### Description of document

The Risk Management Strategy sets out the process by which the Trust identifies, manages, reduces and mitigates risks to achieving the organisational objectives. It sets out the framework required at strategic and local level to ensure this occurs.

### Scope

Identifies the risk management structure, roles, responsibilities and authority of staff, committees and groups with responsibility for risk.

### Author and Designation

Vivian Whittaker, Assistant Director Risk Management & Information Governance

### Equality Impact Assessment (EIA)

Equality impact assessment identifies a positive impact. The Risk Management Strategy is a requirement of good governance to minimise risk regardless of source while maintaining high quality service provision.

### Associated Documents

The implementation of the Risk Management Strategy is linked to other policies and procedures of the Trust including but not exclusive to the following: Incident Reporting, Investigation and Management Policy; Assurance and Escalation Framework; Health & Safety Policy; Quality Strategy; Board Assurance Framework; Clinical, Financial, Workforce, Estates and Performance Policies; Complaints Policy; Claims & Litigation Policy; Information Governance; Continuity and Business Planning Procedures;

### Supporting References

- NHSLA Risk Management Standards (2011/2012)
- NHSLA Standard 1 Governance. CQC requirement that organisations manage their risk to promote patient safety.

### Consultation or Development Process

The Risk Management Strategy is a required document.

### Training Implications

Training for staff is identified in the strategy and the Risk Management Training policy. See Section 7.

### Process for Monitoring Compliance

See Section 8.

### Duties, Accountability and Responsibility

Specific roles and responsibilities are identified within the policy.

### Dissemination

This procedural document is published on NCH&Cs Intranet and also communicated to all staff via the Monthly Briefing.
Exchange and Weekly Messages.

Is there any reason why any part of this document should not be available on the public web site? ☐ Yes ☑ No
This document is also available on request through the publication scheme.

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Section 1: Introduction

1.1 Risk Management is the process to identify, assess and prioritise the Trust's exposure to risk whether clinical or non-clinical, which may affect its ability to meet its strategic objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated.

1.2 The Risk Management Strategy sets out the strategic direction for Norfolk Community Health and Care NHS Trust (NCH&C) to systematically manage its risks regardless of source. It underpins the commitment by the Trust Board to reduce and mitigate risk by ensuring a robust risk management system is in place and implemented at all levels of the organisation to support delivery of excellent quality care for patients.

1.3 The strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trust’s work and service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring services are focussed on the patient, provided in a cost effective and efficient manner, and without compromising safety.

1.4 The Trust is committed to this positive approach and the consistent management of risk, where managing for safety, in a culture that is open and fair, supports learning, innovation and best practice for the benefit of the service users, patients and carers.

1.5 This strategy applies across the organisation from the front-line services through to the Board to promote the identification and reduction of clinical and non-clinical risks associated with healthcare provision.

1.6 The Risk Management Strategy drives the risk management process but is underpinned by other operational policies and procedures. Further detail on the management of specific types of risk e.g. Clinical, Human Resources, Health & Safety, can be found within the policies relevant to those areas.

1.7 This strategy does not consider the specific management of financial risk as this has separate statutory control systems documented elsewhere, but does recognise that poor management of risk whether clinical, non-clinical or financial can have an impact on the Trust’s ability to meet its strategic and financial objectives.

1.8 This strategy is based on regulatory guidance and best practice identified at national level including but not exclusive to the requirements of the Department of Health (DH), Care Quality Commission (CQC), National Health Service Litigation Authority (NHSLA), National Patient Safety Agency (NPSA) and Health & Safety Executive (HSE).

1 See financial control policies
Section 2: Purpose of the Risk Strategy

2.1 The purpose of the Risk Management Strategy is to set out the organisational approach to the management of the principal risks and hazards which may prevent achievement of the Trust strategic objectives.

2.1.1 It identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. This includes the process to be followed where deficits are identified.

2.1.2 It describes the means by which this strategy will be implemented at strategic, corporate and operational management levels to ensure a consistent approach to the identification, assessment, control and monitoring of risks regardless of source.

2.1.3 It describes the process for Trust Board and delegated committees as part of the quality assurance framework to review the effectiveness of the controls in place to manage, mitigate and escalate risk.

2.1.4 It assists the Trust Board to identify the scope of the Trust risk appetite (See 2.4) and the means by which risk may be accepted where the Board identifies that this is appropriate, but kept under review.

2.2 Implementation of this strategy:

2.2.1 Supports the requirement for Trust Board to be aware of its risk profile across the entire range of activities whether, clinical, non-clinical or financial.

2.2.2 Provides a consistent, clear and integrated process for management and escalation of risks.

2.2.3 Informs the decisions on which the Trust Board determines the level of risk appetite it is willing to accept.

2.2.4 Supports the means by which assurance is provided to the Trust Board to enable an accurate declaration against regulatory compliance, including the Statement of Internal Control, to be made.

2.2.5 Supports transparency, openness and early identification of areas where risks may not be managed as well as anticipated to enable corrective action to be taken.

2.3 As such, it supports delivery of the Trust objectives to:

2.3.1 Deliver public and patient safety by meeting statutory, mandatory and agreed clinical and operational standards

2.3.2 Continually modernise services to ensure they are patient focussed, clinically led and sustainable within an increasingly competitive climate without compromising safety or quality
2.3.3 Build on existing reputation as a recognised leader for innovative, integrated community health care services by understanding the risks to this occurring

2.3.4 Achieve robust financial performance and sustainable growth in accordance with the NCH&C strategic direction without compromising quality and patient experience

2.3.5 Ensure the future of NCH&C as a successful Foundation Trust which understands its breadth of risks regardless of source.

2.4 Risk Appetite

2.4.1 The Trust identifies its risk appetite as the amount of risk the organisation is prepared to accept, tolerate, or be exposed to at any point in time.

2.4.2 The level of risk deemed acceptable is decided by the Trust Board, based on available information, risk assessment and option appraisal of the action being considered.

2.4.3 This may be affected by both internal and external drivers and is kept under review by the Trust Board as this may change over time.

2.4.4 The Trust Board will identify explicitly the level of risk they are prepared to accept for any given situation, development or opportunity whether financial, commercial, clinical or operational, with defined parameters.

2.4.5 The aim is not to remove all risk but to assess and identify the threats and vulnerabilities in the business and clinical situations which together can produce the risk. This ensures that risk taking occurs in an appropriate, balanced and sustainable way across the full breadth of the Trusts portfolio of risks.

2.4.6 The Trust recognises that controlled risk taking within defined parameters (policies, procedures, objectives, risk assessment, review and control processes) and agreed by the Trust Board, encourages creativity, maximises financial rewards and improves service performance to produce benefits for patients, staff and all stakeholders.

2.4.7 Financial and commercial risk appetite and controls are agreed by the Board and defined as requiring compliance with legal, statutory and mandatory requirements to meet explicit financial objectives and to ensure these are delivered.

2.4.8 Clinical risk appetite is agreed by the Board with the aim of eliminating avoidable harm. This is achieved by having systems in place for early identification of harm or potential harm events, thorough investigation to identify root causes and to use the learning identified to reduce the risk of the harm event being repeated wherever possible.
Section 3: Key Aims and Objectives

3.1 The Risk Management Strategy identifies:

3.1.1. The organisational structure and reporting systems for the management of risk

3.1.2. The duties, scope, responsibility, accountability and authority of individuals, teams, departments, committees and subgroups which have some responsibility for risk

3.1.3. Requirements for the local management of risk to reflect this strategy

3.1.4. The link into committee structures, service monitoring and assurance processes in place to safeguard patient safety and the assets of the Trust

3.1.5. The management tools which enable the Trust to assess its risks systematically at strategic and operational levels, document the outcome of risk assessment and improve transparency of decision making

3.1.6. The process to ensure consideration of risks and options of managing them is integrated into the wider management and financial processes of the Trust

3.1.7. The process to ensure regular review and monitoring of required actions to mitigate risks

3.1.8. The process for monitoring compliance with this strategy at strategic and local level and to remedy any deficiencies identified

3.1.9. The process to disseminate the strategy and ensure lessons are identified to support learning from actual and potential risks that arise to reduce the risk of recurrence

Section 4: Overarching Organisational Structure for Risk Management

4.1 The Trust Board is responsible for ensuring that it receives appropriate assurance that risk is managed. This role is delegated to the key assurance committees with some responsibility for risk management. Section 5 gives the responsibilities of the Trusts Committees and Appendix B details the roles and responsibilities of individuals. Appendix D provides the overarching structure for risk management.

4.2 While all parts of the organisation will have a duty to manage risk within areas of delegated responsibility and/or expertise, the Quality & Risk Committee is the key committee which receives assurance on patient safety, clinical and non-clinical risk other than specific financial, performance and workforce issues.

4.3 Membership consists of Non-Executive Directors, with Executive Directors either as members or in attendance in line with the relevant committee terms of reference. This cross membership with other assurance and operational committees ensures reports addressing the breadth of risk information can be used to triangulate and assess the management of risk across the Trust profile.

4.4 The organisational and assurance structure provide an integrated framework for escalation and provision of assurance that risk is managed and that all reasonable action is taken to identify, assess and manage risks to the Trust and its stakeholders in a consistent and transparent way.
Section 5: Responsibility of Trust Committees for Risk Management

5.1 Trust Board

The Trust Board is responsible for the effective functioning of the Trust, the provision of managerial leadership and accountability. Its purpose is to ensure that the Trust’s systems and working practices support good corporate and quality governance, financial probity and the management of risk to underpin safe high quality service delivery in line with its terms of reference.

To do this the Trust Board:

5.1.2 Establishes the strategic objectives for the Trust

5.1.3 Ensures these support delivery of the Quality Strategy and Quality Governance Framework

5.1.4 Sets out the arrangements for obtaining assurance on the effectiveness of key controls across areas of principal risk, which may threaten achievement of those objectives, including from committees where this has been delegated

5.1.5 Establishes a reporting system to receive relevant documents including the Corporate Risk Register and Board Assurance Framework in an appropriate timeframe to enable the Board to ensure that its members are properly informed of the totality of their risks, not just financial, and to be assured that the systems to manage the principal risks are in place

5.1.6 Reviews the strategic risks as part of the Board Assurance Framework, to ensure appropriate management, identification and escalation of risks as per its schedule of reporting.

5.1.7 Evaluates the key controls to manage the principal risks, using external and internal assessment and assurance processes including residual risk.

5.1.8 Establishes a process to receive assurance that appropriate actions are taken following any serious event and are evaluated for effectiveness, learning and improvement

5.1.9 Receives summary reports on progress against compliance with specific aspects of identified risks that may occur

5.1.10 Receives performance management reports identifying key indicators monthly

5.1.11 Delegates the daily strategic management of risk to the Chief Executive who is accountable for delivery of this strategy

5.1.12 Approves the Risk Management Strategy and reviews it annually or more frequently in the event of significant changes whether internally or externally driven.

5.1.13 Demonstrates that it takes reasonable action to assure itself that the Trust’s business is managed efficiently through the implementation of controls to manage risk.

5.1.14 Undertakes a self assessment of its effectiveness annually
5.2 **Committees of the Trust Board**

5.2.1 Any high level committee where the responsibility for overseeing the different elements of risk management has been delegated by Trust Board, clearly indicates by its terms of reference which aspects of risk management it is responsible for, and whether its role is one of assuring or being assured. It also identifies the extent of its delegated authority.

5.2.2 Each delegated committee receives regular reports as part of its schedule of reporting to enable it to take a view as to whether it can assure the Board that the controls to manage specific aspects of risk which fall within its remit are in place and working.

5.2.3 It is the responsibility of the Chair of the delegated committee to alert the Trust Board to any concerns regarding the management of risk it oversees and to request additional information as necessary. To assist this process, committees have cross membership and appropriate representation from the executive team, senior managers and clinical teams. Minutes or summary action points by means of a Chair’s report from the high level assurance subcommittees are received by Trust Board at the next available meeting.

The main high level risk assurance sub committees are:

5.3 **Quality & Risk Assurance Committee (Q&RAC)**

5.3.1 The Quality & Risk Assurance Committee is constituted by the Board and has delegated authority in line with its Terms of Reference as the committee with overarching responsibility for risk management. As part of this role it:

5.3.1.1 Reviews the quality and safety of services to ensure the Trust provides safe, high quality, continually improving, patient centred care

5.3.1.2 Ensures the maintenance of an effective system of integrated governance and risk management that supports achievement of the Trust’s objectives

5.3.1.3 Obtains assurance through its reporting shedule and additional reports received to enable it to assure the Board that risk is managed effectively within NCH&C

5.3.2 This includes but is not exclusive to risks from clinical incidents, complaints, claims, litigation, health and safety, information governance and clinical audit as identified within its terms of reference.

5.3.3 It receives relevant reports and updates on actions taken to comply with specific external assessments to fulfill this remit and within an appropriate timescale.

5.3.4 On agreement with the Committee Chair, it also receives additional items on any other activity which creates a potential or actual risk to good clinical governance or patient safety.
5.3.5 It reviews the corporate risk register and Board Assurance Framework in line with its schedule of reporting.

5.3.6 The Chair and deputy are Non Executive Directors and cross membership of this committee with the Audit Committee assists in ensuring an integrated approach to manage clinical, non clinical, financial and performance risk which may affect the clinical service delivery, compromise patient safety or the Trust’s ability to meet its strategic objectives.

5.3.7 Its minutes are shared with the Audit Committee and received by Trust Board for information at the next available meeting. Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

5.3.8 The Q&RAC operates in line with its terms of reference and assesses its effectiveness against these annually reporting to the Board on the outcome.

5.4 The Audit Committee

5.4.1 The Audit Committee is a committee of the Trust Board. The committee has the responsibility to assure the Trust Board and to be assured, that appropriate action is taken to minimise and control all aspects of non-clinical risk including financial within its remit.

5.4.2 It receives relevant reports to enable it to do this and in an appropriate time scale. This includes reports from internal and external auditors in respect of the Trusts’ effectiveness at mitigating specific risks.

5.4.3 As such it has delegated authority from the Board as identified in its terms of reference.

5.4.4 It monitors the actions taken and progress against all financial requirements, and certain external assessments to identify and control risks as per its work plan and reporting schedule.

5.4.5 As the assurance agenda crosses clinical and non-clinical boundaries, the minutes are received by Trust Board for information.

5.4.6 The Chair and deputy are Non Executive Directors and cross membership of this committee with the Quality & Risk Assurance Committee assists in ensuring an integrated approach to manage financial, non clinical and clinical risk identified through the audit process which may affect the clinical service delivery and the Trust’s ability to meet its objectives.

5.4.7 Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

5.4.8 The Finance Committee and the Remuneration Committee review financial and remuneration risks as part of their remit, with identified risks reported back to the Board through the relevant assurance committees.

5.4.9 The assurance committees receive assurance as per their terms of reference from the nominated operational and management committee structure as
identified in the Assurance & Escalation Framework. Each committee or group has terms of reference identifying their purpose, level of authority, reporting line, membership including a nominated deputy, requirements to be quorate, expected attendance, schedule of reporting and monitoring process.

5.5 **Trust Management Team (TMT)**

5.5.1 The Trust Management Team is chaired by the Chief Executive and has representatives from executive, corporate, clinical and operational teams. This meeting reviews strategic and operational risks both internal and external to the Trust. These may be as a result of internal or external factors, service development and planned changes or from clinical, non clinical or financial sources.

5.5.2 It ensures that all aspects of Trust activity are considered and risk assessed when decisions are made, to minimise organisational risks whether clinical, non clinical or financial.

5.5.3 It delegates authority to senior managers, business units, localities and corporate departments to manage risk to local service provision as appropriate.

5.5.4 It monitors performance against the Trust objectives, identifying variance, assessing risk management priorities and co-ordinating the Trust response.

5.5.6 It supports business unit, localities and departmental activities to ensure appropriate use and allocation of resources to support and maintain service delivery and to minimise and control risks.

5.5.7 It receives updates on work and measures undertaken to mitigate risks by specific subgroups, operational committees and any other time limited group which it has established or delegated authority to, to take forward specific work.

5.5.8 It oversees the implementation of an effective system of risk management, reviews risks for escalation from the Corporate Risk Register to the Board Assurance Framework and manages residual risks identified as 16 or above on the Board Assurance Framework.

5.6 **Standing Committees**

5.6.1 A standing committee is a committee with delegated authority from Trust Board. Each standing committee is responsible for managing the cross Trust issues relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit.

5.6.2 This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise.

5.6.3 A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care.
5.6.4 The standing committees will provide a summary of their work as part of the schedule of reporting to either a designated assurance committee or by a direct report to Trust Board as stated in their terms of reference.

5.7 **Operational, time limited or task specific groups**

5.7.1 In addition to clinical and operational standing committees, other groups may be established to cover work which may be strategic, time limited, task driven or have a combined operational role. These may be required to oversee large projects or to co-ordinate delivery of a specific objective.

5.7.2 These groups or committees are chaired by a senior manager or executive director and the remit of the group, scope of authority, any time limits and reporting lines are included in the terms of reference.

5.7.3 Reporting lines are into an identified committee. This is to ensure that all work undertaken on behalf of the Trust can link into the existing reporting, monitoring and assurance systems in place.

**Section 6: Process for Managing Risk Locally in Support of this Strategy**

6.1 **Locality Business Unit and Department Structures**

6.1.1 The management of risk locally will reflect this organisational risk management strategy. Locality Business Units and departments will have in place as a minimum:

6.1.1.1 Documented internal meeting and governance structures with the roles, responsibilities and reporting lines of individuals, groups and committees identified.

6.1.1.2 A process for identifying, assessing, recording reviewing and controlling risks relevant to their service delivery and development in line with this strategy.

6.1.1.3 Authority within staff roles and responsibilities to manage risk at local level including financial and service risks.

6.1.1.4 Documented internal meeting and governance structures with the roles, responsibilities and reporting lines of individuals, groups and committees identified.

6.1.1.5 A process to escalate risk in line with this strategy through the local management and governance reporting structure to Director level as appropriate.

6.1.1.6 A process to comply with the requirements of Trust Policies including but not exclusive to risk management, record keeping, finance, performance, induction, mandatory training, employment, workforce and supervision.

6.1.1.7 A process to act upon non compliance or where deficits may be identified including monitoring and reporting on action plans at local and corporate level.

6.1.1.8 A process to share information and learning across their business unit, locality or department.

6.1.1.9 A process to comply with reporting and monitoring requirements.
6.1.2 The documented internal meeting and governance structure will identify how this will occur and how these structures link into the broader assurance structure of the Trust in line with the requirements of the Assurance and Escalation Framework.

6.2 Incident Reporting, Complaints, Comments, Early Warning Trigger tool

6.2.1 Incident reporting is part of the early warning process to identify where systems and processes may not be working as well as anticipated.

6.2.2 Locality business units and corporate departments must have a process to review their reported incidents and levels of reporting monthly.

6.2.3 The Incident Reporting, Investigation & Management Policy describes the process to report, record and investigate individual incidents in detail to ensure consistency.

6.2.4 Levels of reporting and aggregated analysis will be monitored by the Risk Manager and reported through to the Quality & Risk Assurance Committee in accordance with the work plan, with feedback to the local teams.

6.2.5 This process must also be applied to Complaints and Comments received and areas of risk identified by the Early Warning Trigger tool or other performance indicators.

6.3 Risk Assessment

6.3.1 Each business unit, locality and corporate department will undertake risk assessments where appropriate and as identified in Trust policies. They will score, grade, prioritise and document the risks using a common assessment matrix (See Incident Reporting, Investigation & Management Policy) to ensure a continual, systematic approach to all risk assessments regardless of the source of risk being assessed.

6.3.2 A risk assessment will be undertaken prior to planned changes or changes to service delivery to identify any additional risks that may be likely to occur. They may be documented for example as part of the business planning process, as part of a project initiation document or as part of a departmental review of compliance with statute e.g. Health & Safety, a Health Technical Memorandum related to specific aspects of corporate risk such as Fire, or following an actual event.

6.3.3 The minimum content will include the nature of the hazard, the likelihood and impact of the risk occurring, controls in place and initial and residual risk grading. It will also include the process for scoring the risk and monitoring the action plan or slippage.

6.3.4 Locality Business units and corporate department managers must ensure staff complete appropriate training to enable these to be completed and are aware of their responsibility to manage risk within their remit.

6.4 Local Risk Registers

6.4.1 Each area will have a risk register which will identify the source and description of identified risks, scored with review dates, the controls in place to mitigate the risk, any additional actions required, the date of review and residual risk rating.
6.4.2 The locality business unit or corporate department must have a process in place to review risk assessments and keep their risk register updated and to escalate risks in line with the Incident Reporting, Investigation & Management Policy.

6.4.3 Risks will be reviewed within a stated time frame by the local team or service to ensure that controls in place are working, and assess whether the risk changes over time. Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments, performance indicators or financial interests.

6.4.4 They may be identified by external factors e.g. national reports and recommendations.

6.4.5 Reports on reported incidents will be made available to local teams, locality business unit or senior meetings as a minimum monthly or in line with the nominated meeting work plan.

6.5 Corporate risk register

6.5.1 The Corporate risk register is the aggregation of the local team and corporate department risk registers where the residual risk is more than 12. It includes any additional sources of risk such as external or internal reviews. It is maintained centrally by the Risk Manager and recorded on the Datix risk management system. As such it identifies the source, describes the risk, scores and grades the risk and provides a summary of the action taken to control it. It includes a review date and a residual risk rating.

6.5.2 Escalation and de-escalation of risks across the local and corporate risk registers and Board Assurance Framework is in line with the Assurance and Escalation Framework and Incident Reporting, Investigation & Management Policy.

6.5.5 Risks identified which may need a corporate approach are referred to the Operational Managers Group and escalated to the Trust Management Team as required.

6.5.6 The corporate risk register is reviewed by the Trust Board and its sub committees as per the committee reporting schedules.

6.5.7 Changes to the risk registers are monitored centrally by the Risk Manager.

6.6 Board Assurance Framework

6.6.1 The Board Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps using the same format as the corporate and local risk registers.

6.6.2 It is informed by the risks where the residual risk is graded 16 or above on the corporate risk register once these ratings have been confirmed and agreed by the local unit or departmental review and escalated for inclusion according to the Assurance and Escalation Framework. They may include internal, external and strategic risks which may affect the Trusts business, those identified by the Executive Team or any additional source where local controls are not sufficient to
manage the risk e.g. infection control, finance or information risk. It includes key risks identified through aggregated analysis of incidents, complaints and claims which may not already appear on the corporate risk register.

6.6.3 Each risk is linked to a Trust objective and has an Executive lead, responsible for receiving assurance that the actions required to mitigate the risk are completed at either local, operational or strategic level.

6.6.4 The Board Assurance Framework provides a vehicle for the Trust Board to be assured that the systems, polices and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust objectives being achieved.

Section 7: Risk Management Awareness Training

7.1 The table below summarises the requirement for training for all staff in respect of clinical and non clinical risk management and is part of corporate and local induction. New staff are booked on joining the Trust by their line manager. (See Incident Reporting, Investigation and Management Policy for further detail).

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<td>Non Clinical Staff</td>
<td>Induction &amp; training sessions</td>
<td>Quality &amp; Risk Team</td>
<td>Attendance monitoring</td>
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<td>Attendance monitoring and Board self assessment</td>
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<td>Complaints Manager</td>
<td>Attendance monitoring</td>
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<td>Staff with responsibility for undertaking Root Cause Analysis</td>
<td>Bespoke training and /or Risk Management Training</td>
<td>Quality &amp; Risk Team</td>
<td>Attendance monitoring</td>
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<tr>
<td>New Managers</td>
<td>Bespoke Training</td>
<td>Quality &amp; Risk Team</td>
<td>Attendance monitoring</td>
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7.2 Additional specific financial, business continuity, major incident and information governance training is identified for staff relevant to their roles and delivered, recorded and monitored through the Learning, Education & Development Team and elearning access.

7.3 Failure to attend relevant training is followed up with the individual in the first instance as part of the attendance monitoring process by the Learning Education and Development Team, then escalated with the relevant manager. A process of audit ensures staff attendance.

Section 8: Monitoring Compliance with this Risk Strategy

8.1 The management of risk applies to all areas of the Trust’s activity. Evaluation may occur by assessment of compliance by an external agency, compliance with statute, internal or external reporting, as part of the independent audit function or by internal quarterly reports via the management systems in place.

8.2 Compliance with specific aspects of this strategy will be monitored as follows:

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<tr>
<td>Organisational structure for risk management and inclusion in risk strategy</td>
<td>Annually when policy is updated</td>
<td>Q&amp;RAC</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Receipt of corporate risk register by relevant committees</td>
<td>Annually as part of compliance audit with the committee reporting schedules</td>
<td>Q&amp;RAC</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Review of involvement of senior managers in risk management process eg Datix, RCA reports, escalation and levels of reporting</td>
<td>Annual</td>
<td>Q&amp;RAC</td>
<td>Trust Board – included in quality report annually</td>
</tr>
<tr>
<td>Role of the Assurance Committees</td>
<td>Annual</td>
<td>Individual committee self assessment</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Role of Clinical Standing Committees</td>
<td>Annual</td>
<td>Individual committee self assessment</td>
<td>Relevant Assurance Committee</td>
</tr>
<tr>
<td>Role of Operational Committees</td>
<td>Annual</td>
<td>Individual committee self assessment</td>
<td>Relevant Assurance Committee</td>
</tr>
<tr>
<td>Board Assurance Framework</td>
<td>Bi annual</td>
<td>Q&amp;RAC</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Risk Register Management</td>
<td>Quarterly</td>
<td>Risk Manager</td>
<td>Q&amp;RAC</td>
</tr>
<tr>
<td>Management of Risk</td>
<td>Quarterly</td>
<td>Risk Manager</td>
<td>QRAC</td>
</tr>
</tbody>
</table>
at local level in line with the Risk Strategy including risk assessment

<table>
<thead>
<tr>
<th>Levels of incident reporting</th>
<th>Monthly</th>
<th>Business, Locality, Corporate department or equivalent meeting</th>
<th>Q&amp;RAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management Training</td>
<td>Quarterly</td>
<td>Training Dept/ Human Resources Dept</td>
<td>Q&amp;RAC</td>
</tr>
</tbody>
</table>

8.3 A report will be received by the relevant committee which will include as a minimum:

8.3.1 Rationale for the audit or review

8.3.2 What is being measured eg attendance, receipt of minutes, completeness of minutes, compliance with any reporting schedule or applicable measure identified to demonstrate compliance, receipt of Chairs report.

8.3.3 Results of the audit or review and whether compliance was demonstrated.

8.3.4 Compliance will be scored as follows

<table>
<thead>
<tr>
<th>Score for compliance</th>
<th>Grade</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>Green</td>
<td>Report to named committee as per reporting schedule</td>
</tr>
<tr>
<td>76-89%</td>
<td>Yellow</td>
<td>Report to named committee with action identified to improve compliance and time scales. Monitoring to be incorporated into the named committee meeting schedule or workplan once agreed.</td>
</tr>
<tr>
<td>&lt;75%</td>
<td>Red</td>
<td>As above. Discuss with responsible person depending on deficit identified eg relevant committee chair, Assistant Director, Executive Director to identify deficit and means to rectify.</td>
</tr>
</tbody>
</table>

Section 9: Management of Non Compliance

9.1 Aspects of this strategy are audited annually prior to updating and reviewed to assess the effectiveness of the processes and tools identified within it and compliance with the stated requirements.

9.2 Where deficiencies are identified, discussion with the relevant manager, executive director or at a relevant committee occurs to assess what remedial action is required. Progress against internal and external audit recommendations is reported back through the appropriate assurance committee depending on the nature of the audit and its source.
Section 10: Dissemination of this Strategy

10.1 The Trust Board recognises that good channels of communication are vital to the achievement of the aims of the Risk Management Strategy. An open and fair\textsuperscript{2} culture which welcomes direct interaction between managers and staff at all levels assists in ensuring the aims of this strategy are achieved.

10.2 Staff are informed of this strategy and linked policies on induction and during mandatory training sessions.

10.3 The strategy is available on the Intranet and on the Risk Management page.

Section 11: Specialist Advice

11.1 Further advice on any aspect of risk management, reporting, assessing, monitoring, compilation of risk registers etc or to identify where additional information is available can be obtained from the Quality & Risk Team.

11.2 Additional staff available to give specialist advice on aspects of managing risk are:

11.2.1 Director of Finance (SIRO) - Advice on financial risk including fraud, information governance and information risk

11.2.2 Medical Director - Advice on medical staffing, clinical issues, partnership working and patient safety

11.2.3 Director of Quality, Risk and Executive Nurse (Caldicott Guardian) - Advice on nursing, staffing, clinical care, patient safety, and appropriate use of patient identifiable information, Caldicott issues

11.2.4 Assistant Director Risk Management & Information Governance - Advice and guidance on aspects of clinical and non clinical risk management, analysis, effectiveness, assurance, information risk and governance

11.2.5 Risk Manager - Advice training and guidance on aspects of clinical risk management, risk assessments, risk registers and root cause analysis, incident reporting

11.2.6 Patient Safety & Compliance Manager – all aspects of internal and external compliance, root cause analysis investigation and report writing, information governance

11.2.7 Complaints & Claims Manager - Advice training and guidance on aspects of complaints management, legal claims, litigation and patient experience

11.2.8 Quality & Risk Team - Advice training and guidance on aspects of external compliance, clinical audit, root cause analysis, investigation process, data protection

11.2.9 Safeguarding Leads, Adults & Children – information on any safeguarding issues regarding vulnerable adults or children

11.2.10 Health and Safety Advisor - Advice training and guidance on aspects of

\textsuperscript{2} See Definitions.
non-clinical risks, health and safety litigation and risk assessments

11.2.11 Local Counter Fraud Management Specialist - Aspects of fraud or potential fraud or financial loss to the Trust

11.2.12 Trust Secretary - Aspects of the Trust constitution

11.3 This list is not exhaustive but any of the above are able to give advice on additional sources of information or assist staff in identifying where this could be obtained.
Appendix A: Duties, Roles and Responsibilities of the key individuals for risk management activities

1.1 The following gives the duties, roles and responsibilities for risk management activity in the Trust at individual, department and team level. Due to the variable nature of risk, this is not exhaustive and may change depending on the type of risk identified and the action required to mitigate it. Where authority is devolved, the extent of this authority is identified with the member of staff or in the relevant job description. Assessment of risks assists in identifying how a risk will be managed and the level of management responsibility required. (See Incident Reporting, Investigation and Management Policy).

1.2 All members of staff are responsible for their own safety and for ensuring risks to the organisation, colleagues, patients and visitors are minimised. All managers have authority to reduce risk within their areas of responsibility whether clinical, non clinical or financial and are responsible for ensuring safe systems are in place.

1.3 Staff are required to report incidents when they occur, mitigate their effect, lead on investigating the causes and escalate to their line manager, Head of Service, Assistant Director or relevant Director as appropriate. If in doubt advice can be sought from the Assistant Director Risk Management & Information Governance.

1.4 Chief Executive Officer

1.4.1 The Chief Executive as the accountable officer is the individual with overall and final responsibility for ensuring an effective risk and quality management system is in place and resourced.

1.4.2 Delegation of responsibility and authority from the Chief Executive occurs to designated executives and senior managers to ensure the necessary organisational structure and resources to implement policy and manage risks effectively is in place. This includes the process to identify and address deficiencies and implement recommendations to reduce risk to the lowest level possible.

1.4.3 The Chief Executive is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems to manage risks and maintain quality service provision, are operating effectively.

1.4.4 The Chief Executive or their nominated Executive Director is actively involved in the work of the sub committees with responsibility for managing risk, ensuring that there is a system to assess and review the effectiveness of the controls put in place to mitigate those risks.

1.4.5 Through the responsibility delegated to the Executive Director Team, they are aware of all key decisions made within the Trust. They ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, including the means by which effectiveness of action to reduce risk and maintain quality and patient safety is monitored.
1.4.6 The Chief Executive uses this information to provide assurance to the Board in the Statement of Internal Control that risk is managed and mitigated regardless of source as far as is reasonably practicable, within the stated risk appetite of the Trust. The Chief Executive identifies to the Trust Board by means of the Board Assurance Framework where a risk may need to be accepted by Trust Board and those risks which may affect the ability of the Trust to meet its strategic objectives.

1.5 Non Executive Directors:

1.5.1 Assurance committees of the Trust Board are Chaired by a Non Executive Director. They are responsible for ensuring that they are provided with the appropriate information to enable them to make a reasoned judgement as to whether the elements of risk for which they assure the Board, are being managed with proper controls in place.

1.5.2 They have a duty and the authority to raise with the Trust Board any risk issue they believe is not being managed appropriately, that may be a threat or opportunity to the Trust, or which has caused them concern. They have a duty and authority to request additional information from any source to enable them to fulfill this function to ensure provision of safe, high quality services.

1.6 Executive Directors:

1.6.1 The Trust Board has designated accountability for risk management and quality service provision to nominated executive directors and as such this is identified within their job descriptions. They meet regularly with the Chief Executive and through the Executive Director Team meetings, ensure all aspects of risk are managed appropriately within their areas of responsibility to enable early identification of an actual or potential problem.

1.6.2 All Executive Directors remain accountable for reducing risk within their areas of responsibility by best practicable means and ensuring the impact of decisions taken and the effect on the viability and reputation of the Trust, is assessed as part of this decision making process. They delegate authority to nominated managers as appropriate to manage local risks and to specific committees or project groups to manage corporate risks. They ensure a feedback mechanism is in place to monitor actions taken and compliance with internal and external regulatory or statutory requirements relevant to their remit.

1.6.3 The Executive Directors are part of the Trust management structure and represent their specific areas of risk management responsibilities at Trust Board and Committees of the Board. They may also chair or be members of

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3 Corporate risks – these are risks which need either a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it identified, this must be agreed with by the Chief Executive and identified to Trust Board.
specific groups or committees to consider areas within their expertise which may be time limited, or to oversee specific tasks.

1.6.4 As part of their risk management role, they will delegate areas of accountability to nominated individuals as appropriate.

1.7 **Director of Quality, Risk & Executive Nurse**

1.7.1 Executive responsibility and accountability for the implementation of risk management, quality improvement and patient experience systems within the Trust.

1.7.2 Executive responsibility for Major Incident Planning and implementation.

1.7.3 Designated Caldicott Guardian for the Trust.

1.7.4 Executive and professional clinical leadership for nursing and allied professional staff.

1.8 **Medical Director**

1.8.1 Executive responsibility and accountability for ensuring mitigation of risk by Medical Staff employed or contracted by NCH&C.

1.8.2 Executive responsibility for medical postgraduate training where this occurs and managing associated risks as a result of changes to medical workforce, whether internally or externally driven.

1.8.3 Executive and professional clinical leadership for medical staff employed or contracted by NCH&C.

1.9 **Director of Operations**

1.9.1 Executive responsibility and accountability for ensuring that clinical and non-clinical risk management is embedded at all operational levels of the Trust to ensure compliance at local and business unit level with strategic objectives.

1.9.2 Accountable for ensuring effective management and mitigation of risk as part of the day to day and operational practice of the Trust.

1.9.3 Accountable for the provision of the safeguarding service.

1.10 **Director of Finance**

1.10.1 Executive responsibility and accountability for all aspects of financial risk and compliance with statutory financial requirements. This includes but is not limited to business planning, objective setting, fraud, information governance and information risk.

1.10.2 Is the Senior Information Risk Owner (SIRO) for the Trust.
1.10.3 Executive responsibility and accountability for the management of the estate, facilities, information technology and procurement.

1.11 **Director of Human Resources**

1.11.1 Executive responsibility and accountability for the effective management of the human resource, training functions and health and safety services within their remit including moving and handling and fire.

1.11.2 Executive responsibility for ensuring these aspects of risk management link back into the wider learning and dissemination process to reduce risk wherever possible.

1.12 **Director of Business Development**

1.12.1 Executive responsibility and accountability for ensuring all risks related to business development and provision of new services are mitigated and managed to provide maximum opportunity for the Trust. This includes financial and service continuity risks and third party risk managed through the contracting process.

1.13 **Director of Performance**

1.13.1 Accountable for ensuring the appropriate processes are in place to monitor performance against defined parameters whether internally or externally set.

1.13.2 Ensuring the process for monitoring, discussion and escalation of risks identified through the performance monitoring process are escalated and acted on appropriately.

1.14 **Trust Secretary**

1.14.1 The Trust Secretary is responsible for ensuring that the Risk Management Strategy meets the requirements for and links into, an integrated system for effective corporate and quality governance.

1.14.2 They co-ordinate the main high level committees and the Trust Board and ensure relevant papers are provided in line with the agreed reporting schedule.

1.14.3 They ensure appropriate reporting occurs from the operational committees into the assurance committees and Trust Board to support the governance and risk management framework of the Trust.

1.14.4 They manage any additional risk and compliance function as delegated by the Chief Executive.

1.14.5 They maintain a process to ensure security and preservation of corporate documents.
1.15 Deputy / Assistant Directors

1.15.1 Deputy / Assistant Directors within each Locality Business Unit or Corporate Department are required to manage risks within their own areas of responsibility and to implement the requirements of this Risk Management Strategy.

1.15.2 They ensure appropriate and effective risk management processes are in place to reduce risks within the work environment, implement and comply with corporate, financial, information risk, departmental and unit policies and guidelines.

1.15.3 They ensure an internal structure is established within the business unit or corporate department to review and discuss risk management issues and that these are included where appropriate on the local risk register.

1.15.4 They will ensure a governance framework is in place within their teams which enables information to be shared, lessons learned, deficits identified and actions monitored and reported back into the wider governance structure of the Trust through the Operational Management Group, Trust Management Team and their local teams.

1.15.5 They ensure internal and external compliance with any regulations or statutory guidance relevant to their own areas of work and seek advice from appropriate advisors where necessary eg. Health & Safety, Care Quality Commission, Occupational Health, Infection Control, Security, Estates, Facilities, Quality & Risk Management, Human Resources, Finance etc.

1.15.6 They are accountable for identifying deficits in compliance within their department or unit, however caused, and agreeing an action plan to remedy any such deficiency with their relevant Executive Director. This is to ensure the continuity of services and reputational risk to the organisation is minimised.

1.15.7 The Deputy/Assistant Director may delegate authority for these roles to specific competent named individuals within their unit or specialty teams who report back to them through the existing internal structures within their department as appropriate.

1.16 Heads of Service & Senior Managers

1.16.1 Heads of Service & Senior Managers in corporate and clinical teams are authorised to manage risk related to their operational areas of responsibility on a daily basis.

1.16.2 They have a duty to ensure that any factors which may create additional risk or affect the ability to manage or control risk relevant to their area of work or service are risk assessed and highlighted to the relevant Assistant Director.

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4 This includes Modern Matrons, Department Managers, Ward Sisters, Assistant Directors, Heads of Departments, Heads of Service or equivalent level staff
1.16.3 Each corporate department must ensure compliance with its policies and procedures by a process of regular review. Staff must be informed of these policies and procedures by means of an induction process that is documented.

1.16.4 Each head of department is responsible for ensuring that any policy relevant to their area of work is current, approved in line with the Trusts Policy for Procedural Documents, and made available to their staff.

1.17 Quality and Risk Directorate Team

1.17.1 The Quality and Risk Directorate Team reports to the Director of Quality, Risk and Executive Nurse.

1.17.2 The team manages the clinical incident reporting, serious incident reporting and investigation, complaints, clinical audit, patient experience, information governance risk and registration compliance functions for the Trust.

1.17.3 It supports the management of local clinical and non clinical risks to ensure these are integrated into the Trust assurance and governance systems.

1.17.4 The team provides information to all levels of the Trust to support effective local implementation of this risk strategy. It maintains the trust wide Corporate Risk Register and escalates information from this into the Board Assurance Framework in line with the Assurance & Escalation Framework.

1.17.5 It has a specific responsibility for collation of information for external statutory and risk based assessments and reporting within its remit to support compliance with registration requirements.

1.17.6 The Deputy Director for Quality & Risk is the Data Protection Officer.

1.17.7 The Assistant Director for Risk Management and Information governance is the Trust Information Governance Lead.

1.17.8 Deputy Executive Nurse is the DIPC.

1.18 Health & Safety Team

1.18.1 The Health & Safety team are accountable for the management and statutory compliance with health and safety functions of the Trust. (See Health & Safety Policy).

1.19 Performance Management Team

1.19.1 The Performance Management Team liaises with Locality business units, teams and corporate departments to ensure access to appropriate and timely information on service provision and the key performance indicators to support the management and monitoring of risk both internal and external to the Trust.
1.19.2 They ensure that the Trust objectives are linked to high level performance indicators to enable early identification of areas where additional actions are required to remedy any deficit.

1.20 **Information Technology Team**

1.20.1 The Information Technology Team ensure that the correct processes and procedures are in place in line with national guidance on Information Governance to ensure the information systems are fit for purpose and the security of data is maintained.

1.20.2 They have a disaster recovery plan in place to reduce risk and an escalation process to inform the Director of Finance in the event of a deficit being identified.

1.21 **Marketing & Communications Team**

1.21.1 The Marketing and Communications Team provide support, advice and guidance to the Executive Team to manage the information process across the Trust and with external agencies in the event of a risk issue being identified. This includes contact with the press, media, government or other relevant organisations as appropriate.

1.22 **All Employees/Visitors**

1.22.1 Employees, whether part of clinical or non clinical teams, are made aware of the risks within their work environment, their personal responsibilities for reporting risks and minimising risk to themselves and others.

1.22.2 They are given the necessary information and training to enable them to work safely.

1.22.3 All clinical and non clinical staff are expected to report incidents when they occur and be involved where appropriate in any investigation to identify the cause of specific risks or as the result of an adverse event (See Incident Reporting, Investigation & Management Policy, Health & Safety Policy).

1.22.4 While visitors have a responsibility for maintaining their own health and safety while on site, employees have a responsibility to ensure that visitors are not exposed unnecessarily to risks, to report and take action to minimise any such exposure.

1.23 **Contractors**

1.23.1 Contractors carrying out work on the Trust’s property are expected to comply with statute. It is the responsibility of the Executive Director contracting with them on behalf of the Trust to ensure that contractors and sub-contractors comply with the relevant safety procedures and, where appropriate, specify detailed health and safety and performance management requirements in any written terms of agreement before work commences.
1.23.2 The Health & Safety manager will support this process to ensure compliance with HSE guidance on the managament of contractors on Trust premises.

1.24 Partnership working with other organisations

1.24.1 Where the Trust links in with other health care providers to deliver a specific clinical service a risk assessment is undertaken as part of the planning process and used to inform any Service Level agreement. This identifies potential risks to the individual parties, service users, the public, patients and other stakeholders and ways to reduce these.

1.24.2 It is the responsibility of the project manager or person managing this process, under the guidance of the relevant Executive Director, to ensure this occurs.

1.24.3 Wherever possible, systems to monitor and reassess risk are included as part of the business plan or tender and incorporated into the regular performance monitoring process of the Trust.

1.24.4 Where appropriate, information sharing protocols will be used to ensure information to support patient care can be managed lawfully between partner organisations.
Appendix B: Definitions

1. Risk Management

Risk Management is the process to identify, assess and prioritise the Trusts exposure to risk whether clinical or non clinical, which may affect its ability to meet its objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated.

2. Clinical Risk

An adverse patient safety incident has been defined by the National Patient Safety Agency as ‘any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage’. Harm is defined as ‘injury (physical or psychological), disease, suffering, disability, or death’. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient’s illness or underlying condition. Those incidents that did not lead to harm, but could have, are referred to as prevented or near miss incidents. Loss or damage occurring within the context of clinical risk to the patient, can equally apply to their family, staff or the organisation and may be both financial and/or to reputation. Clinical risk can also occur due to latent decisions eg change to service delivery which create different risks not just an adverse event but which may not be apparent at the time the change is made.

3. Non Clinical Risk

Non Clinical risks are any event or circumstance arising during NHS care that could have or did lead to impairment of the Trust’s ability to deliver its objectives, whether intended or unexpected. These risks are the outcome of hazards that have the potential to cause, or actually cause, harm by affecting the organisations ability to deliver high quality services. They may relate to a number of the Trusts support mechanisms including health and safety, estates and facilities, technical, information technology, personnel, training or financial aspects of the Trusts business. They may have a direct or indirect affect on patient care, member of staff, visitor, contractor or other stakeholder and result in loss or damage. This loss may be both financial and/or to reputation.

4. Principal Risks

Principal risks are those that have significant potential to impair or affect the operational or financial ability of the organisation to deliver ongoing services. These can be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require a system of regular review, as their priority for the Trust in relation to meeting its objectives may change over time.
5. **Significant Risk**

A significant risk is defined as any risk identified as having a medium or high risk consequence and which requires an achievable action plan\(^5\) to identify the controls to be put in place and monitored for effectiveness at reducing the risk. Hazards are assessed using a matrix to identify the likelihood of harm occurring and the impact of the risk. Risks are prioritised using a common format and system across the Trust (See Incident Reporting, Investigation & Management Policy).

6. **Acceptable risk**

The Trust makes every effort to ensure that all risks are as low as reasonably achievable. It is not possible to reduce all risks to zero, as there is no such thing as clinically neutral care and decisions must be made as to whether the benefits and best use of resources outweigh the risks. The risk assessment tool enables the Trust to assess the impact and likelihood of a risk occurring and is an aid to decision making to identify what it is reasonable to accept.

Acceptable risk is defined using the following principals:

6.1 If following the rigorous approach to risk assessment, it is decided on balance to accept a risk, those accepted risks should still be controlled. To tolerate risk and accept a risk does not mean to disregard it. Any accepted risk must be reviewed on an annual basis and all options reviewed with an aim to reduce risks further. Patients, staff, visitors, contractors must be made aware of the risks they are being exposed to. No person should be exposed to serious risk unless they agree to accept the risk. In order to be fully informed of the risk, this must be done in a way they can understand.

6.2 It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all the other alternatives, including doing nothing, is even greater.

6.3 Accepted risk is a High Risk and is monitored through the Board Assurance Framework. Acceptable risk can only be agreed by escalation through to the TMT/EDT or by the Chief Executive. Accepted risks are discussed at Trust Board as part of the performance monitoring and assurance systems and may be clinical or non-clinical.

6.4 The Board Assurance Framework is the means by which the principal risks to the Trust are identified and control and assurance gaps reported. It is the tool by which the Trust Board is able to take a view as to whether a specific risk has been reduced to an appropriate level and whether any residual risk in that instance will be accepted.

7. **Transferring, Delegating, Eliminating risk**

Transferring Risk - a service and the associated risks are transferred to another provider

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\(^5\) An action plan may be in the form of a business case, written report, included on the risk register or be presented in any applicable format. It should contain what action is required, who is responsible for taking the action, when it will be completed and where it will be reported to.
Delegating Risk – a service and associated risks are delegated to another team
Eliminating Risk – a service is no longer provided and the risks are removed

8. Open and Fair culture

8.1 The Trust continues to develop a culture that is open and fair where patients, their families and carers know they can approach staff about problems without their treatment being affected; and staff feel able to report hazards, risks and mistakes without fear. Prejudging events by adopting a punitive approach to staff stops information giving, learning and improvement and the risk to patients is increased.

8.2 An open culture means that staff are aware of their professional accountability for safe practice, well trained to identify risks early, and know that the outcome of any subsequent investigation is based on fact not assumption (See Incident Reporting, Investigation & Management Policy). Levels of reporting are monitored internally and externally at least quarterly.

8.3 A fair culture recognises that events rarely occur as a result of a single, negligent, deliberate or reckless action, but as part of a sequence of human error, systems failures and contributory factors. Each of these factors is considered in any investigation which is undertaken into an adverse event. As professionals, staff are held accountable for their actions and are expected to report incidents or hazards and to co-operate in any investigation as a result. This includes a duty to report when they feel they are a risk to patients either due to competency, conduct or health reasons as well as any concerns regarding other staff members. A consistent and unified stance for all professions throughout the Trust is maintained and any subsequent actions deemed necessary following a full and thorough investigation, is managed through the appropriate processes already established within the Trust.
Appendix C: Organisational Structure Chart for Risk