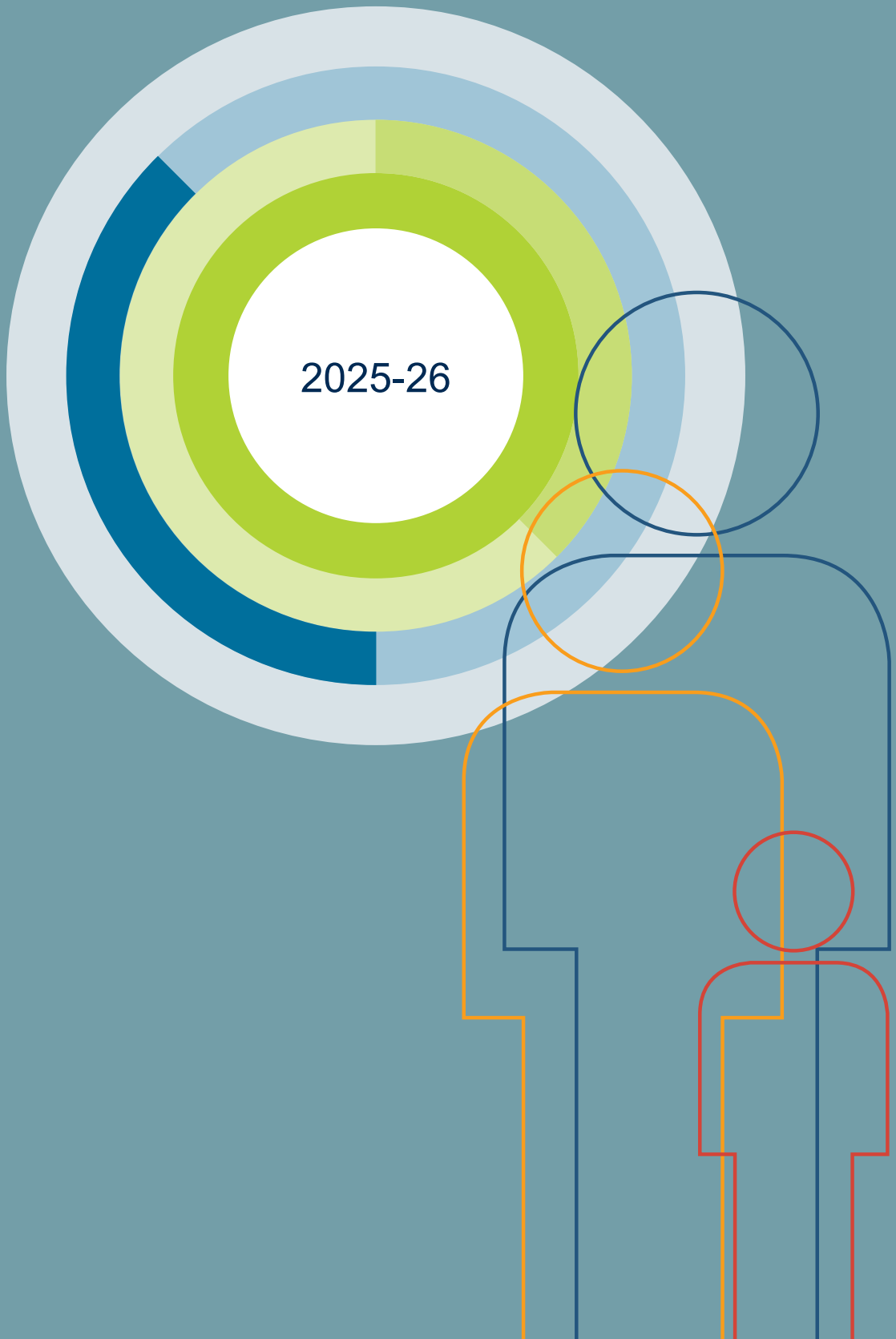
Belfast Health and Social Care Trust
caring supporting improving together

Risk Management Strategy

2025-26



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Policy Statement

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

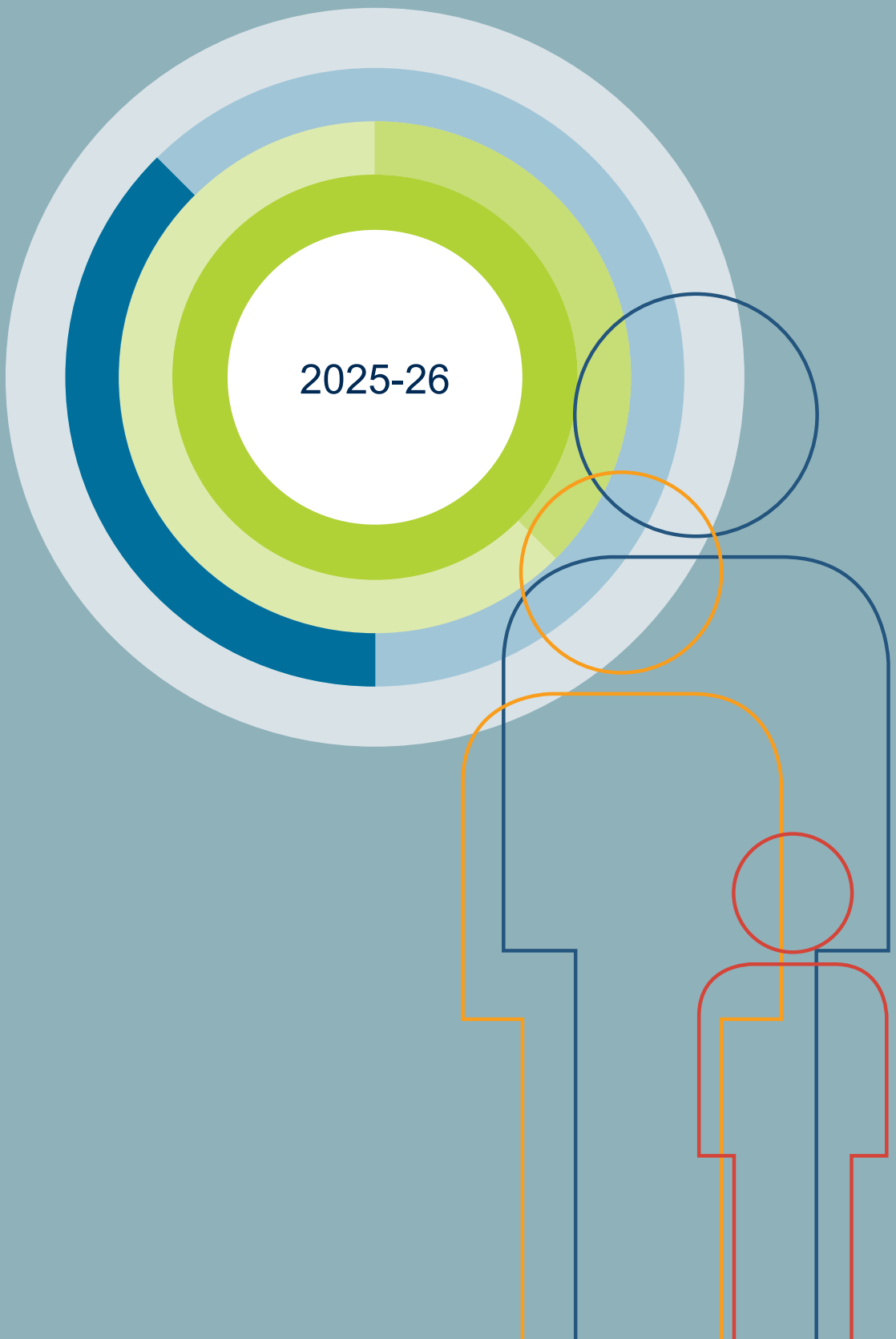
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust integrated governance and assurance framework, risk management strategy, integrated with QMS and performance management, focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through "an open and just culture".

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably, the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective assessment process, incorporating risk appetite. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

1. Introduction



1. Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years.

Public sector organisations cannot be risk averse and be successful. Risk is inherent in everything we do to deliver high quality services. Effective and meaningful risk management in health care remains as important as ever in taking a balanced view on managing opportunity and risk. It must be an integral part of informed decision-making; from policy, project inception through implementation, to the everyday delivery of public services (Orange Book HMT 2020)[1].

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

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

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

1.1 Purpose of the Risk Management Strategy

The purpose of the Risk Management Strategy is to provide a clearly defined and documented framework to ensure that risks to the achievement of the Trust's objectives are identified and managed in a consistent manner, appropriate to the level of risk in order to reduce or control the risk.

The 5 key messages that all staff should note form this strategy are:

1. Risk is integral to everything we do.

1 The Orange Book HMT

1. Introduction

2. All staff have a responsibility to raise and share identified risks within service areas; to ensure that risks are escalated, considered and placed (when appropriate) on divisional risk registers.

3. Managers have a responsibility to review and manage risks related to their service.

4. Identified and implemented actions are essential contributions to a safer and more resilient environment for all.

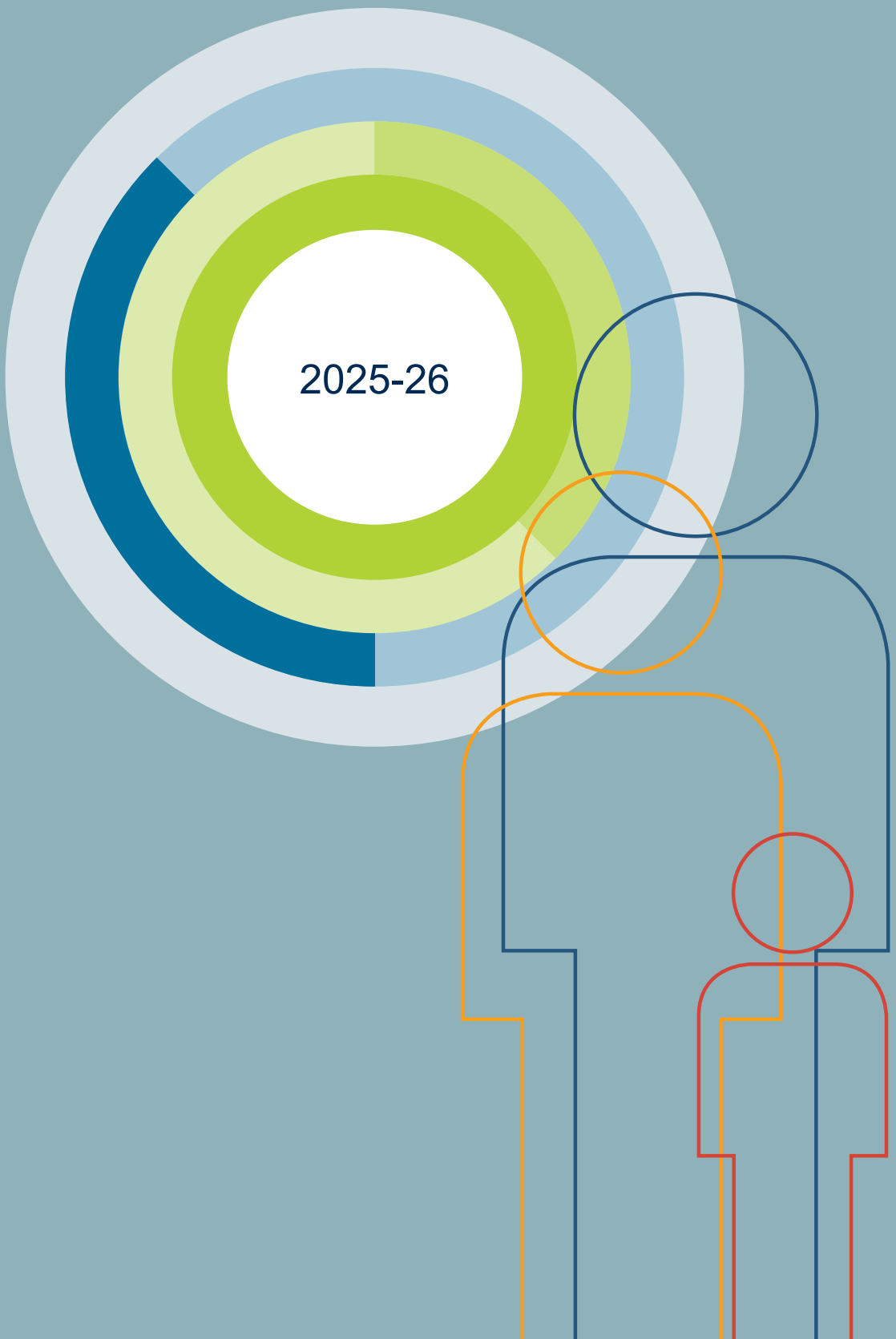
5. Risk that cannot be managed within the capability and resource of the service must be escalated accordingly. Appropriate escalation is essential when a risk cannot not be managed within the capability and resource of the immediate service.

The Risk Management Strategy is closely linked to the Trust's Corporate Management Plan and the Integrated Governance and Assurance Framework. It will inform the management planning process and assist us in achieving Corporate and Directorate priorities. In endorsing this strategy Trust Board recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

1.2 Scope of the Risk Management Strategy

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2. Strategic Context



2. Strategic Context

Trust Board has overall accountability for the risk management strategy, policy, procedures and risk activity of the organisation. They require that systems, policies and people are operating effectively, are subject to appropriate scrutiny and that Trust Board is able to demonstrate that they have been informed about key risks affecting the Organisation.

Trust Board aims to take all reasonable steps in the management of risk to ensure that the organisation's priorities, as outlined in the Corporate Management Plan, are achieved.

They recognise and acknowledge the importance of effective risk management; and how it contributes to and supports the successful delivery of the Trust's Corporate objectives.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives/Priorities[2]
- Identified strategic risks that may threaten the achievement of those objectives
- Controls in place to manage these risks, underpinned by core Organisational Assurance Standards
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas.

On an ongoing basis, Trust Board will:

- Assess the assurances given
- Identify where there are gaps in controls and/or assurances
- Take corrective action where gaps have been identified
- Maintain dynamic risk management arrangements including, crucially, regularly reviewed strategic risks.

The Corporate Management Plan (2021-2024) has identified six priorities:

- New Model of Care for Older People - We are committed to ensuring the specific needs of older people are considered in everything we do
- Urgent and Emergency Care - We are committed to providing timely, urgent and emergency care for patients

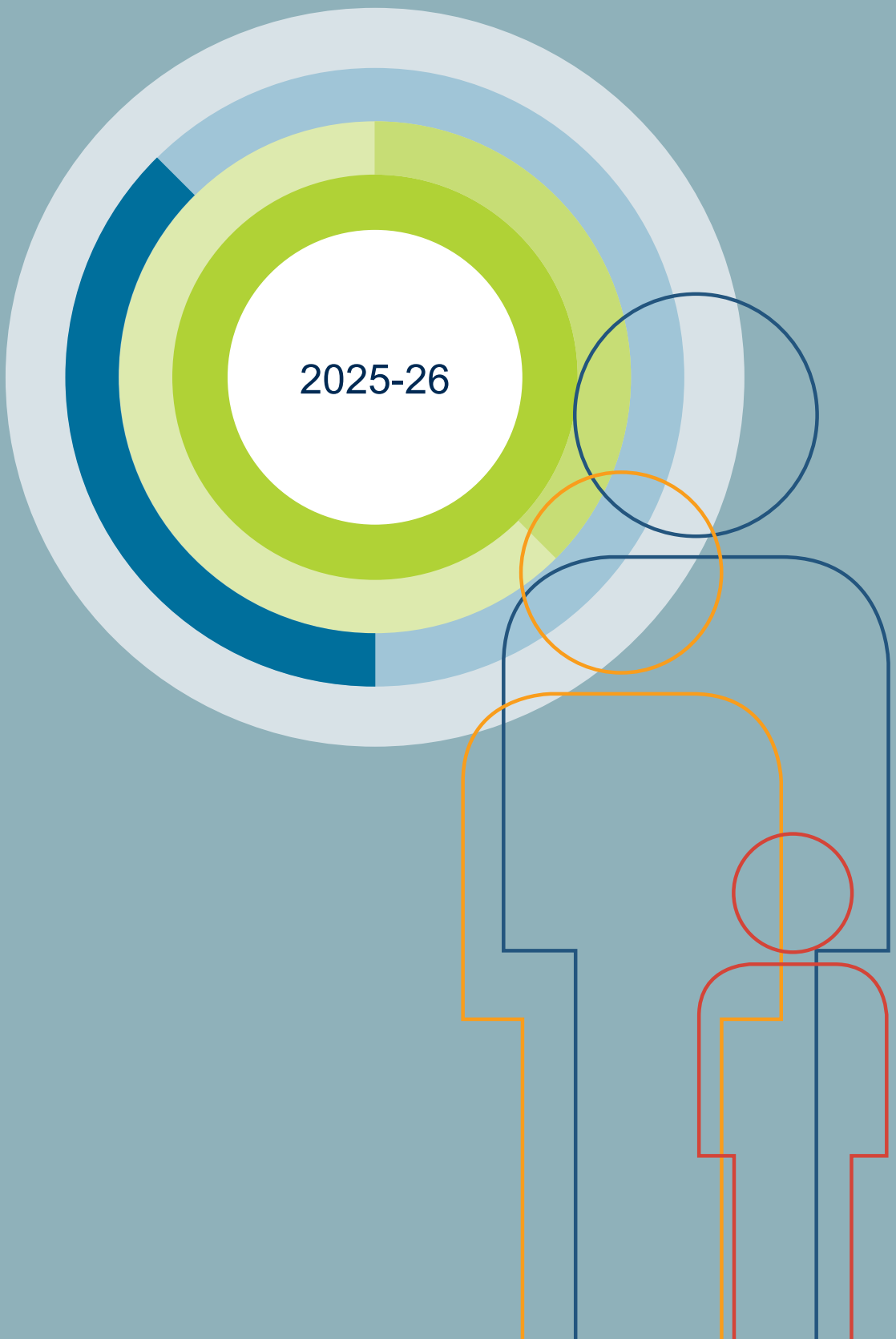
2 BHSCT Corporate Plan 2021-2023

2. Strategic Context

- Time Critical Surgery - We recognise the impact of Covid on those who are waiting for surgery, and are working as part of a wider health and care system to ensure that those most in need receive their surgery first
- Outpatient Modernisation - We are committed to modernising our outpatient services to enable patients and service users to receive the right care in the right place at the right time
- Vulnerable Groups in our Population - We are committed to improving and promoting the wellbeing of vulnerable people
- Seeking real time feedback from our patients and staff - We are committed to listening to you and changing the way we work for the better.

These organisational priorities are cascaded to Directorate, Division and Service Areas, where more detailed targets and actions are set in order to support or help meet the Trust's overall aims and objectives.

3. Risk Management



3. Risk Management

3.1 Responsible risk taking

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Healthcare can never be free of risk and taking decisions about risk and opportunity is part of everyday practice and management. Only by taking risks can the Trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed unacceptable from time to time by Trust Board and, by extension, external inspectors/regulators and relevant legislation.

The Trust will develop a risk appetite which reflects a low threshold for risks that impact on safety and a greater appetite to take considered risks in terms of their impact on operational and reputational issues. The Trust has the greatest appetite to pursue quality improvement and innovation and will take opportunities where positive results can be anticipated.

3.2. Objectives of Risk Management

This strategy details how the Trust approaches Risk Management. The Trust recognises that an effective risk management strategy is critical to the delivery of the Organisations priorities, and can support innovation, and the development of a learning environment, alongside the development of a culture where all staff are aware of risk. It incorporates risk assessment, treatment, escalation, risk registers, roles and responsibilities and links closely to the integrated governance and assurance framework.

To ensure a systematic, consistent and standardised approach, all principles should be Trust wide, encompassing both clinical and non-clinical risk management.

The Trust has a number of key objectives in relation to risk. These are to:

- Raise awareness of the principles and practice of risk management
- Establish an ‘open and just culture’ encouraging lessons to be learned and good practice to be maintained
- Achieve improved patient outcomes and experience through the implementation of effective governance arrangements
- Protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust Activities
- Establish priorities for the control of risks, based on a suitable assessment process

3. Risk Management

- To be a problem sensing organisation that learns from past harm and identifies risks
- Minimise financial liability through effective assurance arrangements
- Minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust
- Involve the public and users of our services in the application of risk management and assurance to the Trusts undertaking.

There are a number of factors that can impact on the Risk Management Strategy, to include;

3.2.1 Risk Management Training

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. Training is linked to reducing risk and is subject to ongoing review. Risk registers can also be utilised to influence training programs through identifying the most significant risks that are challenging the Organisation.

Risk management training is available and it is expected all staff will undertake this to assist them identify and manage risk within their own service area. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

The oversight of appropriate risk management training must be incorporated into the appraisal/supervision/managerial processes of all Trust Staff and be in line with professional standards.

3.2.2 Culture and Risk Management.

All members of staff have an important role to play in identifying, assessing and managing risk. The Belfast Health & Social Care Trust are committed to our HSC values of openness and honesty, compassion, excellence and working together. These provide the framework for achievement of a Just Culture approach through supportive, constructive and fair evaluation

of the actions of employee involved in an incident, error, concern or complaint.

Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An “open culture” that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong. The Trust is fully committed to regional collaboration to support the implementation of the statutory Duty of Candour as this develops.

To embed risk management into the culture of the organisation, risk management must be included on all governance/assurance meeting agendas and included in policies. Thus encouraging the reporting of risks and standardising practice across the organisation.

As a learning organisation, culture and risk management can be embedded further through a focus on learning and seeking assurance on effective system change, from both internal and external sources in order to improve standards and reduce risk.

3.2.3 Innovation

Risk management can support innovation and change, and supports the effective use of Trust resources. Leadership and accountability are fundamental in supporting this. As such, Directors are expected to ensure the development of local risk management frameworks to actively monitor change, innovation and effective use of resourcesto ensure risks are identified at the earliest opportunity and appropriately managed.

Through the Corporate Plan, Trust priorities have been identified. All Directorates are focused on their achievement. As such, risk management activity across the Trust should reflect actions towards the achievement of these priorities and should be incorporated into Directorate and divisional action plans.

3.2.4 Service User and Public Expectations

The interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

Our service users need to be confident about the quality of care they receive. They want services that are readily accessible, safe and are provided by competent and confident staff who will always work in their best interests. As a Trust, we provide and are accountable for the delivery of high quality, safe and compassionate care in an environment of openness and transparency.

3. Risk Management

We are committed to embedding learning from many sources and in doing so improving the quality of care provided. High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Embedding learning from all sources and following recommendations and guidance are fundamental to the proactive management of risk.

Trust Board is committed to implementing and incorporating the learning from all sources of inquiry (eg. Hyponatremia related deaths[3], Neurology Inquiry, the 2020 Muckamore Leadership and Governance review[4] and the pending Muckamore Inquiry), complaint/ NIPSO investigations, SAI reviews, external reviews etc., alongside being committed to the implementation of all new guidance issued eg. Duty of Candour.

The Trust has a statutory duty to engage and involve service users[5]. It values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

3.2.5 Modernisation

The Trust continues to strive to provide the right care, at the right time, in the right place to our patients and service users. Our commitment to continuous improvement means that we will continue to modernise services, taking on board patient feedback, and in line with Trust and Regional priorities.

During the COVID-19 pandemic it has remained important that we listen to and learn from our staff, patients and service users, as at any time of crisis, considering what worked well, what didn't and how we can improve. Learning from COVID-19 is part of a Trust wide effort intended to help us reflect and learn, at pace and in an agile way to support and inform how we shape our plans moving forward and to help us shape our culture.

Appropriate risk assessment and management of change processes remain vital to ensure that established and developing initiatives will enhance organisational effectiveness whilst supporting the safe delivery of services and ensuring effective engagement with staff. This is important for short term changes to service delivery in response to COVID 19 and longer term permanent modernisation initiatives.

3.2.6 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3 Home | Inquiry Into Hyponatraemia-related Deaths (ihrdni.org)
4 A Review of Leadership & Governance at Muckamore Abbey Hospital (health-ni.gov.uk)
5 PPI HSC Reform Act NI 2009

3.2.7 Communication

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent, accessible and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication.

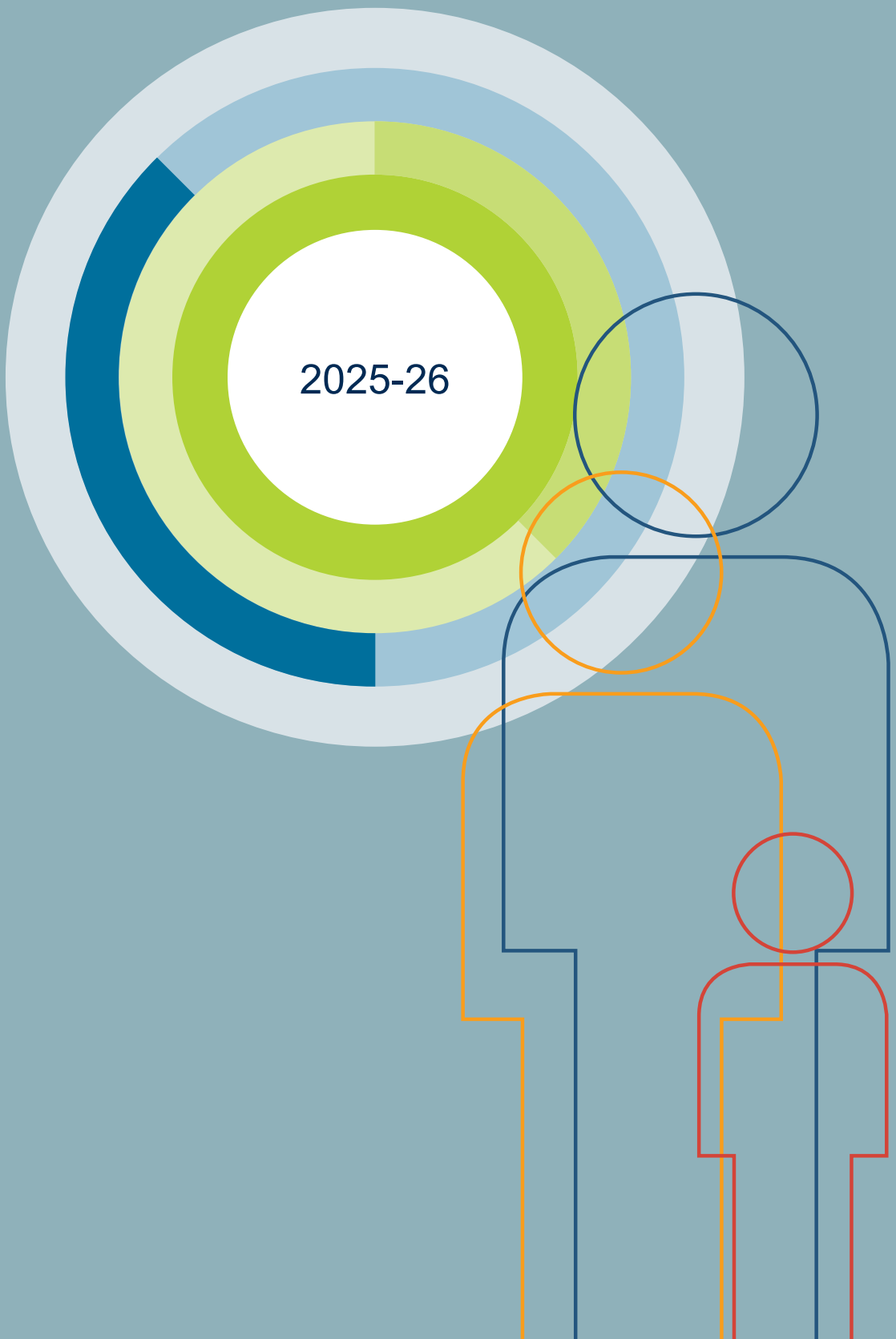
Each Directorate has established and will maintain a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's regular performance reports, QMS, the Charles Vincent Huddle and other service area specific reports.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways.

The Trust understands the importance and value of whistleblowing in identifying and addressing potential risk. The Trust's Whistleblowing Policy recognises that its staff and contracted service providers have a right and duty to raise with the Trust, in the public interest, matters of concern they may have and that members of the public may also raise such concerns. The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way to highlight potential improper/unethical conduct, patient safety issues, health and safety matters, environmental concerns or potential concealment of these; all of which if unidentified represent significant risk to the Trust. For those not comfortable with raising their concerns with line management, the Trust has identified Whistleblowing Advocates throughout the organisation who can be approached for advice and support. The Trust has further demonstrated the value and relevance it places on whistleblowing in addressing risk by its recruitment of a dedicated Senior Manager for Whistleblowing whose role is not only to manage and monitor whistle blow cases, ensuring appropriate resolution and learning, but also to advise and educate managers and staff alike.

The Trust has a large number of external partners including the DoH, SPPG, Commissioner's and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including, but not restricted to the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

4. Responsibilities



4. Responsibilities

As an organisation, the Trust is required to demonstrate compliance with risk management standards as part of the annual Governance Statement. This compliance is attained through the implementation of robust governance and assurance arrangements.

To do this, there are systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risks and incidents at every level of the organisation:

- Undertaking a quarterly assessment of the organisation's priorities and identifying the strategic risks to achieving these objectives. These will create the Board Assurance Framework Risk Document
- Ensuring there are appropriate systems to monitor and review risks which are delegated at Corporate and Operational level
- Utilising sources from across the 3 lines of assurance[6] to verify the accuracy and completeness of the risks, their controls, assurances and any gaps identified
- Regular monitoring and review of the effectiveness of the Board Assurance Framework Risk Document by the Board of Directors, the Assurance Committee and the Audit Committee
- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk.

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Integrated Governance and Assurance Framework document[7].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Service Managers - Risk and Governance (Medical Directorate) and Governance and Quality Managers

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust.

They are responsible for collecting data on governance performance and providing reports on collated data for use by the Trust Board, Executive team, Senior Leadership teams,

6 3 Lines of Assurance
7 Belfast HSC Trust Integrated Governance and Assurance Framework

4. Responsibilities

External Stakeholders, committees within the Integrated Governance and Assurance Framework and staff.

These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures. Central to their role is to ensure that investigation/review reports identify learning, have SMART recommendations for implementation and monitoring of improvement where appropriate. They will also act as a resource for expert governance advice.

4.2 Senior Leadership Team

Senior Leadership Teams (SLT) must ensure that all activities within their division are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce registers of risk with appropriate action plans, to address identified risks, which are linked to corporate objectives/priorities. These teams must ensure the implementation and monitoring of local risk action plans.

All members of the SLT must escalate any rising issues, themes or trends. They will ensure that risk management processes are implemented and functional within their respective divisions. These processes should form a key part of directorate/divisional governance structures.

To support this:

- Risk escalation/management/emerging risks should be a standing agenda item on all directorate/divisional governance meetings
- Risk registers should feature as a standing agenda item on divisional governance meetings
- Divisions will ensure that there are structured processes in place to review and update risk registers routinely, with risks being escalated as required
- All Divisions should have a formalised Governance Framework in keeping with this strategy, which evidences how risks are escalated, managed and discussed.

Senior Leadership Teams are responsible for:

- The effective application of all risk management procedural documents
- Ensuring their service risk registers are appropriately maintained;
- Seeking assurance of Implementation action plans

- Seeking assurance staff are appropriately trained
- Ensuring systems are in place to identify, analyse, evaluate, treat and reduce risks
- Ensuring risk registers are used as a live dynamic process across all their services/wards and departments and will review risks to the achievement of objectives and delivery of services
- Escalation of risk to the responsible director in keeping with this strategy (table 6).

4.3 Managers

Managers, including clinicians managing services are responsible for the implementation of risk management policies.

All managers and clinicians must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the senior leadership team and director is advised. It is a requirement that each directorate produce risk registers and associated action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

They must ensure that all incidents are properly documented; including incident investigation and where identified, that learning is implemented and shared.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

Managers are also responsible for acting on risks or concerns that staff may raise with them. This needs to be done in a timely and appropriate manner, to ensure that all elements of the concern are considered and addressed. If manager are unable to address the concern raised, then they must follow relevant operational or professional escalation procedures. Escalating concerns are a key component of risk management.

4.4 Employee (including Bank Staff)

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. Contributing to effective risk management is everyone's responsibility and all employees should:

- Comply with risk management policies and procedures

4. Responsibilities

- Attend and maintain training as required
- Report incidents, near misses and support the identification of risks in their day to day work
- Be aware of existing risk assessments, alongside relevant procedures or control measures to mitigate/reduce identified risk.

In participating in effective risk management, each member of staff has the responsibility and the right to highlight their concerns about any risk issue. The matter should be raised in the first instance with their Line Manager or if they feel unable to do this then the Trust whistle blowing policy should be referred to. Staff are required to co-operate with this strategy, to take any reasonable action to minimise any perceived risk and adhere to Trust policy and procedure.

All staff working within the Belfast Trust, must also familiarise themselves with the Code of Conduct for HSC Employees and crucially, if any staff member has a concern, that an acceptable standard of care or practice is not being adhered to, that they should always raise that concern.

The Code of Conduct for HSC Employees, identifies the values and core standards expected of all staff. It details a number of key principles that all staff must follow, alongside staff responsibilities when an individual staff member has concerns about improper conduct or poor standards. The principles expect all HSC employees to:

- Make the care and safety of patients and clients their first concern and act to protect them from risk
- Contribute to improving and protecting the health of the population as appropriate to their role
- Maintain confidentiality, respecting and protecting, at all times patients/clients, service users and their families' right to confidentiality, privacy and dignity
- Communicate openly and honestly to promote the health and well-being of patients/ clients, service users and their families
- Respect the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. Show commitment to working constructively as a team member by working collaboratively with all colleagues in the HSC and the wider community
- Be accountable and accept responsibility for their own work and be honest and act with integrity

- Share responsibility for their learning and development in order to improve the quality of care to patients/ clients/service users and their families.

4.5 Patient/Service User/Carer

Patients and service users can have an influential role in identifying and reducing risk. As experts by experience, their cooperation with staff can help to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust. Patient and service users are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

All staff working within the Belfast Trust have defined responsibilities within the Trust's complaints policy and procedures to facilitate and respond to patients/service users/carers seeking to provide feedback about their experiences of treatment and services. Such feedback is encouraged to help identify problems, risks and potential service improvements.

All complaints are risk assessed and a level of investigation undertaken proportionate to the risk grading agreed between the complaints department and relevant service areas.

Trust processes associated with complaints and other sources of patient experience feedback (eg. Real Time Patient Experience, and Care Opinion) allow the organisation to learn from comments, concerns, complaints and compliments. This feedback is expected to effectively improve the quality of services and prevent recurrence of factors giving rise to a concern or complaint. This information must also inform professional assurance processes, including identifying areas of individual concern that need separate investigation.

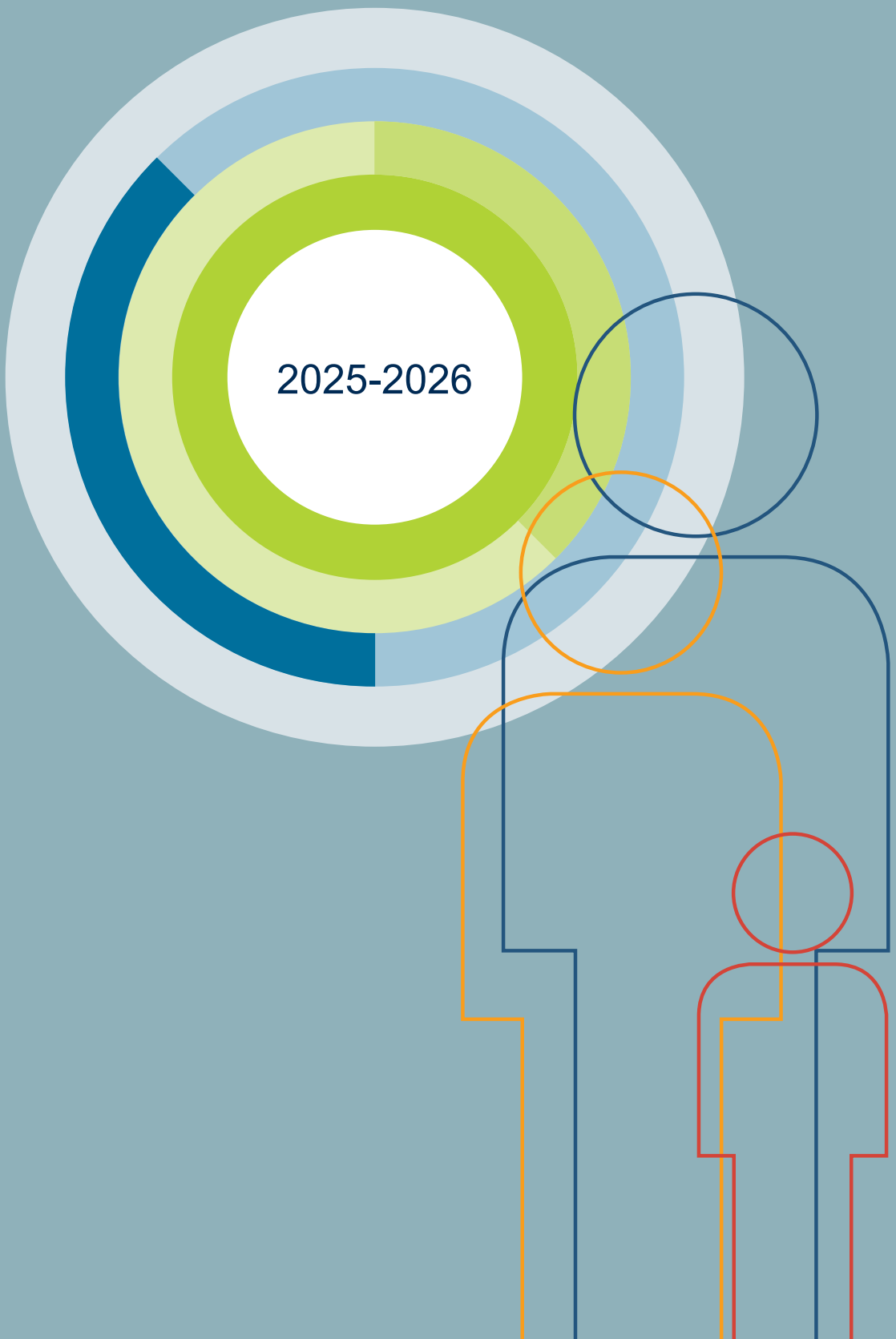
4.6 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5. Committee Structure



5. Committee Structure

The Trusts Integrated Governance and Assurance framework details the organisational arrangements for governance and assurance.[8] The framework details how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

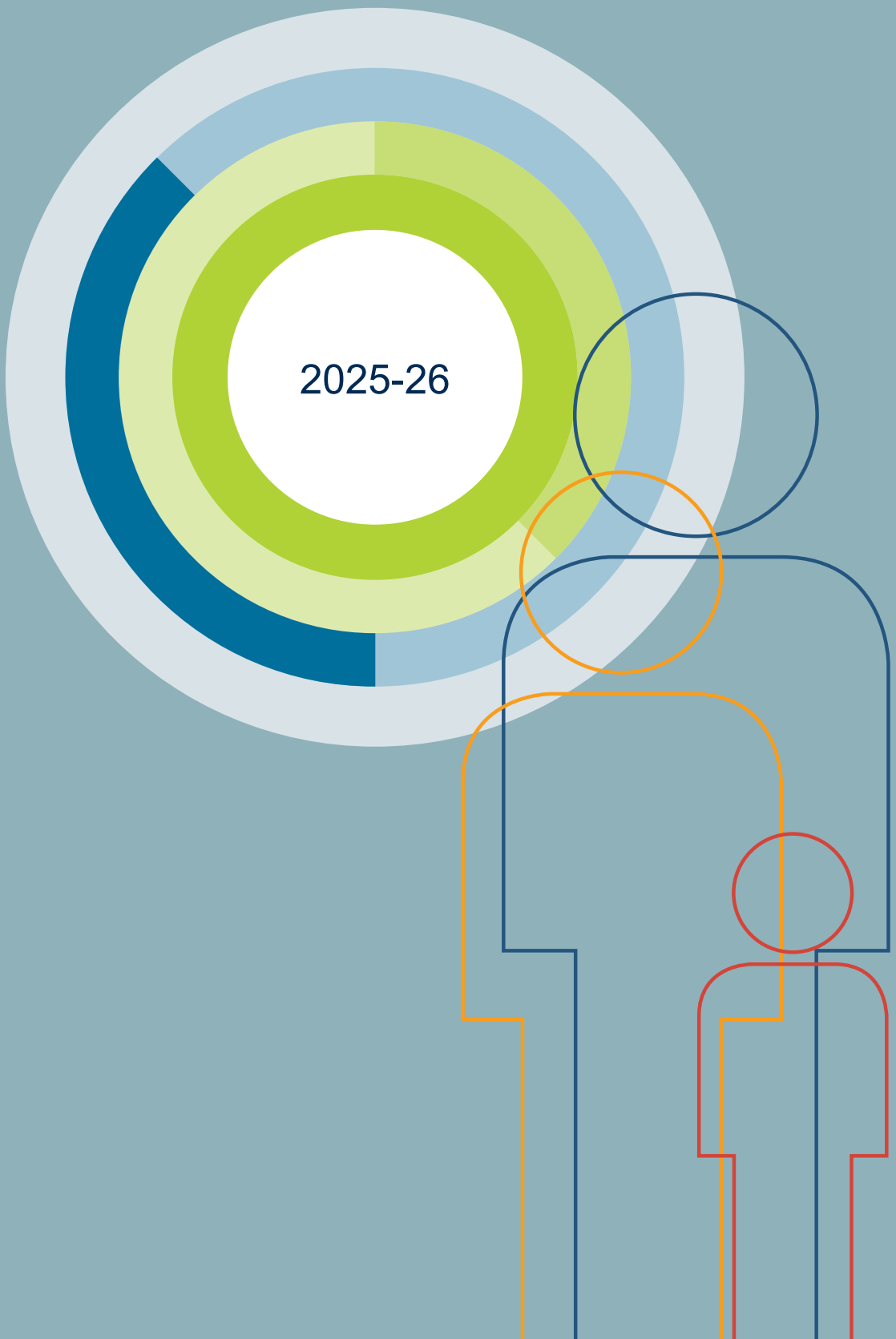
All Directorates are required to have formalised Governance and assurance structures, incorporating the management and review of risk. As a minimum, this should include:

- Clear processes for the escalation of risk
- Charles Vincent Huddle
- Live Governance Meetings
- Divisional Governance Meetings
- Directorate Governance Meetings
- Representation at Assurance Committee sub committees as required.

Service Directors are responsible for ensuring that their committee structure for risk is reviewed as part of the implementation of this revised strategy to ensure that all groups/ committees/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

8 Belfast HSC Trust Integrated Governance and Assurance Framework

6. Risk Management Process



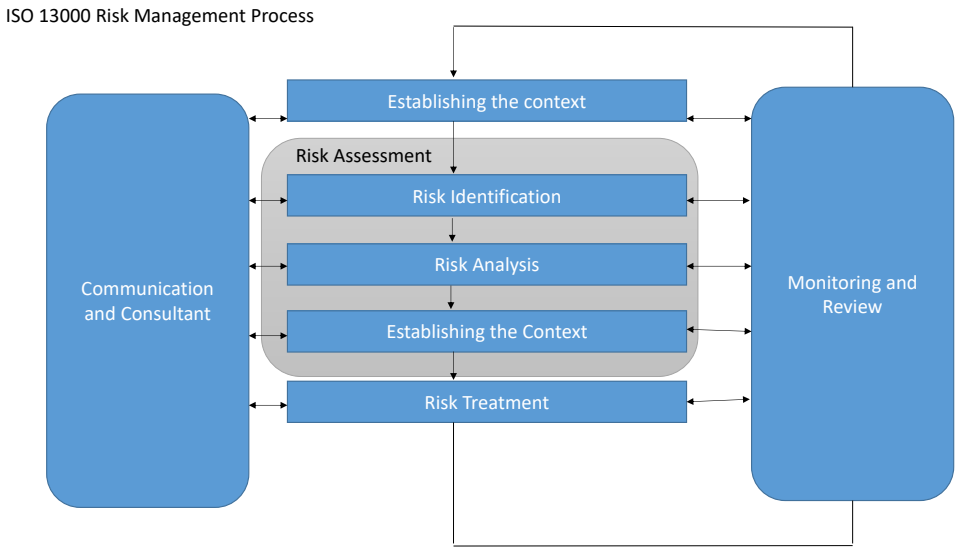
6. Risk Management Process

Organisations face a wide range of uncertainties and factors that may affect the achievement of their objectives. This can create a positive risk (opportunities) or a negative risk (threats).

Risk management focuses on identifying these threats and opportunities while internal control helps counter threats and takes advantage of opportunities. Effective risk management should help organisations make informed decisions about the level of risk that they want to take and implement appropriate internal controls that allow them to pursue their objectives[9].

The risk management process involves the systematic application of policies, procedures and practices and the activities of communicating and consulting, establishing the context and assessing, treating, monitoring, reviewing, recording and reporting risk. The diagram below demonstrates this:

Figure 1: ISO 13000 Risk Management Process



Establish the Context: Establish the external, internal and risk management context in which the rest of the process will take place. Criteria against which risk will be evaluated should be established, the structure of the analysis defined and the boundaries of that analysis established.

Identify the risk: Identify what, why and how things can arise as the basis for further analysis.

9 HSC Board Member Handbook

6. Risk Management Process

Risk analysis: Determining the relative importance if individual risks is a key element of the risk management process, enabling risk control priorities to be identified and appropriate action to be taken in response. This is achieved by utilising the regional risk matrix in appendix 1.

Evaluate Risks: Compare estimated levels of risk against pre-established criteria.

Treat Risks: Risk treatment involves identifying the range of options for controlling or treating risk, assessing those options, preparing risk treatment plans and implementing them.

Constant Monitoring and Review: Monitor and review the performance of the risk management system and changes which might affect it.

Communicate, consult, learn and adapt: Communicate and consult widely, including with external stakeholders as appropriate at each stage of the risk management process.

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk.

Risk is the “effect of uncertainty on objectives”.

Risk is also often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence. It is something that might happen that could have an effect on service users, staff, individual service areas or the wider organisation.

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

A risk has a combination of three elements:

1. Cause: What might trigger the event to occur
2. Event: An unplanned or unintended variation from an objective
3. Effect: How the organisation could be impacted upon should the risk occur.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must

6. Risk Management Process

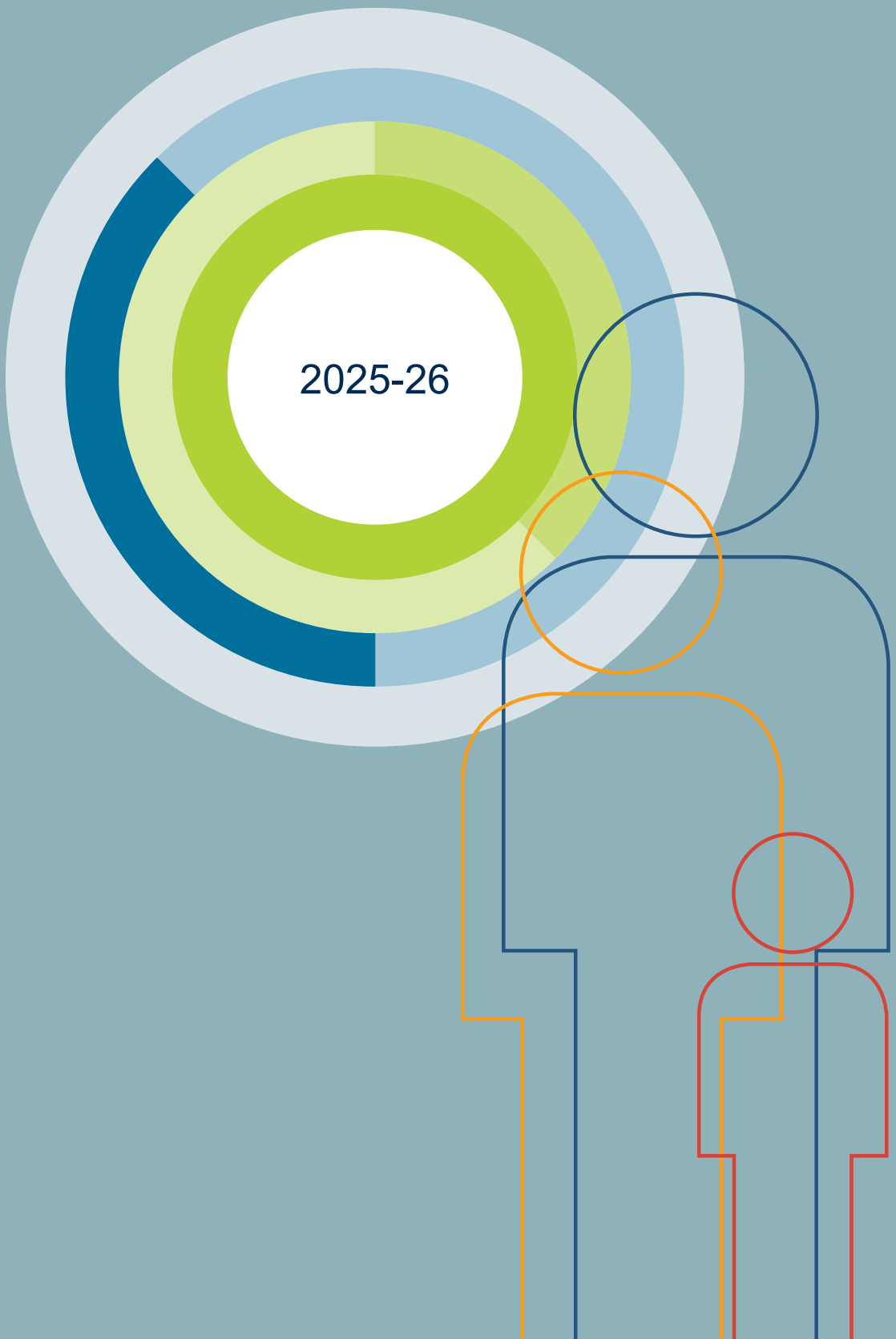
be evaluated in a consistent manner. The Trust has adopted a standard methodology in line with DoH guidance [10]and will work to the principles, framework and processes for Risk Management as contained in BSO IS0 31000: 2018 for identifying and measuring risks (see Appendix 2). This standard methodology will be applied where appropriate in Directorates and in Trust wide assessments of risks.

This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk
- Likelihood descriptors for frequency and probability
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales
- Management authority for each level of risk (extreme, high, medium and low).

10 DHSSPS How to classify incidents and risk guidance 2006

7. Delivering Successful Risk Management



7. Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk
- Embedded learning from all sources and risk management processes to ensure continuous improvement
- Communication with staff, service users and the public
- Education and training for risk management and related issues for staff, service users and public
- Partnership working with staff, service users and public to ensure continuous improvement
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk Appetite

Risk appetite is:

'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time' (HMT Orange Book definition 2020)[11].

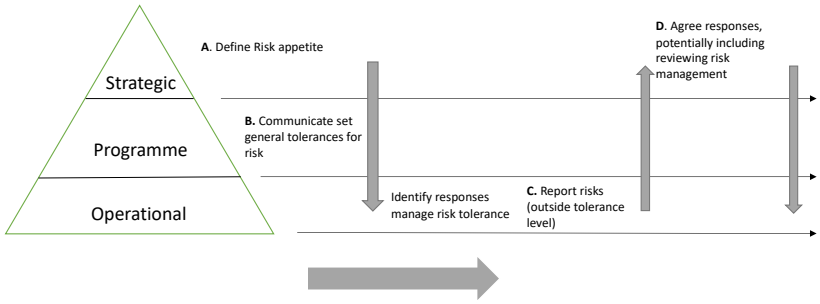
Risks must be well considered and managed. To do so, the Trust must provide guidance on the acceptable level of risk across the whole of the organisation.

It is the role of Trust Board to decide which risks they need to reduce, which they are prepared to accept and what their tolerances are for those risks they are willing to accept.

Public strategy, public expectations, legal obligations and the business of delivering healthcare all impact on risk appetite. Over time, these can change and conversely risk appetite will change, depending on the circumstances at a given point in time. The diagram below, from HM Treasury (2006) helps describe this concept. As such Trust Board must make a considered choice about its risk appetite, taking account of its legal obligations, business objectives, and public expectations.

11 The Orange Book HMT

Figure 2: Risk Management (HM Treasure, Thinking About Your Risk: Managing Your Risk Appetite, A Practitioner's Guide. November 2006)



The Trust needs to know about risk appetite because:

- If the Trust does not know what it's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If Trust leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both risk appetite and risk tolerance, an organisation clearly sets out both an optimal and acceptable position in the pursuit of its strategic objectives.

The benefits of adopting a risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making
- Supporting performance improvement
- Focusing on priority areas within an organisation
- Informing spending review and resource prioritisation processes.

A key part of determining risk appetite is the analysis and assessment of each risk. This needs to be done against a common set of metrics.

7. Delivering Successful Risk Management

The Good Governance Institute (GGI) believes it helps to identify different vectors of risk appetite (money, policy, outcomes and reputation) but always to assess these in the round. To support this, GGI have developed a Risk Appetite Maturity Matrix for NHS organisations to support better risk sensitivity in decision-making. (See Appendix 2).

The GGI Matrix sets five levels of risk appetite for each of the risk vectors (money, policy, outcomes and reputation). There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, taking into account the risk appetite of others and the capacity for management to communicate and deliver. Trust Board should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help Trust Board to better manage its agenda and the level of routine reporting required.

It is important to note that no system can be risk free and this strategy is focused on the effective management of risk to support efficient service delivery.

There is a clear recognition that we must accept a level of risk in order to meet the high standard we set ourselves. The Trust is committed to providing and safeguarding the highest standards of care for service users. We will do our reasonable best to protect service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. We acknowledge our staff regularly accept and manage significant risk in order to help others.

The Trust recognises that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Trust may have to set priorities for the management of risk and risk appetite should align to strategic and/or directorate objectives. We will identify acceptable risks through a systematic and objective process.

There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm.

Each objective/priority will be assessed individually. The following risk appetite principles will be applied:

a. Appetite for risks relating to objectives or priorities associated with patient safety and employee health and safety is very low, with controls required to reduce the risks so far as is reasonably practicable.

b. Appetite for risks relating to objectives or priorities associated with regulatory compliance,

fraud, and information governance is also low, requiring appropriate risk controls.

c. Appetite for risks to objectives or priorities associated with non-critical functions and services is higher, whilst taking into account any potential impact on any strategic/business objectives.

Completing this assessment will require consideration of additional controls/actions to terminate, treat or transfer the risk.

7.1.2 Risk Tolerance

Risk tolerance is defined as:

'The level of risk with which an organisation is **willing** to operate'

It is important to highlight, that tolerance in this situation is an 'organisational position', as opposed to where tolerance is a 'considered choice' when managing the risk.

Risk tolerance reflects the boundaries that the Trust is willing to allow risk to fluctuate, during the implementation of its corporate plan and in line with strategy. It is the level of residual risk within which the Board expects to operate and management to manage. Breaching risk tolerance requires escalation to The Board for consideration of the impact of the risk on objectives, resources and timeframes[12]. These are considered as strategic risks.

Ref Appendix 1 (Analysing & Evaluating Risk) Table 6

Where issues have been identified as LOW RISK (green), and where it is likely nothing further can be done to eliminate/reduce/control risk further, this is deemed acceptable. These risks will be added to Directorate / Service Area / Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process. These should be reviewed at least annually.

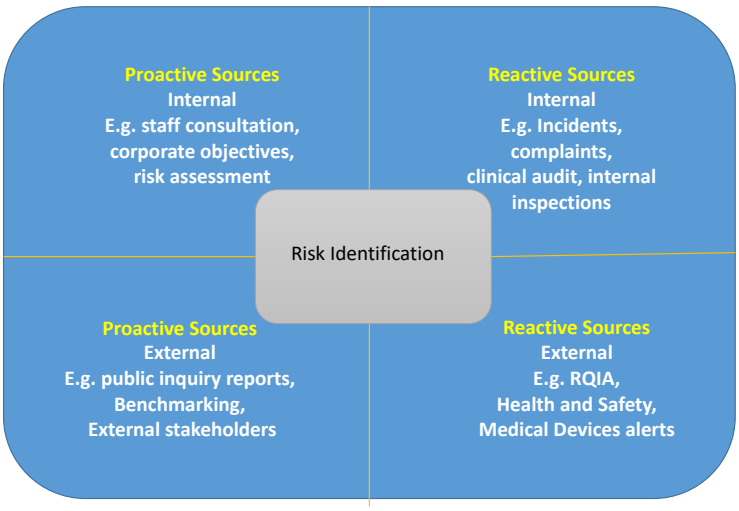
7.1.3 Risk Assessment

Risk assessment is the overall process of risk identification, risk analysis, and risk evaluation. The process supports the Trust to manage, reduce and/or eliminate identified risks in order to maintain the safety of patients, staff, visitors and the organisation as a whole.

Risk identification can be both proactive and reactive, in addition to coming from both internal and external sources. The following diagram gives some examples.

12 May 2020 GGI: Board guidance on Risk Appetite

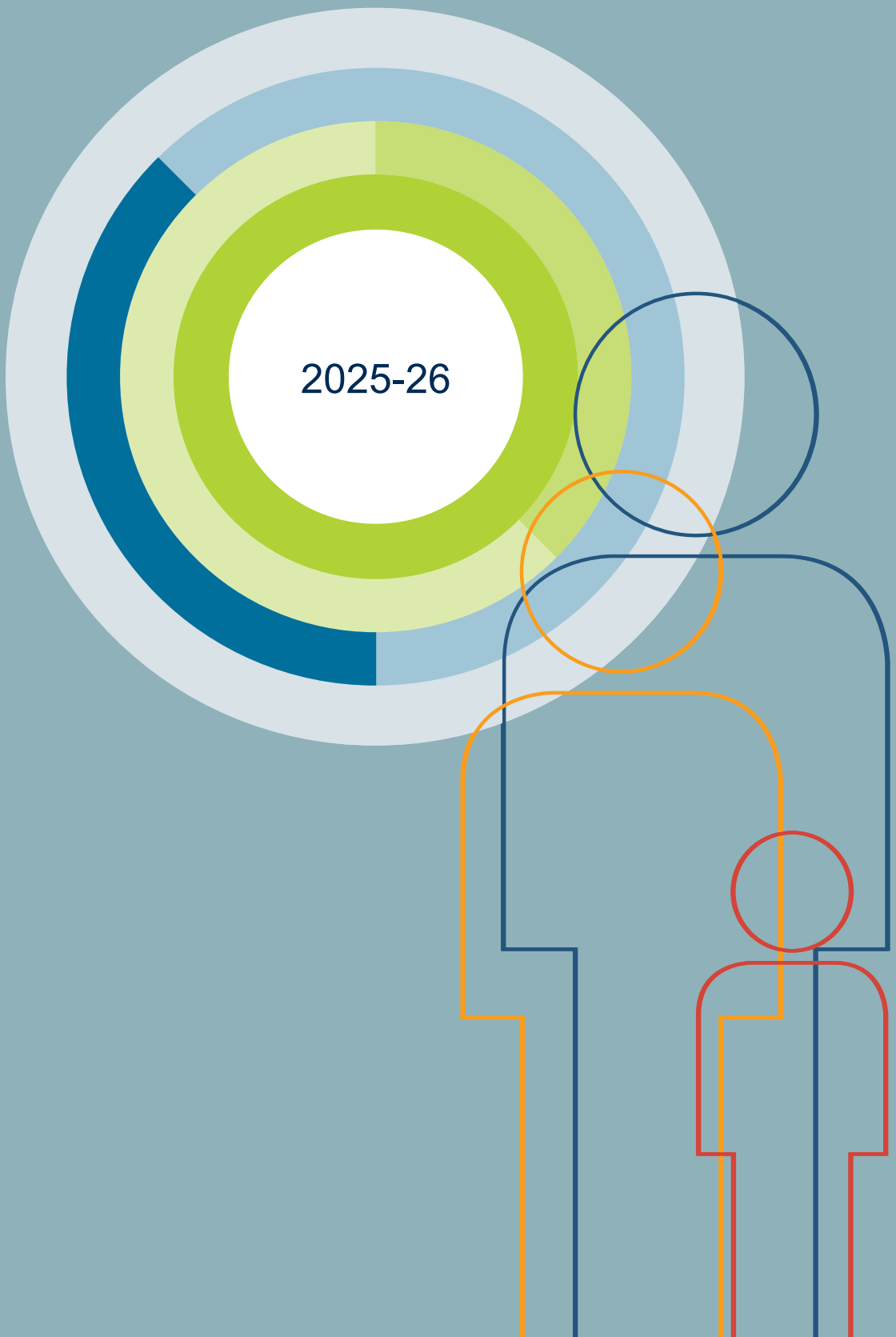
Figure 3: Example sources of risk identification



Once identified, risks and associated control measures should be managed in line with local governance arrangements, utilising the risk management strategy. This will support the prioritisation of risks and appropriate escalation through the Organisation.

Local governance framework's should have risk escalation process, to ensure that where risks cannot be managed at a local level, that there is an escalation line through local governance meetings and line management for consideration and adding to the appropriate Risk Register. This will enable the Board of Directors to prioritise risk and allocate resource (where necessary) accordingly.

8. Risk Registers



8 Risk Registers

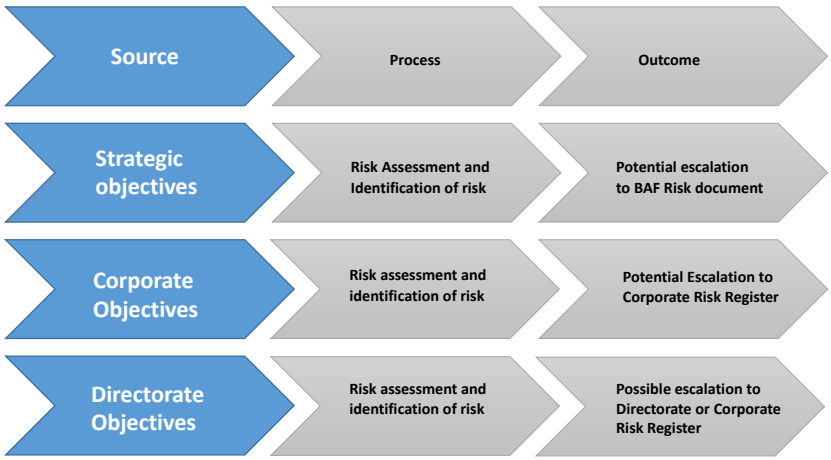
The management of risk at strategic, directorate and divisional levels needs to be integrated so that the levels of activity support each other. All staff should be aware of the relevance of risk to the achievement of their objectives.

Risk registers are a record of all forms of residual risks ie. those risks which remain after treatment. It is accepted that, in order to be accurate and complete, the risk register should be constantly updated to reflect new risks and changes to existing risks.

Risk registers can gather risk details from many assessment sources. As such, it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives.

Risks will be risk assessed through the review of strategic, corporate and local directorate objectives, alongside the corporate risk register criteria, regional risk matrix and GGI risk appetite matrix. Following assessment and if appropriate risks will be placed on the relevant risk register.

Figure 4



A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such, a risk register becomes a management tool as well as an audit and assurance process. Its effectiveness is dependent on regular monitoring and adherence to the Risk Management Strategy and the Integrated Governance and Assurance framework.

8. Risk Registers

There are a number of different risk registers within the Trust:

- Divisional Risk Registers
- Directorate Risk Registers
- Corporate Risk Register
- Board Assurance Framework Risk Document (BAF).

8.1 Divisional Risk Registers

All Divisions are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. These registers should include identified risks related to operational issues that are identified through both proactive risk assessment and reactively through incident reporting and other risk and governance activities. These risks are part of the Directorate risk register and should be reviewed through service area meetings, local governance meetings and a range of other activities, such as supervision.

when utilising Datix, Divisional risk registers come under the field of Service area. Divisions will need to choose all service areas that sit within their Division to export their entire Divisional risk register

8.2 Directorate Risk Registers

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate.

These registers may identify risks related to strategic, corporate and local objectives. Actions required to mitigate risks should be identified within the risk register and incorporated into Directorate business plans. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least 4 times a year. A description of fields utilised on Datixweb is in appendix 3

Directorate risk registers will be presented and subject to scrutiny through the Quality Management System presentations at Executive Director Group. Directorate risks, graded high or above will also be subject to scrutiny as part of these presentations.

8.3 Corporate Risk Register

The Corporate Risk Register (CRR) is a live document that identifies risks that impact on the corporate priorities.

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

  Is evaluated as below 25 but:

- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Board Assurance Framework Risk Document (BAF Risk Document). This provides an assurance to the Board of Directors as to the identification and management of the organisations strategic risks. The BAF Risk Document will be reviewed and reported to Assurance Committee four times a year

8.4 Board Assurance Framework Risk Document (formerly Principal Risk Document)

The purpose of the Board Assurance Framework Risk Document (BAF Risk Document) is to provide the Trust Board with a simple but comprehensive method for the effective and focused management of the strategic risks that arise in meeting its priorities.

8. Risk Registers

This document differs from the corporate risk register in that it is a high level summary of risk to the delivery of key priorities, focusing on existing controls and confirming internal and external arrangements. This is to ensure that controls are adequate, identifying where there are gaps in controls and assurances, to enable the Trust Board to be assured or seek additional assurance that appropriate actions and timeframes are in place. The corporate risk register is a dynamic account of risks identified.

The BAF Risk Document is developed by identifying the strategic risks that may threaten the achievement of the Trusts strategic priorities and is reviewed and updated quarterly.

It includes the following information:

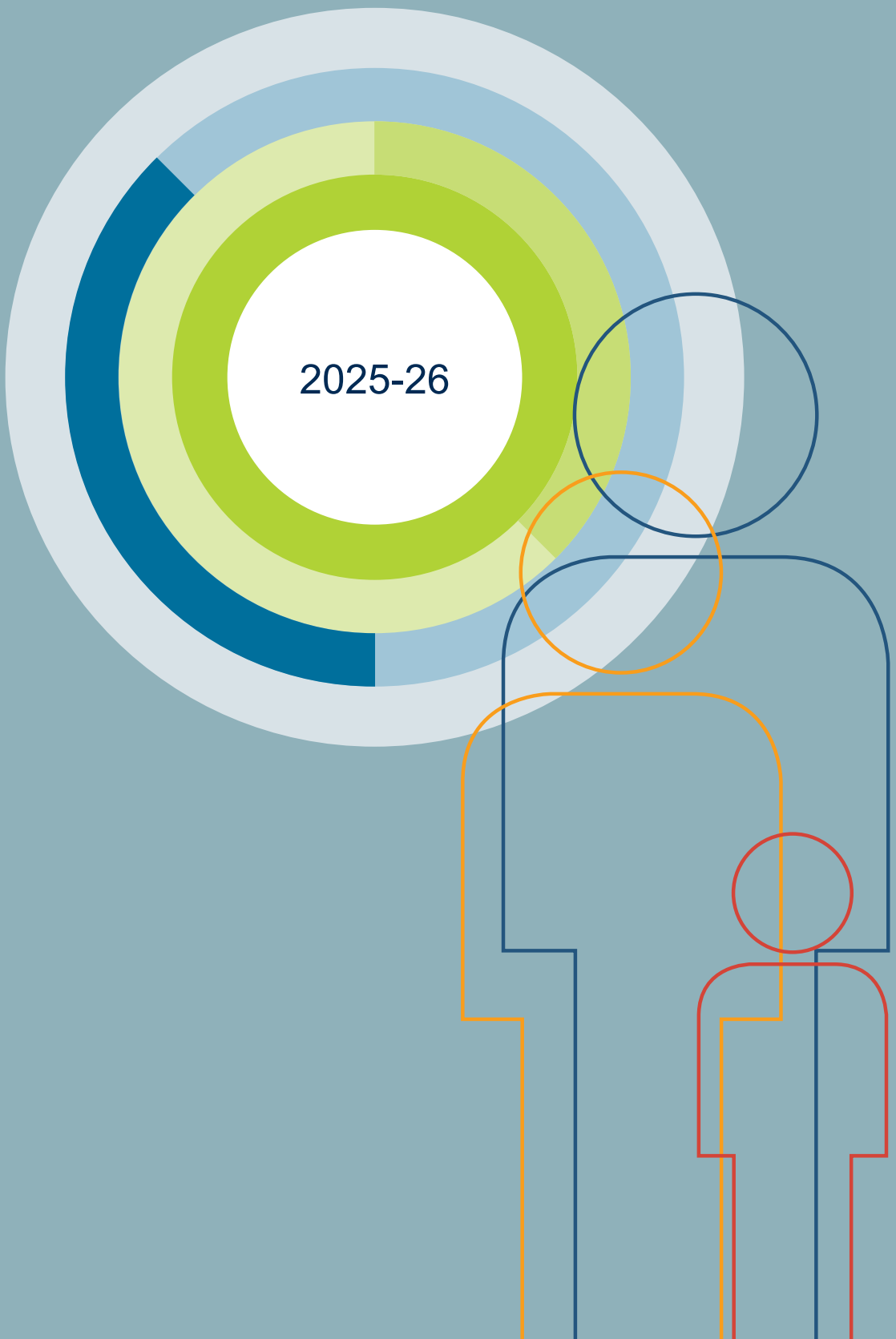
- Linkage to priorities and QMS
- Details of key controls to mitigate the identified risk
- Assurances that controls operate effectively
- Gaps in controls and/or assurances
- Planned actions to mitigate for gaps in controls/assurances
- Risk Appetite
- Risk Score.

Risks on Divisional, Directorate and the Corporate Risk Register are reviewed and linked to BAF Risks where relevant.

The BAF is submitted for review and approval to Assurance Committee on a quarterly basis. By exception, new BAF risks may be submitted in the intervening months by Directors to Trust Board.

The ongoing development and review of the Integrated Governance and Assurance Framework supports robust processes to monitor and escalate concerns and risks associated with organisational priorities. This supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

9. Incident Reporting

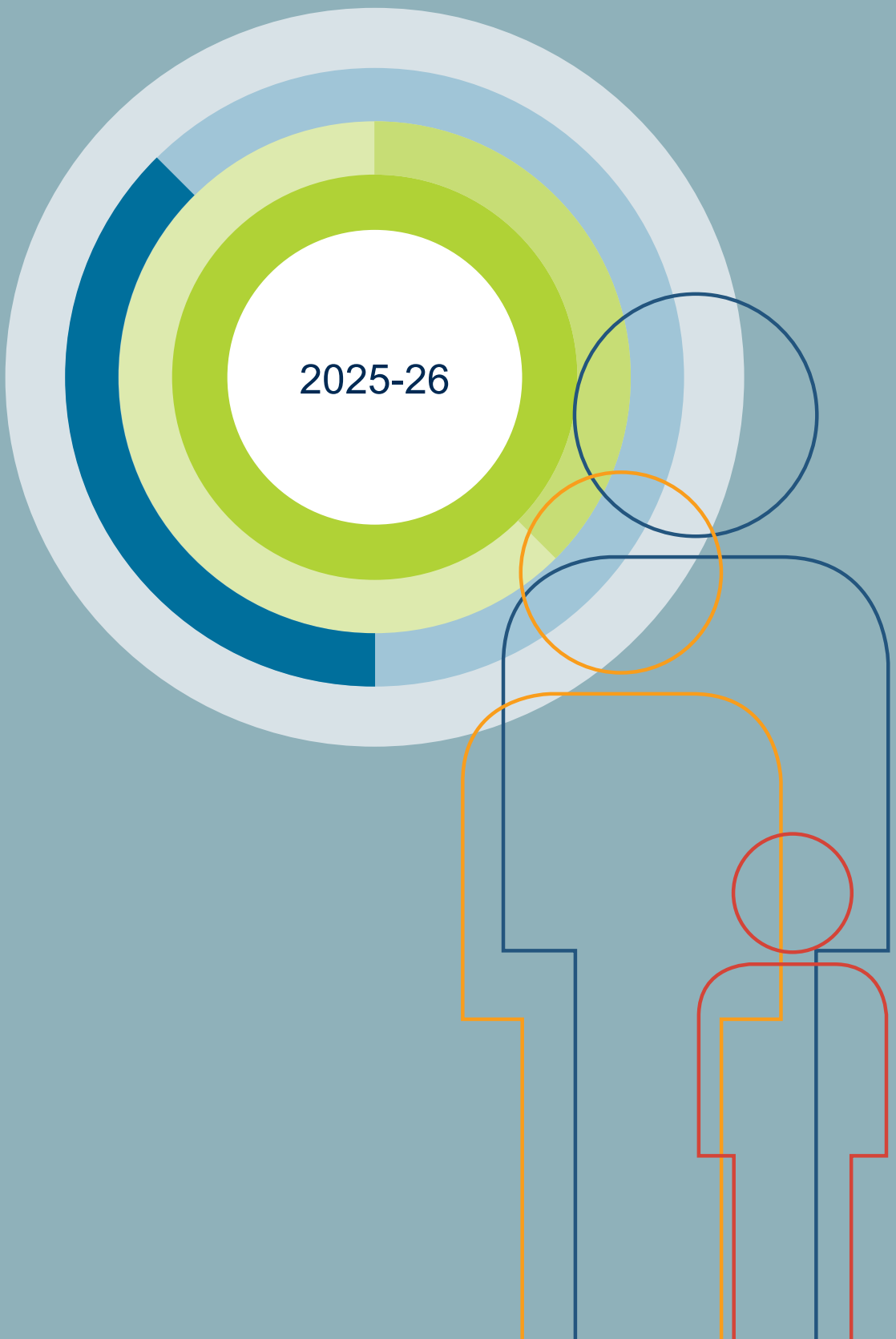


9 Incident Reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

10. Learning Lessons from Risk Management



10 Learning Lessons from Risk Management

Lessons learned from the identification and management of risk will be disseminated widely across the Trust. The Risk Management Strategy alongside the Integrated Governance and Assurance Framework will support this.

The Trust has systems and processes in place to support risk management activities, storing data on incident reporting and management (including SAI's), complaints, claims, coroner's inquests and risks.

Organisational learning from risk management activity is also supported and informed by:

- March to Safety and Safetember
- Adult safeguarding reviews
- Case management reviews
- Shared learning letters
- Directorate governance reports
- Risk Register Review Group
- QMS sense making
- Shared learning events
- Sense making of governance reports
- Independent reviews eg. Royal College reviews
- Reports on the Intranet for access by all staff eg on RQIA/NIPSO/NHS England websites
- Charles Vincent Safety Huddle
- Patient Safety Clinical Governance discussion (previously M&M)
- Weekly Telecom
- Assurance Committee
- Domestic homicide review.

A just culture is paramount in the development of an infrastructure to ensure that lessons are embedded from risk management activities. The Trust is committed to having safe and effective systems in place.

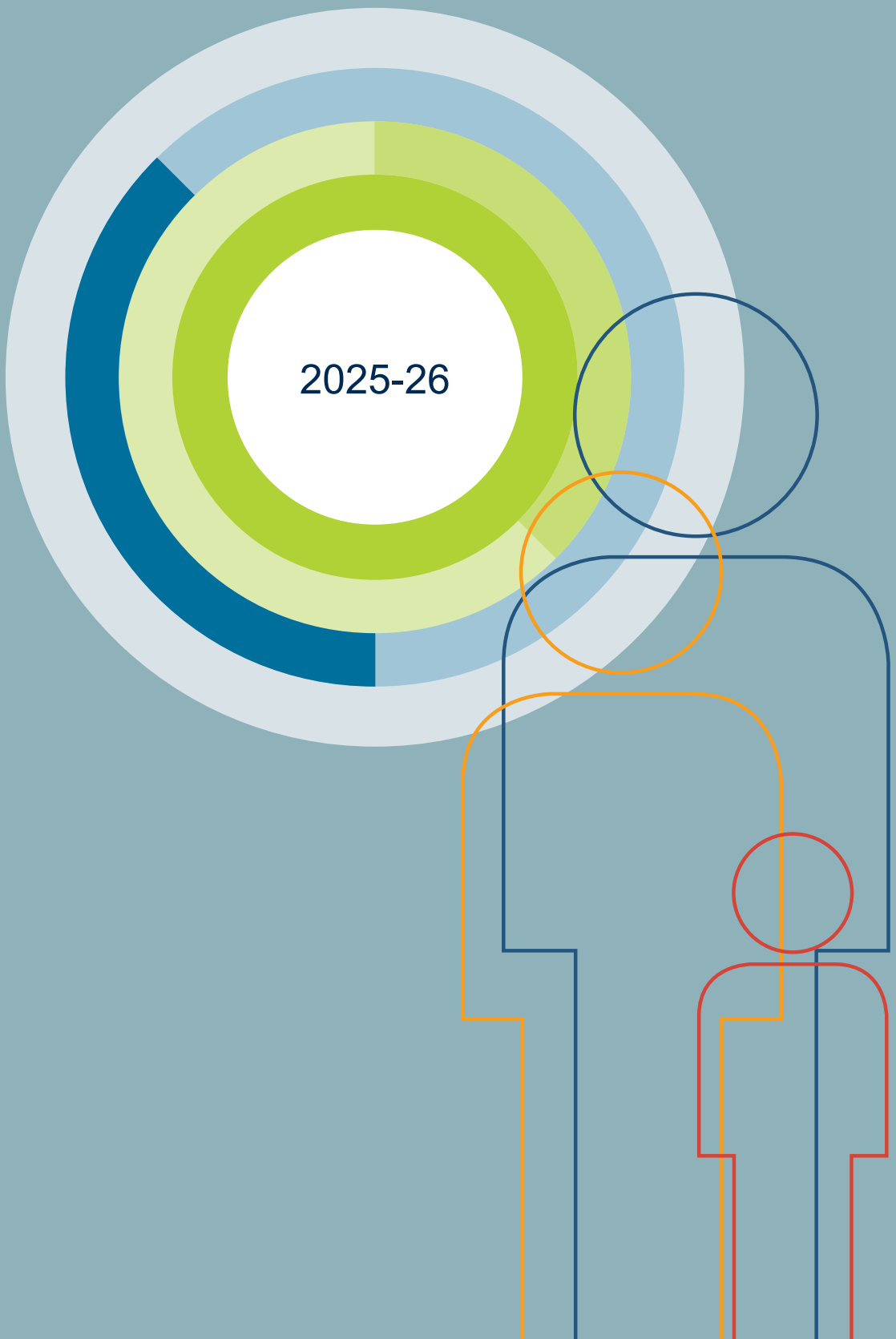
10. Learning Lessons from Risk Management

In 2018, Professor Sir Norman Williams stated that 'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. His report went on to state that 'generally, in a just culture, inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.[13]' This will mean that staff feel reassured that the review of incidents will be undertaken in a fair and open way.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

13 NHS England A Just Culture Guide

11. Evaluation, Monitoring and Audit of Policies, Procedures and Systems



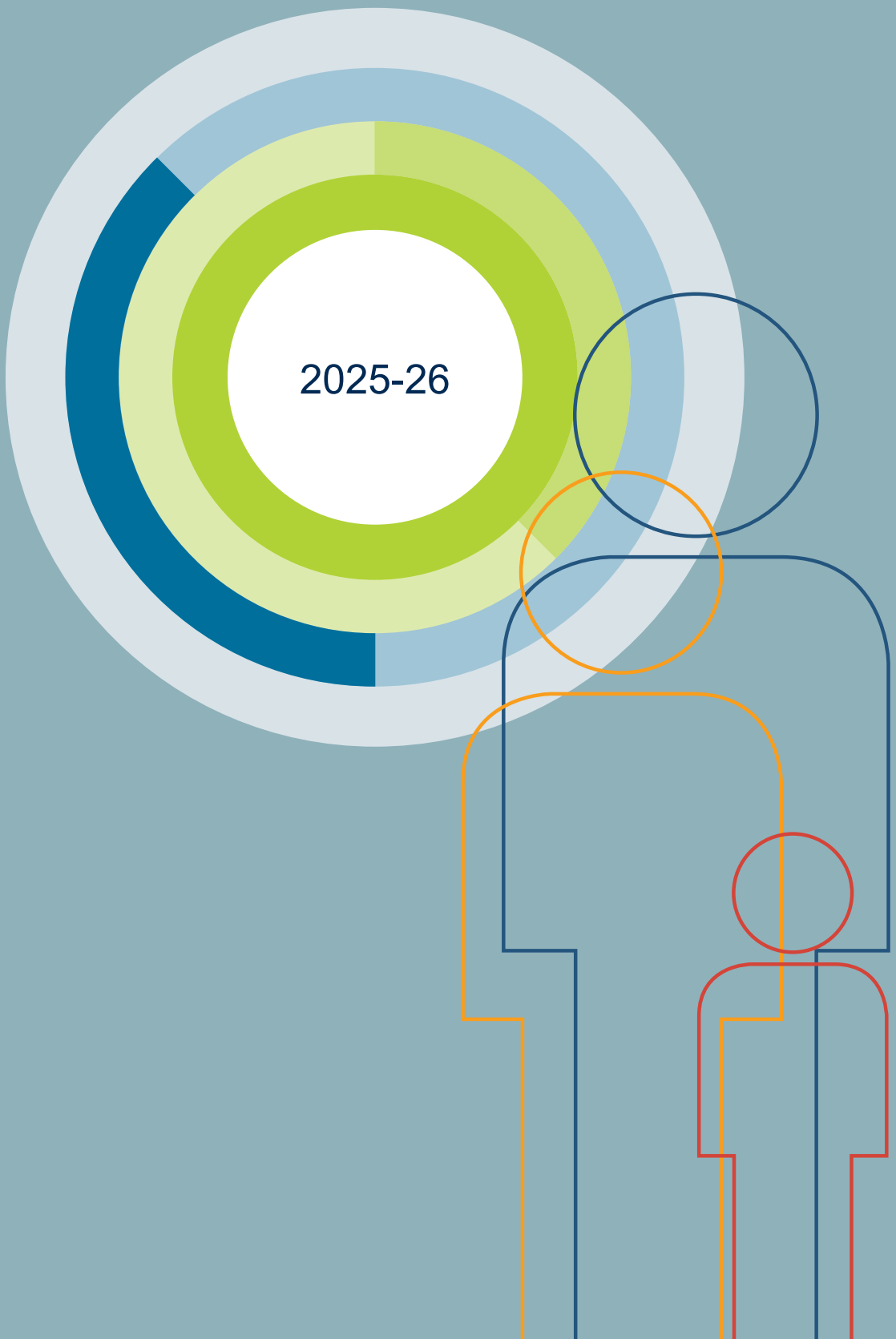
11 Evaluation, Monitoring and Audit of Policies, Procedures and Systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of “working groups” will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the structures within the Integrated Governance and Assurance Framework.

Organisational Assurance follows a similar process for seeking assurance from the relevant lead assessors and Directors providing an annual overview of gaps and actions.

The Policy and External Guidance group monitors the introduction and review of policy/ procedures, seeking assurance in relation to the effectiveness of Trust Policies and guidelines alongside the implementation of External Guidelines, and associated risk.

12. Conclusion



12 Conclusion

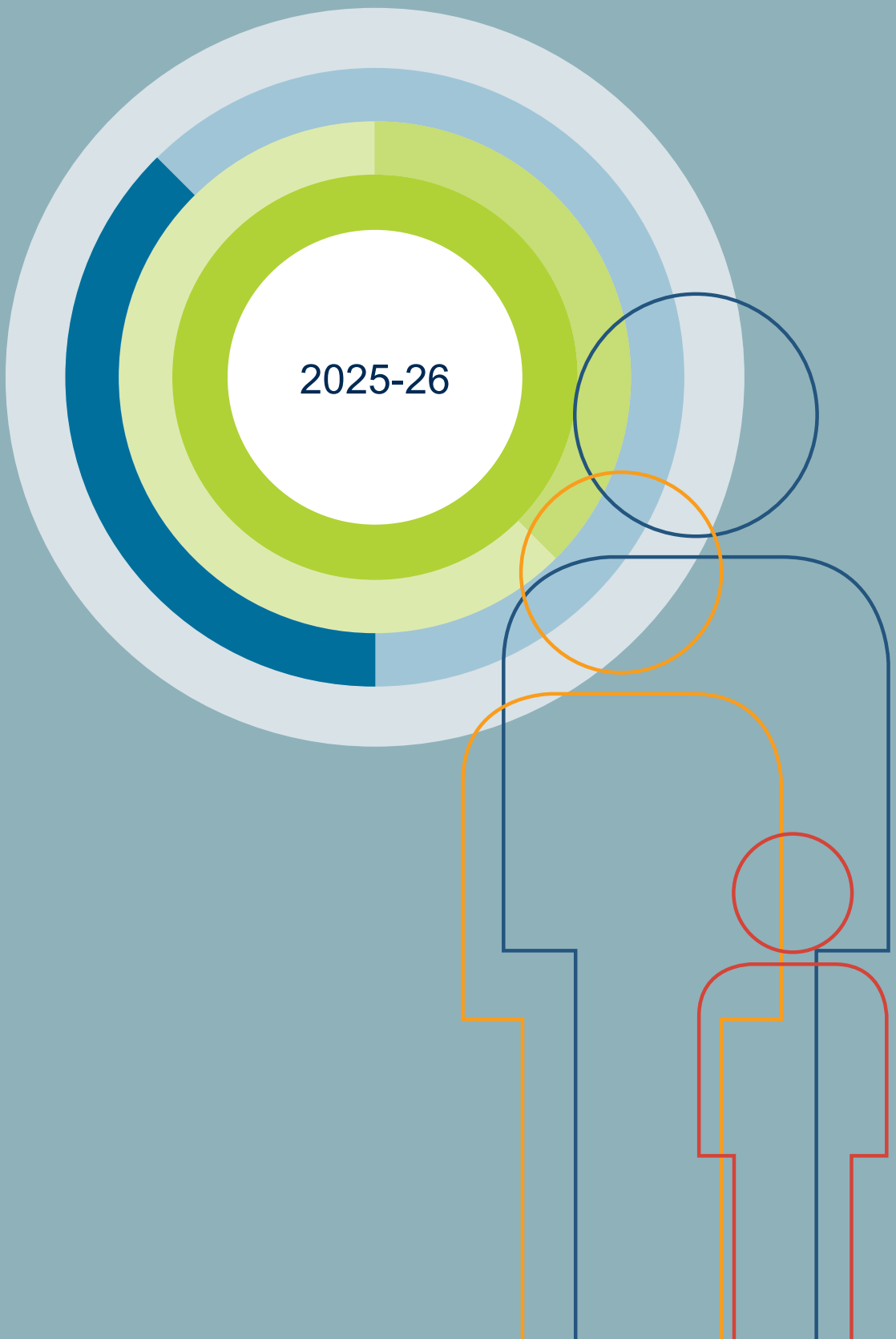
The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the 24 months, which will build on this work and ensure that improvements are sustained. The Trust will focus on “closing the loop” and utilising the information that risk profiling and reporting can provide. Ultimately, this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust’s resources.

Success of the Risk Management Strategy will be demonstrated by:

- Development and implementation of an action plan to drive forward improvements;
- Raised awareness and a culture developed where risks are identified, understood and managed;
- All directorates will have a robust governance structure in place where they can identify, escalate and manage risks;
- Information is reliable to support appropriate decision making;
- Risk assessment and risk management will be embedded into all Trust activities.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

13. Related Risk Management Policies and Procedures



13 Related Risk Management Policies and Procedures

- Adverse Incident Reporting and Management Policy
- Being Open Policy
- Claims Management Policy & Procedural Arrangements
- General Health and Safety Policy
- Guidance on RIDDOR reporting
- Guidance on Writing a Witness Statement
- Guidance on General Health & Safety Risk Assessment Process
- Management of Complaints & Compliments Policy
- Management of Medical Devices Procedures and Guidelines
- Procedure for Grading an Incident
- Procedure for Investigating an Incident
- Procedure on Memorandum of Understanding
- Procedure for Reporting and Managing Incidents
- Procedure for Reporting and Managing Serious Adverse Incidents
- Risk Register Production and Management Guidance
- Whistle Blowing Policy
- Sharing Learning Policy
- BSO IS0 31000: 2018
- IT Project Risks (added following internal audit recommendation in IT inspection)
- HR disciplinary procedure.

Appendix 1

Appendix 1

Analysing and Evaluating the Risk

In keeping with the Trust's risk appetite, risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

Step 1

Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

Step 2

Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

Step 3

Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Appendix 1

Table 1 BHSCT Impact Table

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

Appendix 1

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
	• Minimal disruption to routine activities of staff and organisation.		• Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	some formal intervention with other organisations.	• Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** **(How often might it/does it happen?)**	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Appendix 1

BHSCT RISK MATRIX

Table 3

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

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational / corporate if meets specific criteria
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review (at a minimum)	By whom
Red- Extreme	Action immediately	Review within 3 month	EDG, Director, SLT, service area
Amber – High	Action within 1 month	Review within 3-6 months	Director, SLT, service area
Yellow – Medium	Action within 3 months	Review within 9 months	Director, SLT, service area
Green – Low	Action within 12 months	Review within 12months	SLT, service area

Appendix 1

Table 6

➢ **EXTREME RISK. These must be referred to the Directorate Director and an action plan agreed to eliminate/reduce/control risk. The risk will be added to the Directorate/Division/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director. Corporate Governance must be informed of all extreme risks not already recorded on Datixweb.**
➢ **HIGH RISK. These must be referred to Senior management i.e., Directorate Director and Collective Leadership Team and an action plan agreed to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Division//Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Division / Service area risk registers for monitoring and review unless already monitored via the general risk assessment process. If meeting one or more of the specified criteria they should also be considered for inclusion on the corporate risk register for monitoring by the Assurance Group.**
➢ **LOW RISK. It is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed ACCEPTABLE. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review. If after 12 months this risk is being effectively managed and monitored via the general risk assessment process, then it can be removed from the directorate risk register, remaining in the general risk assessment process.**

Articulation of risk

A risk is something that might happen that could have an effect on the organisation. For a risk to occur there needs to be an event or a trigger that causes an unplanned or unintended variation from an organisational objective.

Within the Trust, objectives are set at a number of levels:

- Strategic
- Corporate
- Directorate
- Divisional
- Team.

Objectives set by teams support the achievement of Divisional objectives, which in turn will support the achievement of Directorate objectives, which in turn support Corporate and Strategic objectives.

All objectives need to be clearly articulated and concise, to enable services areas to understand what they are expected to achieve. Objectives are then utilised as part of the

Appendix 1

business planning process and are used to inform ward/service area/divisional business plans.

When there is an untended or unexpected deviation from one of these objectives, there is a possibility that a risk might happen, which may have an effect on the organisation. How we describe a risk is fundamental in order to understand and control it. It is something that might happen that could have an effect on the organisation. It consists of a combination of 3 elements:

1. An EVENT – the unplanned or unintended variation from an objective

2. A CAUSE - for this to happen, this is the trigger for the EVENT to occur

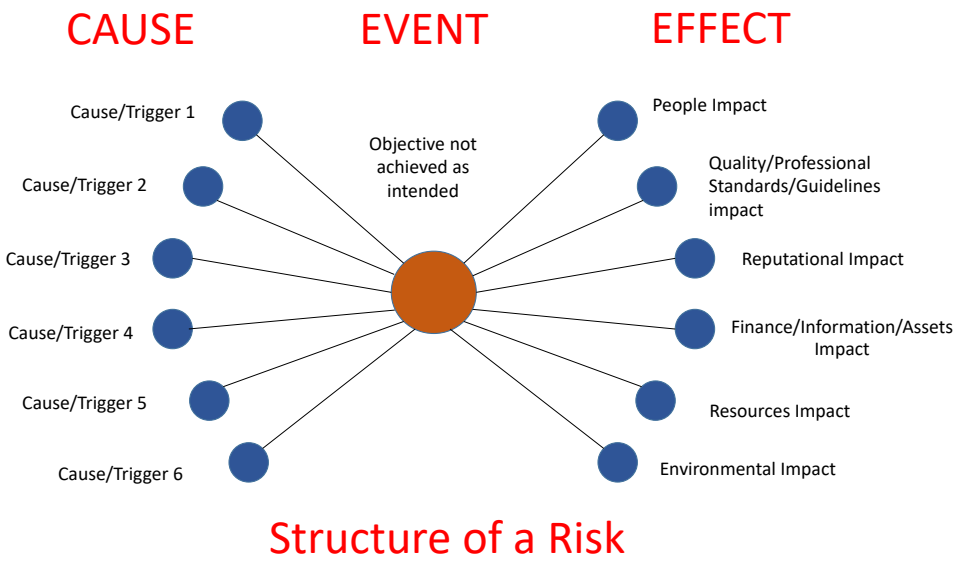
3. An EFFECT – how the organisation will be impacted upon should the EVENT occur

When describing a risk, it is useful to use the terminology of 'If', 'Then' and 'Resulting in'.

'If' the trigger/CAUSE occurs, 'Then' an unplanned EVENT or variation from the objective may occur, 'Resulting in' the EFFECT or impact on the organisation.

The structure of a risk is articulated in figure xx below. When service areas are reviewing risks, this 'bow tie' approach is a helpful tool to map and fully examine the effects alongside the range of identified triggers on a particular objective.

Figure 5



Structure of a Risk

Appendix 1

Examples of Describing Risk:

The following are hypothetical examples of how risks can be described using the '**If**', '**Then**', and '**Resulting in**' approach.

Example 1:

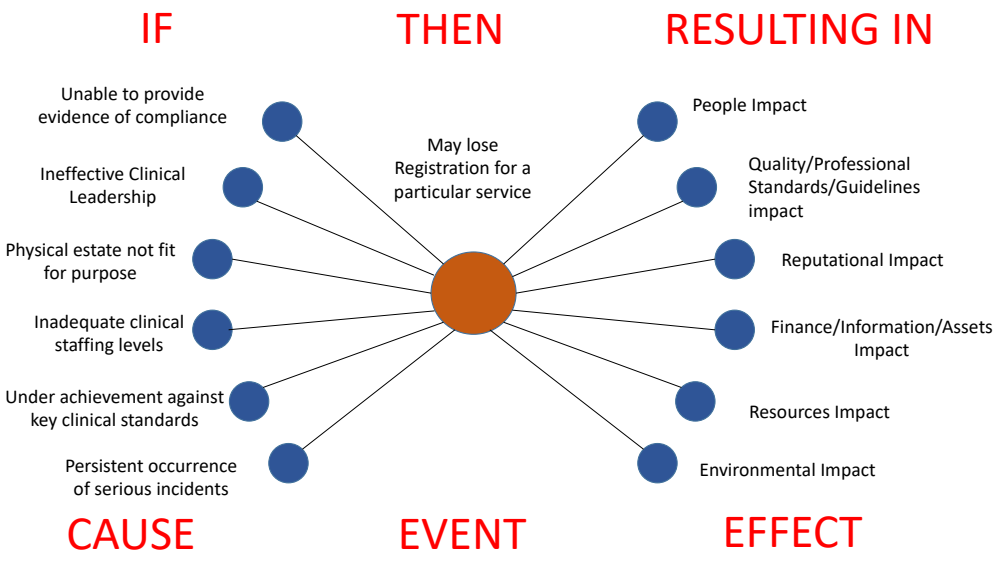
In this example, the service are concerned with loosing registration for the delivery of a regulated service.

> '**IF** the Trust is unable to provide evidence of compliance with a standard during a regulatory inspection, **THEN** the Trust may lose registration for that service, **RESULTING IN** (a) disruption to service users, (b) damage to the Trusts reputation.'

Utilising the bow tie method, a service can examine other triggers that could contribute to losing registration. This identification of triggers can help the service map out actions they need to take to manage the risk, or identify that they have more than one risk that needs articulated, with its own action plan.

EG

Figure 6:



Example 2:

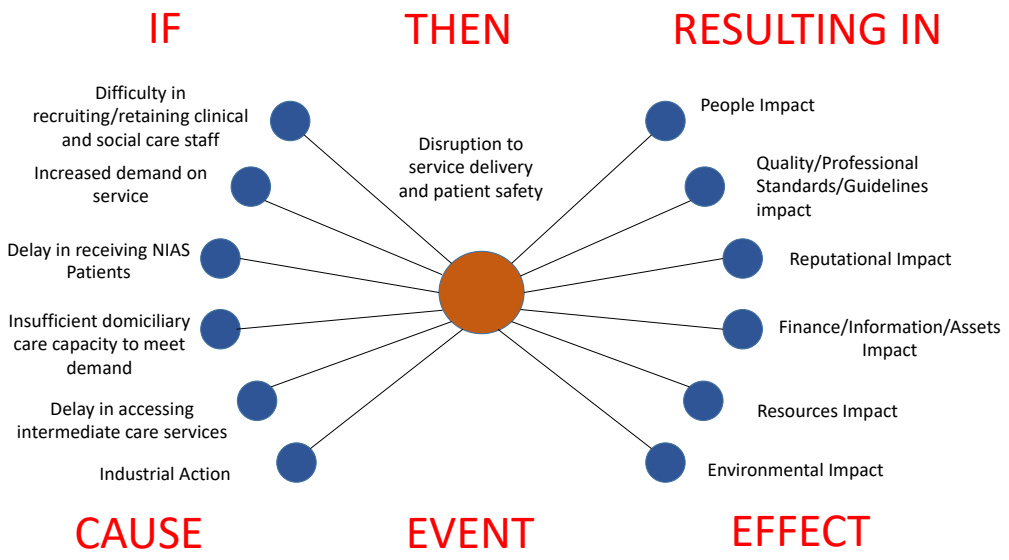
In this example, the service are concerned with disruption to service delivery and patient safety caused by staffing challenges.

'**IF** the Trust continues to experience challenges with the recruitment of staff, **THEN** there may be a disruption to service delivery and patient safety, **RESULTING IN** (a) inability to maintain high quality effective clinical care in acute and community settings (b) delay in diagnosis/intervention/treatment of patients/service users.'

Utilising the bow tie method, a service can examine other triggers that could contribute to disruption in service delivery and patient safety. This identification of triggers can help the service map out actions they need to take to fully manage the risk, or identify that they have more than one risk that needs articulated, with its own action plan.

EG:

Figure 7



Appendix 2

Good Governance Institute

RISK APPETITE FOR NHS ORGANISATIONS
A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

Risk levels / Key elements	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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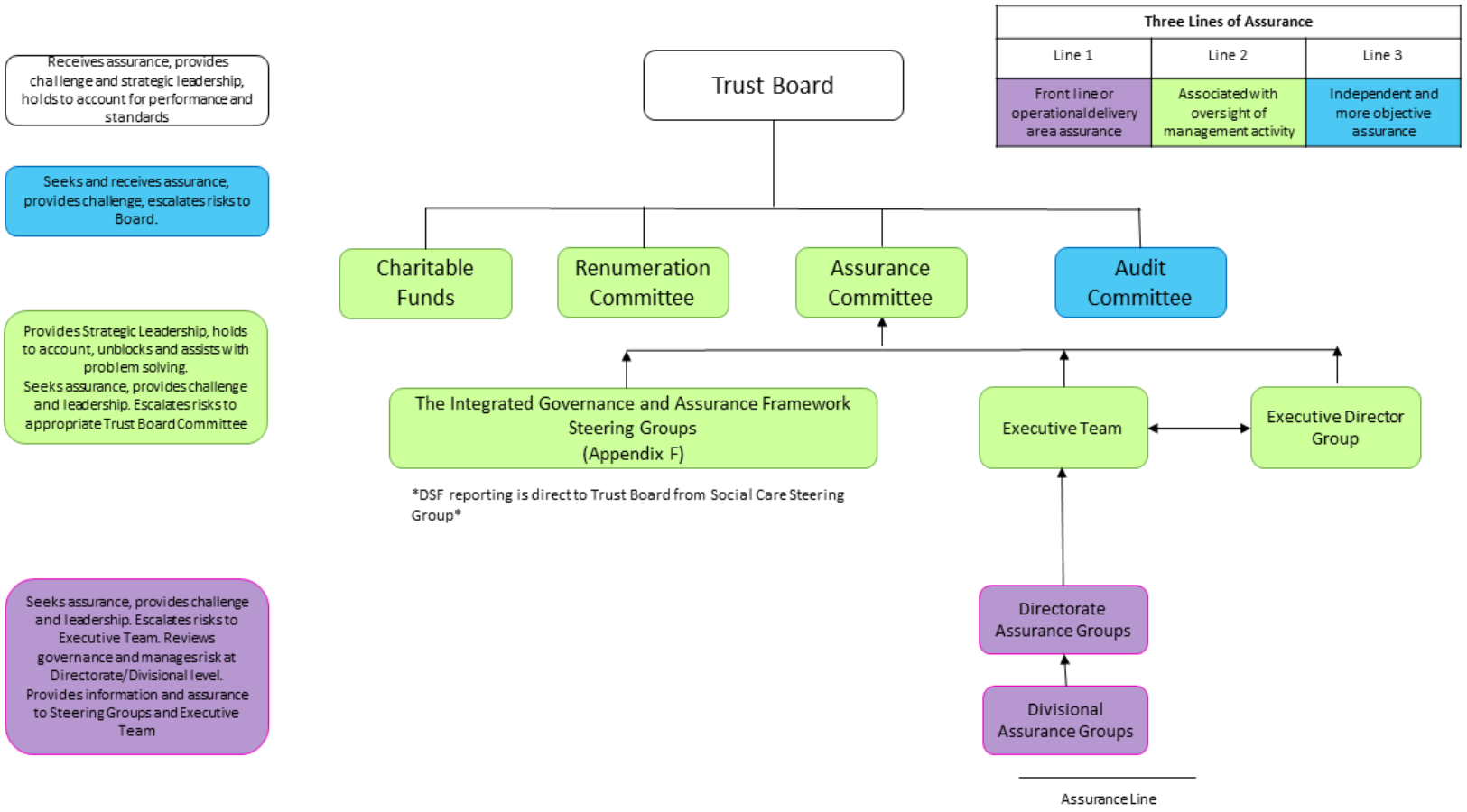
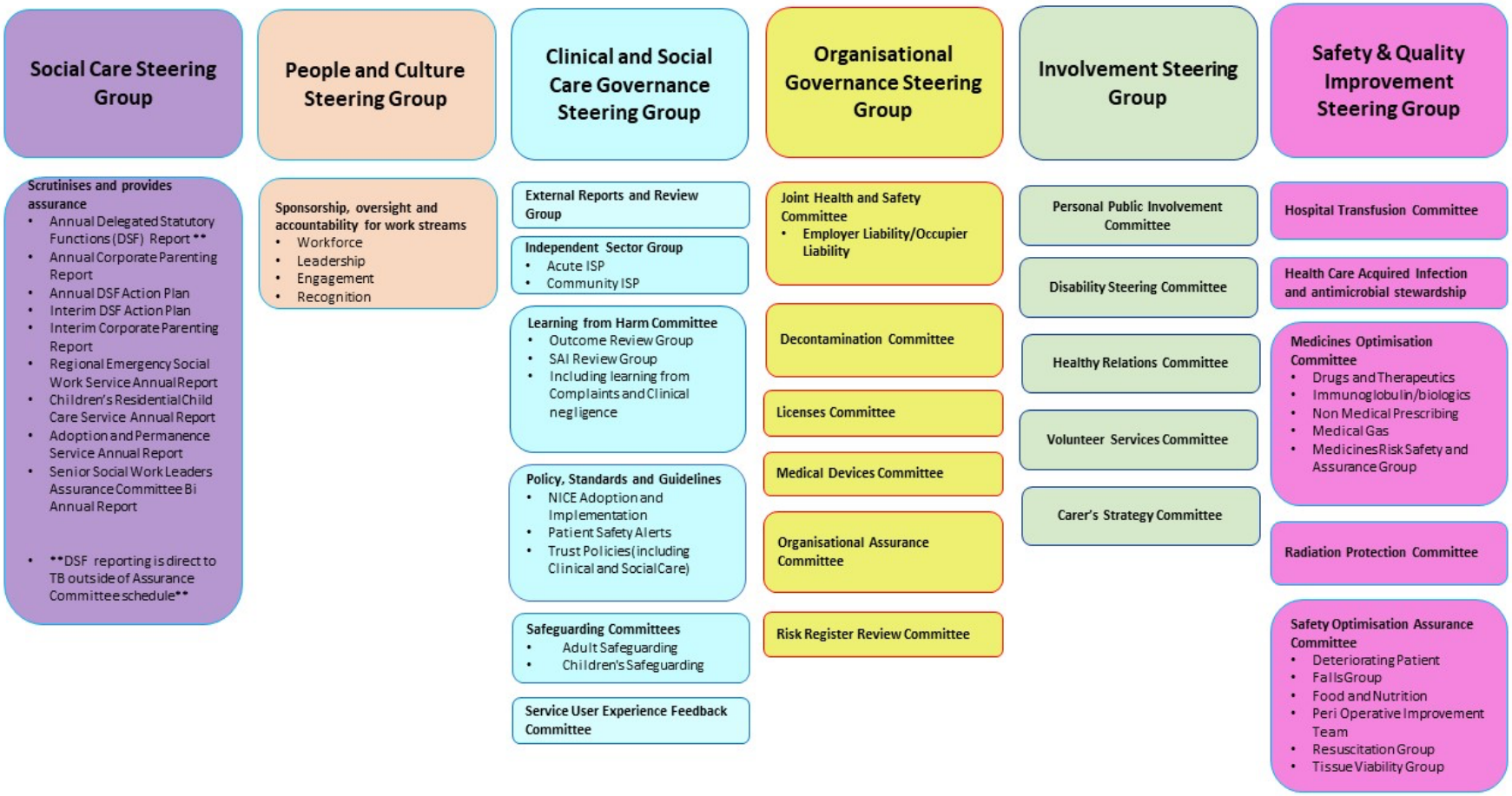
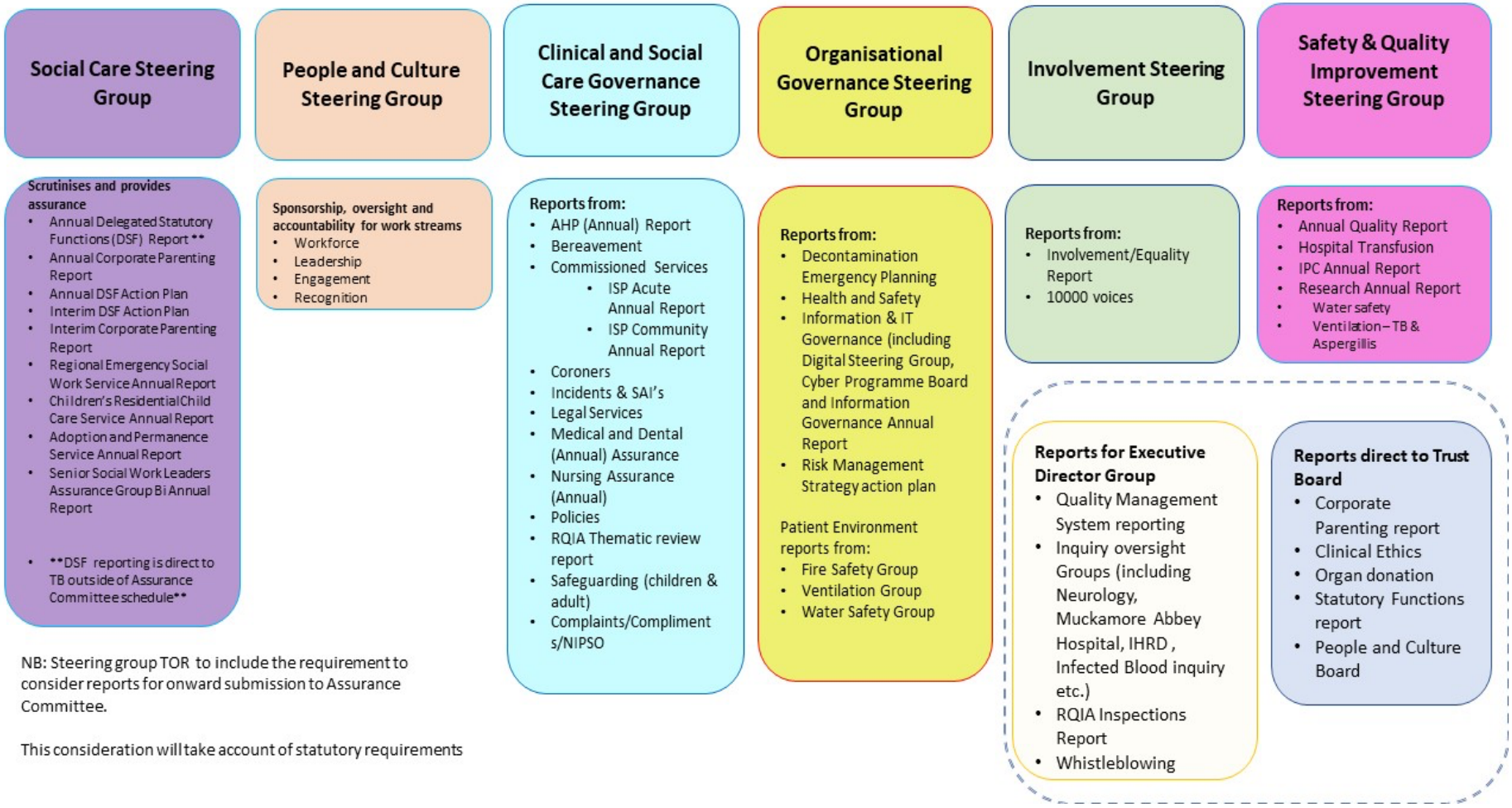
Appendix 2A


Receives assurance, provides challenge and strategic leadership, holds to account for performance and standards
Seeks and receives assurance, provides challenge, escalates risks to Board.
Provides Strategic Leadership, holds to account, unblocks and assists with problem solving.
Seeks assurance, provides challenge and leadership. Escalates risks to appropriate Trust Board Committee
Seeks assurance, provides challenge and leadership. Escalates risks to Executive Team. Reviews governance and manages risk at Directorate/Divisional level. Provides information and assurance to Steering Groups and Executive Team
Trust Board
Three Lines of Assurance
Line 1
Line 2
Line 3
Front line or operational delivery area assurance
Associated with oversight of management activity
Independent and more objective assurance
Charitable Funds
Renumeration Committee
Assurance Committee
Audit Committee
The Integrated Governance and Assurance Framework Steering Groups (Appendix F)
Executive Team
Executive Director Group
DSF reporting is direct to Trust Board from Social Care Steering Group
Directorate Assurance Groups
Divisional Assurance Groups
Assurance Line

Appendix 2B


Social Care Steering Group
Scrutinises and provides assurance
• Annual Delegated Statutory Functions (DSF) Report **
• Annual Corporate Parenting Report
• Annual DSF Action Plan
• Interim DSF Action Plan
• Interim Corporate Parenting Report
• Regional Emergency Social Work Service Annual Report
• Children's Residential Child Care Service Annual Report
• Adoption and Permanence Service Annual Report
• Senior Social Work Leaders Assurance Committee Bi Annual Report
• **DSF reporting is direct to TB outside of Assurance Committee schedule**
People and Culture Steering Group
Sponsorship, oversight and accountability for work streams
• Workforce
• Leadership
• Engagement
• Recognition
Clinical and Social Care Governance Steering Group
External Reports and Review Group
Independent Sector Group
• Acute ISP
• Community ISP
Learning from Harm Committee
• Outcome Review Group
• SAI Review Group
• Including learning from Complaints and Clinical negligence
Policy, Standards and Guidelines
• NICE Adoption and Implementation
• Patient Safety Alerts
• Trust Policies (including Clinical and Social Care)
Safeguarding Committees
• Adult Safeguarding
• Children's Safeguarding
Service User Experience Feedback Committee
Organisational Governance Steering Group
Joint Health and Safety Committee
• Employer Liability/Occupier Liability
Decontamination Committee
Licenses Committee
Medical Devices Committee
Organisational Assurance Committee
Risk Register Review Committee
Involvement Steering Group
Personal Public Involvement Committee
Disability Steering Committee
Healthy Relations Committee
Volunteer Services Committee
Carer's Strategy Committee
Safety & Quality Improvement Steering Group
Hospital Transfusion Committee
Health Care Acquired Infection and antimicrobial stewardship
Medicines Optimisation Committee
• Drugs and Therapeutics
• Immunoglobulin/biologics
• Non Medical Prescribing
• Medical Gas
• Medicines Risk Safety and Assurance Group
Radiation Protection Committee
Safety Optimisation Assurance Committee
• Deteriorating Patient
• Falls Group
• Food and Nutrition
• Peri Operative Improvement Team
• Resuscitation Group
• Tissue Viability Group

Appendix 2B



NB: Steering group TOR to include the requirement to consider reports for onward submission to Assurance Committee.

This consideration will take account of statutory requirements

Appendix 3

DATIXWEB – Fields on Datixweb when adding a new risk

Field Label	Guidance to Completion
Risk Reference Number	Usual format is initials of the Directorate/Service Area/Specialty followed by a sequential number. Check the naming convention on current risks for the area and follow on sequentially.
Risk Title	A **short** title to describe the risk.
Description of Risk	Full description of the risk that is **clear** and **concise** and that includes both **cause** and **effect**.
Overall Lead	Director/Co-Director/Manager with overall responsibility for the area within which the risk has been identified.
Risk Lead	Manager with lead responsibility for the risk.
Risk Log Date	The date the risk was first recorded.
Closed Date	Only complete this field if the risk no longer exists. If a date is present here it documents the date the risk was removed from the organisation/area. A blank field here indicates that the risk is still current.
Current Controls in place	Risk control measures currently in place to reduce level of risk.
Current Risk Score	Identify the Consequence x Likelihood using guidance tables accessed via the link in the Datxiweb form. Click as appropriate in the risk matrix. The risk should be graded taking into account controls already in place.
Proposed Actions	Actions required to further reduce or continually review the risk. Enter an expected date of completion against each proposed action.
Target Risk Score	What the risk score would be reduced to after the proposed action has been implemented, making the assumption that the action is effective.
Risk Review Date	The date the risk will next be reviewed.
Risk Type	This field is only accessible to Governance Managers and their admin support. Indicates that the risk has been approved for inclusion on the Corporate Risk Register.
Directorate	The Directorate within which the risk sits.
Service Area	The Service Area within which the risk sits. If the risk affects the entire Directorate, this field can be left blank.
Specialty	The Specialty within which the risk sits. If the risk affects the entire Service Area, this field can be left blank.
Site	Choose as appropriate if the risk affects a particular site, otherwise leave blank.
Location (type)	Choose as appropriate if the risk affects a particular Location (type) within a Site, otherwise leave blank.
Location (exact)	Choose as appropriate if the risk affects a particular Location (exact) within a Site, otherwise leave blank.
Investment Required	Estimate of revenue or capital expenditure (if applicable) to fully implement proposed actions.
Corporate Themes/Objectives	The corporate themes that the risk impacts. More than one can be chosen.
Progress Notes	This field becomes visible once the risk is saved. Can be used to record updates regarding the risk which do not form part of the current controls or proposed actions. Must also be used to record the reason for closure of a risk.