operational responsibility.

6.2.2 Identify – Risk Identification

When identifying a risk, consideration should be given to what could pose a potential threat, or opportunity to the organisation.

It is important to understand the difference between risks, incidents, and issues.

- Risks are things that might happen and would stop the Trust achieving their objectives, or otherwise impact the success of the organisation.

- Incidents/issues are things that have already happened, which were not planned and require management action, must be reported as appropriate and where required in line with the Trust Incident Management including Serious Incidents Policy (Ref 3).

Once identified, the risk needs to be described clearly to ensure that the risk is understood. Once understood, the risk should be added to the Risk Management Tool (Datix). Guidance on how to access Datix and complete the Risk Form can be found on the Intranet (Ref 4).

A risk description should be described explaining the three following points:

1. **The Risk** (There is a risk that…) Think about what / who is at risk.
2. **The Root Cause** (Because of…) Why could this risk happen?
3. **The Impact** (Resulting in…) What would happen if the risk materialised?

6.2.3 Assess and Evaluate - Risk assessment and evaluation

A risk assessment is an evaluation of the nature and magnitude of the risk. The assessment is completed by scoring the likelihood of the risk occurring and the impact should it occur. Appendix B sets out the Trust's scoring matrix in accordance with the National Patient Safety Agency (NPSA), which has been adapted to our organisation. The table below shows the overall risk ratings that a risk could have.

The overall residual risk rating
Low Risk (1 – 3)
Moderate Risk (4 – 6)
High Risk (8 – 12)
Extreme Risk (15 - 25)

Once a risk score has been determined, the risk evaluation involves making a decision about what should be done with the risk. It includes determining appropriate controls and or treatments for the risk, and what level of risk can be tolerated within the Trust as per the Risk Appetite.

- A **control** is an **existing** process or strategy in place, such as policies, systems, procedures and practices.

- An **action** is an **additional** strategy/activity that the Trust needs to develop, and implement should the risk level be unacceptable after controls are applied.

If there are no actions identified because the controls listed on the risk are adequate and no further action is possible, it is recommended that an action is added to the risk stating 'Controls to be reviewed on a monthly / quarterly basis to ensure they are still appropriate'.

Where there is an immediate risk to the health and wellbeing of patients, employees or visitors, this must be escalated immediately. If outside of normal working hours, the risk must be reported to the on-call manager for assistance.

Not all risks can be dealt with in the same way, and some require different responses to others. The table below provides an explanation of the different risk responses that the Trust can take.

Risk Response	
Terminate	Where an activity or system gives risk to significant risk to the Trust, an informed decision to not become involves in the risk situation takes place, e.g., terminate the activity.
Tolerate (Accept)	Where it is considered that nothing more can be done at a reasonable cost to reduce the risk, the likelihood and consequence of a particular risk happening is accepted. See below for accepted risk criteria.

Treat	Actions are carried out to reduce the likelihood or consequences of the risk (this is the most common response).
Transfer	Shifting the responsibility or burden for loss to another third party. E.g., the risk is insured against or subcontracted to another company.

The Trust recognises that it is not possible to eliminate all risks, either because of the high costs of elimination in comparison with the potential severity of the risk, other priorities or other external factors.

When all reasonable control measures have been put in place some residual risk might remain and this level of risk can be accepted if the risk:

(i) is minor in nature, with minimal potential for financial loss or damage to structure, persons, equipment or property; or
(ii) will occur rarely and might cause serious harm, damage or loss but which would take disproportionate resources to eliminate or reduce.
(iii) the target risk score has been reached, and that target risk score is within the organisation's risk tolerance (See risk appetite Ref 2)

Where risks are deemed tolerable (accepted) with no further action to be taken, they should still be reviewed in case circumstances have changed. The frequency of the review will depend on the level of risk. The minimum review frequency for accepted risks is set out below.

All accepted risks will have an action added to them to review them at quarterly intervals as a minimum. Any risks scoring 15+ which are accepted will be required to be reviewed monthly. The action will be added by the Risk & Legal Facilitator and will be assigned to the risk owner. The description will state 'Accepted risk action - Review controls in place and ensure they are still appropriate and effective. The risk is to be reviewed as a minimum every quarter to ensure that the risk is still relevant. Details of the review need to be recorded.'

Risk score	Level of risk	Review frequency
1 - 3	Low risk	Quarterly
4 - 6	Moderate risk	
8 - 12	High risk	
15 - 25	Extreme risk	Monthly†

†All risks that score 15 or above can only be deemed 'accepted' by Trust Board. All risks which score 15 or above must be reviewed at least monthly, irrespective of whether they are deemed 'accepted'.

100% of all risks that have been accepted on the Risk Management Tool must have evidence attached to the risk in the form of documentation that records the decision to accept the risk. Each division's compliance with evidencing acceptance is reported to The Audit Risk and Assurance Committee on a quarterly basis.

6.2.4 Plan – Action Plan

The risk will require action to reduce the likelihood and/or impact of a threat, or maximise the likelihood or opportunities, a risk action plan should be devised and documented on the Risk Management System.

The actions must have individual owners and should be specific to the risk and SMART (specific, measurable, achievable, relevant and time bound) to evidence how the risk score can be reduced.

When agreeing actions to control the risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

If a risk has already occurred and cannot be prevented or is a risk is rated high or extreme, then a contingency plan should be in place should the risk materialise. These plans should be recorded under the 'Controls' section on the Risk Management Tool. Good risk management is about being risk aware and able to handle the risk, not being risk adverse.

6.2.5 Monitor and Review

The implementation of actions must be kept under review along with the risk score to measure their effectiveness. If the actions are not reducing the risk, other actions need to be considered.

Once an action has been implemented the risk will be re-assessed and rescored and that action will become a control.

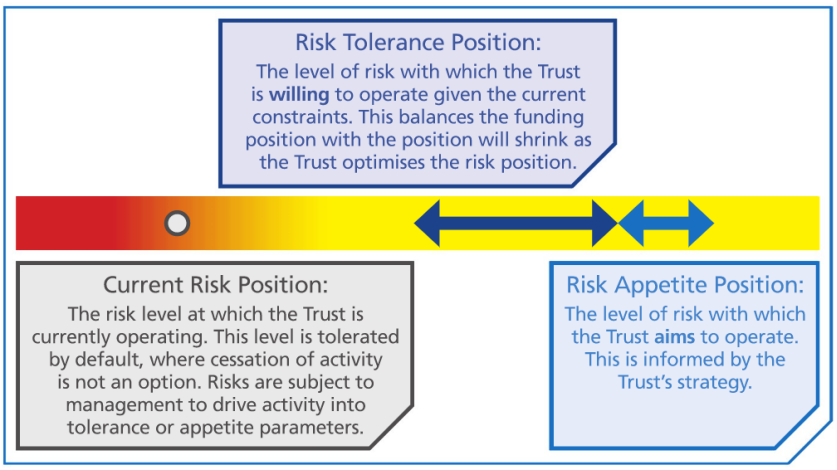
The risk will be reviewed periodically depending on the risk score. The minimum review frequencies are below:

Risk score	Level of risk	Minimum review frequency
1 - 3	Low risk	Annually
4 - 6	Moderate risk	Bi - annually
8 - 12	High risk	Quarterly
15 - 25	Extreme risk	Monthly

6.3 Risk Appetite & Risk Tolerance

Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time to deliver the Trust strategy, whilst ensuring we provide safe and effective patient outcomes.

Risk Appetite is defined as 'the level of risk at which the Trust **accepts** to achieve its objectives'
Risk Tolerance is defined as 'the level of risk at which the Trust is **willing** deviate from the risk appetite'



On an annual basis the Trust will publish its Risk Appetite Statement (Ref 2) as a separate document covering the overarching areas of:

- Quality Outcomes
- Legal, regulatory, compliance
- Workforce
- Continuous Quality Improvement/Innovation
- Operational
- Commercial
- Reputation
- Finance
- Estates
- Digital Technology / Data Information

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

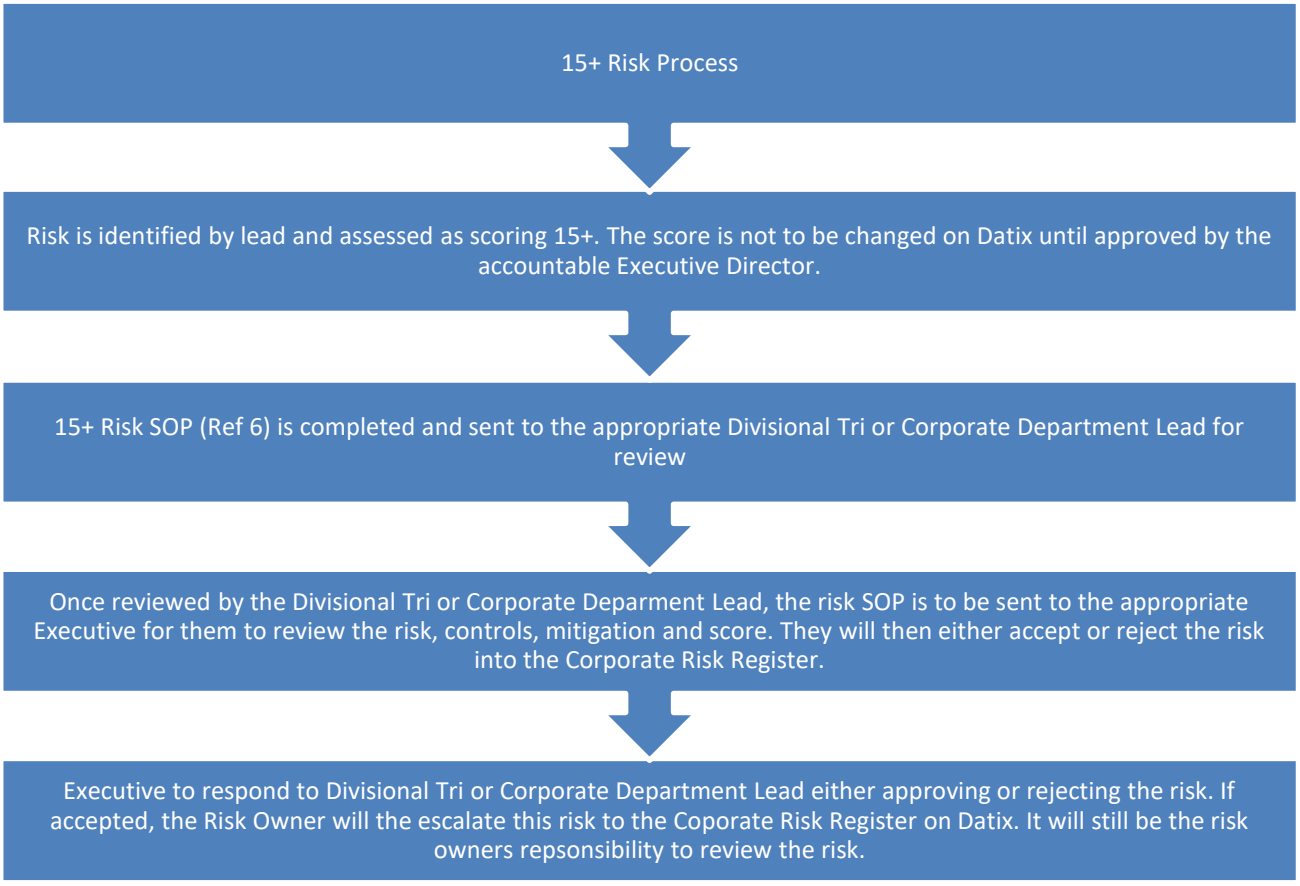
Risk Appetite Scale	Appetite	Tolerance
Averse Avoidance of risk and uncertainty is key objective	1-3	4-6
Minimal Preference for very safe business delivery options that have a low degree of inherent risk and only for limited reward potential	4-5	6-10
Cautious Preference for safe options that have low degree of inherent risk and only limited potential for benefit and may only have Limited potential for reward	6-8	9-15
Open Willing to consider all options and choose one that is most likely to result in successful delivery while also providing an acceptable level of reward (and VFM)	8-10	12-20
Eager Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	12-15	16-25

Risk Tolerance is the level of risk the organisation is willing to take in order to achieve strategic goals given the current constraints.

6.4 Risk Management Assurance

6.4.1 15+ Risk Process

When a risk scoring 15+ is identified, please follow the flowchart below.



6.4.2 Escalation and De-escalation (Appendix C)

Depending on the score of the risk, it will need to be escalated and de-escalated throughout the Trust. Appendix C sets out the process for how risks can be escalated for inclusion on the Divisional and GWH Corporate Risk Registers.

A How to Guide on escalation and de-escalation via Datix is available on the Intranet (Ref 5).

6.5 Risk Management Tool

The purpose of the Risk Management Tool (Datix) is to enable oversight and scrutiny of risks and support the reduction of risk by identifying mitigating actions. The centralised system allows for oversight of all enterprise risks, identification of risk themes and monitor of risk management across the Trust.

The Trust requires the following minimum content on the Risk Management Tool:

- Risk Identification (ID)
- Risk Title
- Risk Description
- Risk Owner
- Status of Risk (Open / Accepted / Closed)
- Target Date for closure
- Category
- Risk Register
- Risk Opened Date
- Next Review Date
- Reports to (Meeting or Committee)
- Risk Score and target score
- Controls in Place
- Actions to mitigate risks with due dates and action lead

6.6 Accountability for Risk

6.6.1 What are Strategic Risks?

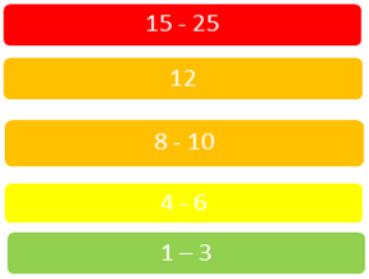
The Trust set out its strategic objectives in the Great Western Hospitals NHS Foundation Trust 5 Year Plan for 2019-24 (Ref 16).

Strategic risks represent major threats to achieving the Trust's strategic objectives, or to its Continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of the strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

6.6.2 Documenting Strategic Risks

The Board Assurance Framework enables the Board to: identify and understand the strategic (principal) risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are needed, action plans are in place and are being delivered; provide an assessment of the risk to achieving the objectives based on the strength of the controls and assurances in place (risk rating).

6.6.3 Strategic Risk Oversight



All Strategic Risks

All strategic risks will be presented to the Trust Board and Trust Management Committee at least four times a year. Discussions should be had to determine if the risk score is accurate and if there are appropriate actions in place to mitigate the risk to an acceptable level.

Annual Board Assurance Schedule

Action	Executive Lead	Management Lead	Date
Strategic **Objective setting** to be undertaken as part of the annual business planning cycle	Trust Chair/Chief Executive	Associate Director of Strategy	Quarters 3 & 4 October to March each year
Review of **Risk Appetite and Tolerance** Statement	Chief Executive	Company Secretary	Quarter 4 Jan to March each year
Strategic and **significant risk** review and identification to be undertaken as part of business planning process	Trust Chair/Chief Executive	Company Secretary	Quarter 1 April each year
Approval of Strategic Risks	Chief Executive	Company Secretary	April each year
Population of Board Assurance Framework	Chief Executive	Company Secretary	Quarter 1 April each year
Board Assurance Framework **updated** every quarter		Company Secretary	End of quarter Sept / Jan / Apr /June
Executive Lead Review prior to Board Committee/Trust Management Committee review	Relevant Executive Lead	Company Secretary	End of each quarter Oct / Jan / Apr / July
Sections of the Board Assurance Framework to be **monitored** by relevant **Board committee and Trust Management Committee** to ensure risk management and delivery of the strategic objective	Relevant Lead Director/Company Secretary	Company Secretary Timetable scheduled by Company Secretary	End of each quarter – Trust Management Committee - Oct / Jan / Apr/July Board Committees – Nov / Feb / May / Aug
Presentation to **Audit, Risk & Assurance Committee**	Chief Executive	Company Secretary	ARAC – Nov / May
Presentation to **Trust Board**	Chief Executive	Company Secretary	Trust Board* – Jan / Apr / July / Oct *month later due to scheduled Board Seminar sessions (Dec / Mar / June / Sept)

6.6.4 Scrutiny and Challenge Including Frequency

The relevant sections of the Board Assurance Framework (BAF) are presented to the Board Committees quarterly to enable the Committee to review the assurances and controls in place to mitigate the strategic risks. The Committees will use the BAF to inform their Committee Forward Plans and their discussion and challenge of agenda items and will draw to the attention of the Board to any issues or concerns through their Chair Board Assurance Reports.

The Trust Management Committee will review the BAF quarterly to scrutinise and challenge the assurances and controls and instruct any actions as necessary. The Audit, Risk and Assurance Committee has a key role in overseeing this process as part of its responsibility in overseeing the overall system of risk management for the Trust. This takes place at least twice a year.

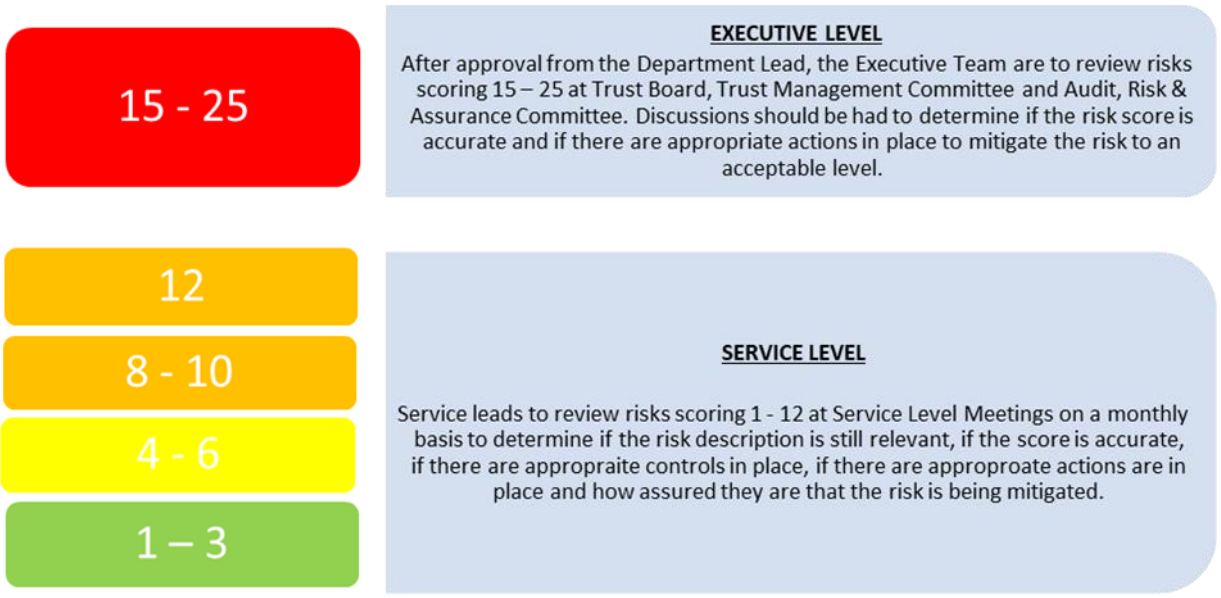
6.6.5 Divisional Organisational Risk Oversight

The structure below shows the oversight for risks within the Divisions of Surgery, Women's and Children's, Unscheduled Care and Integrated and Community Care

15 - 25	**EXECUTIVE LEVEL** After approval from the Divisional Tri, the Executive Team are to review risks scoring 15 – 25 at Trust Board, Trust Management Committee and Audit, Risk & Assurance Committee. Discussions should be had to determine if the risk score is accurate and if there are appropriate actions in place to mitigate the risk to an acceptable level.
12	**DIVISIONAL LEVEL** Divisional Tri to review risks scoring 12 at Divisional Governance meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.
8 - 10	**SERVICE LEVEL** Service leads to review risks scoring 8 – 10 at specialist service meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.
4 - 6 1 – 3	**DEPARTMENT LEVEL** Departments to review risks scoring 1-6 at team meetings to determine if the risk description is still relevant, if the score is accurate, if there are appropriate controls in place, if there are appropriate actions are in place and how assured they are that the risk is being mitigated.

6.6.6 Corporate Departments Organisational Risk Oversight

The structure below shows the oversight for risks within the Corporate Departments.



6.7 Continuity and Transferring Risk / Existing Staff Members

To ensure that risk management continuity is maintained, it will be a requirement of all line managers to ensure that as part of the process of overseeing the exit of a staff member, the line manager checks whether the “exiting staff member” is a risk owner. Where the exiting staff member is a risk owner, the line manager will be responsible for reallocating the risk into the name of an alternative risk owner prior to the departure of the staff member.

6.8 Triangulation to inform Patient Safety Incident Investigations

Work will be completed on a bi-monthly basis to take a specific department/service risk and triangulate with incident data and complaints. This information will be presented at the Risk Group for documented discussion to ensure themes from incidents and complaints are accurately reflected on the Risk Management Tool.

6.9 Risk Management Process – Project Risks

Project risks are managed within the project management process throughout the life of a project, and are not placed on GWH Risk Management Tool.

Where the success or failure of a project poses a risk to GWH achieving one of its strategic aims, this will be recorded on GWH’s Board Assurance Framework.

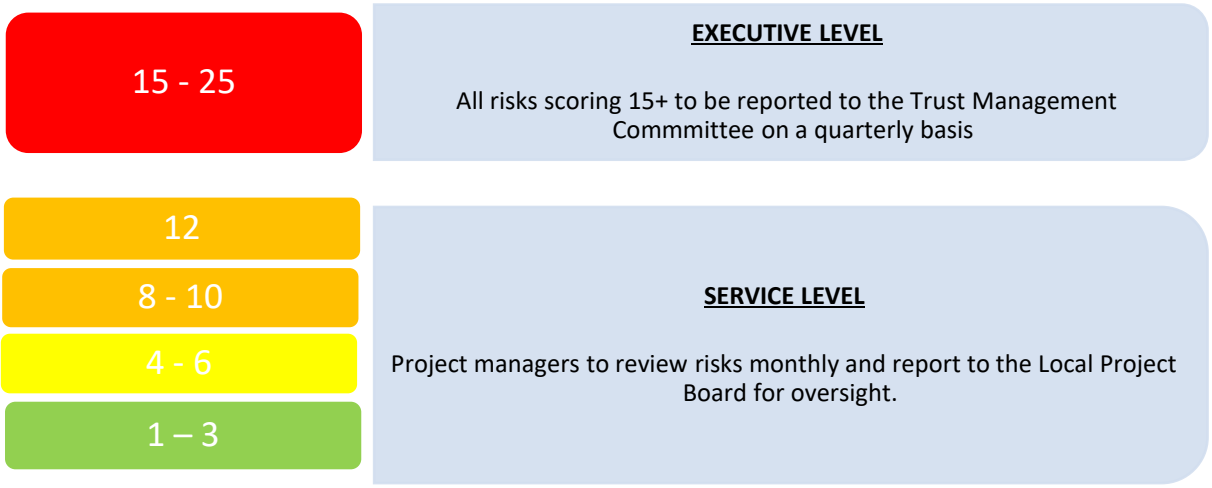
Where the implementation of a project poses a risk to the day to day running of the business of GWH, this should be added to the organisational risk register, and managed as an organisational risk. Such risks will usually have been considered prior to the initiation of a project, and a decision made by the Trust Management Committee that the benefits of implementing the project outweighed the risks caused by implementing the project. The effectiveness of the controls to mitigate the risks of implementing the project will have been considered as part of this exercise.

Where project risks are ranked highly after mitigation (i.e. project risks actively scoring 16+), these will be reported to the Trust Management Committee at a frequency agreed by the Trust Management Committee (which may vary from project to project). It will be the responsibility of the Executive Lead

overseeing the project to ensure that significant Project risks are escalated to the Trust Management Committee.

Where project risks are escalated to the Trust Management Committee, they will consider the actions being taken to mitigate those risks and may direct that additional/alternative actions are taken.

Project risks may be reported to the Local Project Board in a manner and at a frequency deemed appropriate by the Trust Management Committee.



7 CONSULTATION

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department .	Date Consultee Agreed Document Contents
Deputy Chief Nurse	07/09/2023
Company Secretary (for risk management in particular the Board Assurance Framework)	12/01/2023
Head of Patient Safety & Quality	20/01/2022
Lead Clinical Risk & Patient Safety Manager, Deputy Head of Patient Safety & Quality	12/01/2023
Quality & Compliance Manager	13/12/2022
Divisional Director – Surgery, Women & Children's	10/01/2023
Chief Nurse	11/01/2023
Patient Safety & Risk Matron	06/10/2022
Director of Pharmacy	05/12/2022

8 TRAINING AND SUPPPORT

Any employee adding or managing risks via the Risk Management Tool requires training which is provided by the Risk & Legal Facilitator. This training will provide information on how to use the system effectively.

A user guide will be provided at the end of the session to aid employees when they are adding, reviewing and closing risks.

9 MONITORING, Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below:-

Element to be monitored	Lead	Frequency	Reporting Arrangements
Development and maintenance of a Board Assurance Framework	Company Secretary	As per internal audit plan	Audit, Risk and Assurance Committee
15+ Risks review and scrutiny	Trust Management Committee Audit, Risk and Assurance Committee Risk Group	Monthly At least 3 times a year Bi-monthly	Trust Board
Division risk review and scrutiny	Division meetings Trust management Committee	Monthly At least once per year	Trust management Committee Audit, Risk and Assurance Committee

10 SUPPORTING DOCUMENTS

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Maternity Services Risk Management Strategy	*T:\Trust-wide Documents*
2	Risk Appetite Statement	Available from the Company Secretary
3	Incident Management including Serious Incidents Policy	T:\Trust-wide Documents
4	Datix User Guide	Quality, Compliance & Risk
5	Datix Escalation and De-Escalation How to Guide	Quality, Compliance & Risk
6	15+ Risk SOP	Quality, Compliance & Risk

APPENDIX A – Initial Screening for Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Risk Management Policy		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet? The aim of this policy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Megan Fernandes
Date completed	01/02/2023
Job Title	Risk & Legal Facilitator

<u>On completion of Stage 1</u>: A full impact assessment will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above

Appendix A -Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

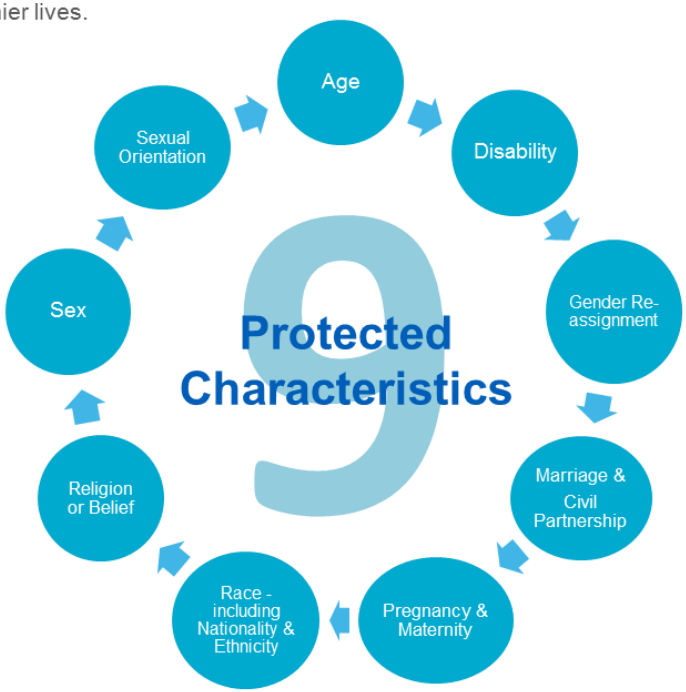
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Appendix B – NSPA Risk Scoring Matrix

	Consequence score and examples of descriptors				
Description	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality.	<5% over budget/schedule slippage. Minor/reduction in quality/scope.	5-10% over budget / schedule slippage. Reduction in scope or quality.	10-25% over budget / schedule slippage. Does not meet secondary objectives.	>25% over budget / schedule slippage. Does not met primary objectives.
Patient / Staff Safety	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	RIDDOR / Agency reportable.	Major injuries, or long term incapacity / disability (loss of limb).	Death or major permanent incapacity.
Patient Experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
Complaints / Claims	Locally solved complaint	Potential claim. Justified complaint peripheral to clinical care.	Potential claim. Justified complaint involving lack of appropriate care.	Likely claim. Multiple justified complaints.	Multiple claims or single major claim.
Clinical Service / Business Interruption	Local interruption with back up.	Local interruption.	Loss / interruption >1 hr.	Loss / interruption >8 hrs.	Loss / interruption >24 hrs.
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objectives / service due to lack of staff. Minor error due to poor training. Ongoing unsafe staffing level.	Uncertain delivery of key objectives / service due to lack of staff. Serious error due to poor staffing	Non-delivery of key objectives / service due to lack of staff. Critical error due to insufficient training.
Financial	Small loss	Loss of >0.5% of budget.	Loss of >1% of budget	Loss of >3% of budget	Loss of >5% of budget
Inspection / Audit	Minor recommendations. Minor non-compliance with standards.	Recommendations given. Non-compliance with standards.	Reduce rating. Challenging recommendations. Non-compliance with core standards.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
Adverse publicity/ reputation	Rumours	Local media coverage – short-term. Minor effect on staff morale.	Local media - long-term. Significant effect on staff morale.	National media coverage with <3 days.	National media coverage with >3 days. MP concerned (questions in the House)

	Consequence score and examples of descriptors				
Description	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Information Governance	Damage to individual reputation, possible media interest. Potentially serious breach, less than 5 people affected of risk assess as low.	Damage to a team's reputation. Some local media interest may not go public. Serious potential breach and risk assessed high. Up to 20 people affected.	Damage to a services reputation / low key media coverage. Serious breach of confidentiality, ie. Up to 100 people affected.	Damage to organisation's reputation/local media coverage. Serious breach with either particular sensitively or up to 1,000 people affected.	Damage to NHS reputation, national media coverage. Serious breach with potential for ID theft or over 1,000 people affected.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	Will occur in exceptional standards	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

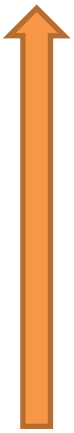
The overall risk rating reflects both the likelihood that harm or loss will occur and the severity of its outcome: **(i.e., risk = likelihood x consequence).**

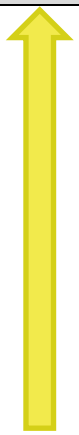
	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5 – Catastrophic	5	10	15	20	25
4 – Major	4	8	12	16	20
3 – Moderate	3	6	9	12	15
2 – Minor	2	4	6	8	10
1 – Negligible	1	2	3	4	5

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

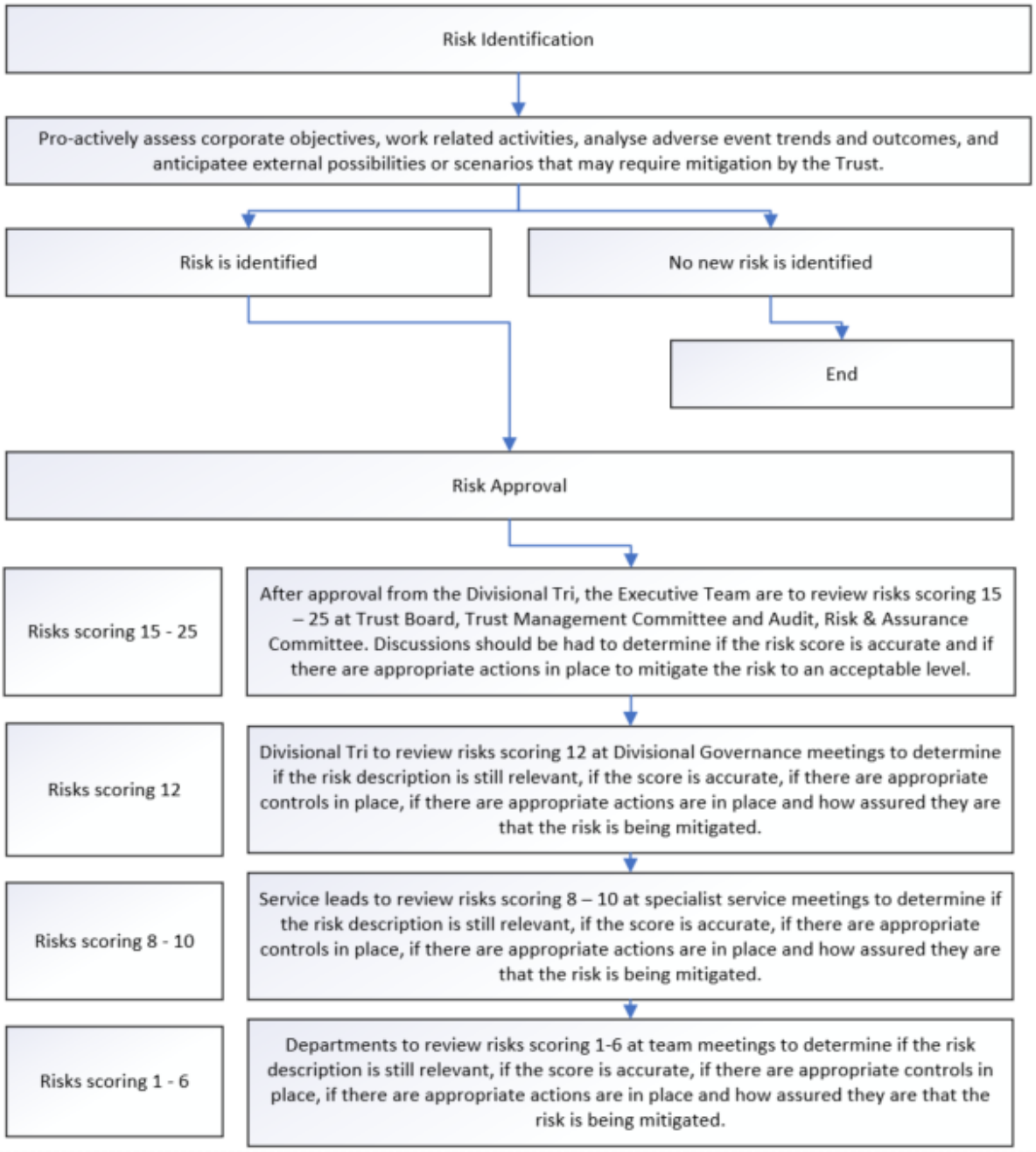
The overall residual risk rating	
Low Risk (1 – 3)	Quick easy measures implemented immediately, and further action planned for when resources permit
Moderate Risk (4 – 6)	Actions implemented as soon as possible, but not later than a year
High Risk (8 – 12)	Actions implemented as soon as possible and no later than six months
Extreme Risk (15 - 25)	Requires urgent action. Trust Board is made aware and implements corrective action

Appendix C – Risk Escalation and Responsibility

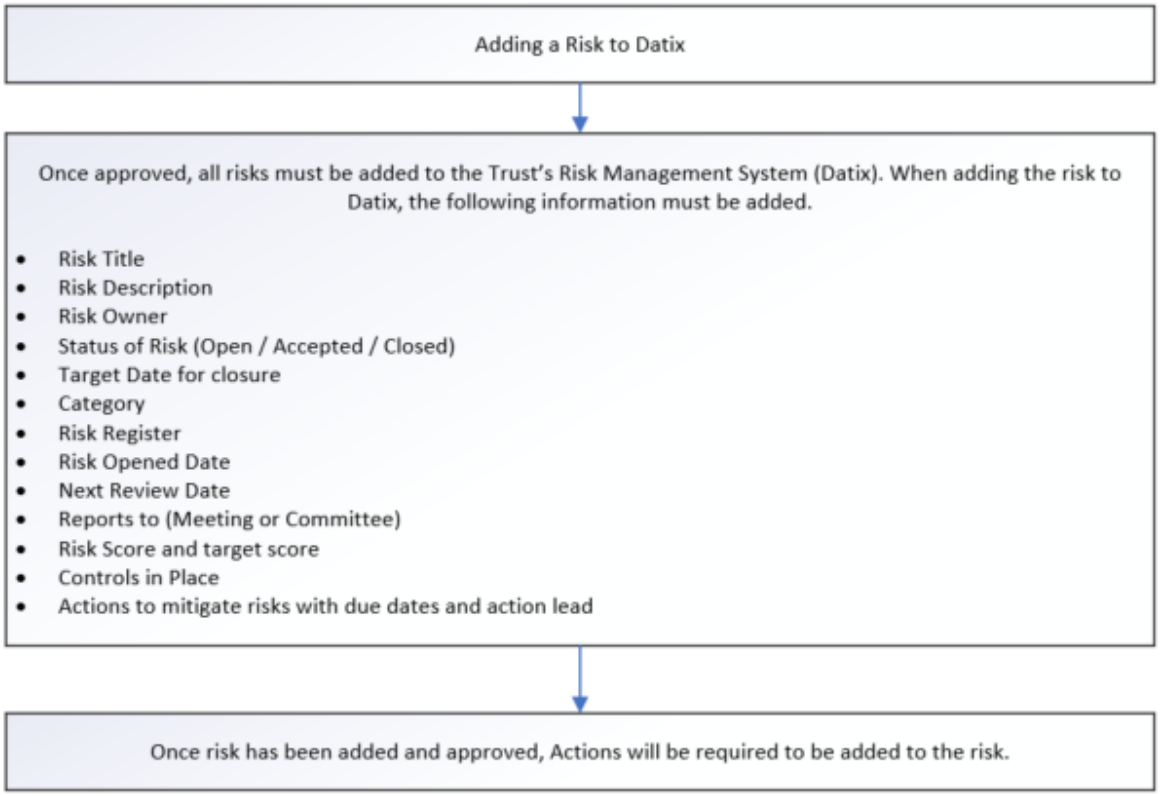
Risk Score	Risk Response	Action	By Whom	Escalation
Extreme Risk	Treat / Transfer / Terminate			
15 - 25	Risks deemed as extreme require a systems approach to identify the root causes of the risk and thereby help choose an appropriate risk response. Where it is not possible to terminate or transfer the risk a treatment (action) plan will be put in place.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risk to be reviewed by the Divisional Tri for score approval. • Once approved by the Divisional Tri, the risk will be escalated to the appropriate Executive for risk score approval. • Once approved, the risk will be escalated to the GWH Corporate Risk Register within Datix. • Risk will be reported to the Trust Board Trust Management Committee and the Audit, Risk & Assurance Committee.	Executive Lead	
High Risk	Treat			
12	Risks deemed as high will require a treatment (action) plan in line with the risk appetite. Those risk where it is deemed there is no further action that can reduce the score will be reviewed regularly to assess their impact on the organisation.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks identified scoring 12 are reviewed by the **Divisional Management** and discussed monthly at Governance Meetings. • It is expected that the Divisions 12 + risk will be reported to the Trust Management Committee on an annual basis.	Divisional Management	
8 - 10		• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks identified scoring 8 – 10 are reported to the Divisional Management	Service Leads	

		and discussed monthly at Governance Meetings.		
Moderate Risk	Treat / Tolerate			
4 - 6 Low Risk 1 – 3	Risks scored as 1 – 6 can be managed through local action or by an appropriate person or department.	• Risk is identified. • Risk added to Datix. • Action to reduce the risk where necessary is considered. • Risks discussed at departmental meetings	Departmental Lead	

Appendix D – Risk Identification Flowchart



Appendix E – Adding a Risk to Datix Flowchart



Appendix F – Risk Review Flowchart