



Risk Management Strategy and Policy

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Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

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1. Introduction

Risk Management is the process of identifying, assessing, analysing and managing all potential risks and when done correctly, assists organisations in successful business planning and management to ensuring the delivery of key and strategic objectives.

Risk management is part of every managers day to day responsibilities, it should inform judgements about the appropriateness of policy options or service delivery methods, and as such should be integral to both strategic and operational management.

The East of England Ambulance Service NHS Trust Board (the Board) recognises that risk management is an integral part of good governance and management practice and to be most effective, should become part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

The Trust aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff and assets. To achieve this objective, the Trust will adopt a proactive approach with a programme of risk management that aims to preserve its assets and reputation and to provide protection against preventable injury and loss to patients, the general public and employees.

2. Purpose

This document comprises of both the Risk Management Strategy and Policy, in order to provide a single in-depth file for risk management.

The aim of the Risk Management Strategy is to set out the way in which successful risk management will be achieved by the organisation, which will assist in the delivery of the Trust's strategic objectives.

The purpose of the risk management policy section within this document is to provide detailed guidance to Trust managers and staff regarding the operation of the risk management system. It highlights the process to be followed and the responsibilities of those involved in the functioning of the Trust. This document explains how the Trust systematically assesses and treats all types of risks across the organisation.

Risk Management forms a core component of good governance and business delivery and as such, adherence to this policy is integral to compliance with the Trust's Governance and Assurance Framework.

3. Duties

3.1 The Board

The Board is accountable for internal control. The Board is required to produce statements of assurance that it is doing its reasonable best to manage the Trust's affairs efficiently and effectively through the implementation of internal controls to manage risk.

In line with Building the Assurance Framework: A practical Guide for NHS Boards, the Board will:

- Establish the Trust's objectives
- Identify the strategic risks that may threaten the achievement of these objectives
- Identify and evaluate the design of key controls intended to manage these strategic risks with rigour
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of strategic risk
- Identify positive assurances and areas where there are gaps in controls and/or assurances to the Principal Risks
- Put in place plans to take corrective action where gaps have been identified in relation to strategic risks
- Maintain dynamic risk management arrangements including, crucially, a well-founded risk register.

3.2 Executive Leadership Board

The Executive Team provides executive leadership to the Trust and is responsible for managing the everyday business affairs of the Trust. They are therefore responsible for ensuring Risk Management is employed throughout all strategic decision making. Other responsibilities include:

- Implementation of the strategies and policies of the Trust as determined by the Board
- Consideration of both upside and downside risks in decisions relating to potential new business
- Monitoring the operation of all Trust services, both front line and back office, against objectives and action / project plans
- Ensuring implementation of risk management systems in accordance with this document and the associated Governance and Assurance Framework
- An awareness of the likelihood and potential impact of risks materialising
- Reducing the incidence of impact on the organisation of risks that do materialise
- Management and mitigation of the Strategic Risks, as well as those Principal Risks escalated through the Senior Leadership Board
- Collective ownership of the Board Assurance Framework

3.3 Senior Leadership Board

The Senior Leadership Board works to ensure that a proactive and integrated approach to risk management is embedded in the organisation, through fully-informed, collaborative analysis and decision-making. In fulfilling this responsibility, the group ensures that the Trust has an appropriate, up to date and co-ordinated range of systems, policies and procedures in place to ensure the effective management of risk at the most appropriate level. In so doing, the group ensures that risks are being identified, assessed, evaluated and managed according to the Risk Management Strategy and Policy. Other responsibilities include:

- Collective management and decision making in relation to the Principal Risks
- Reducing the incidence of impact on the organisation from risks which do materialise
- Maintaining, controlling and mitigating the SLB risk register, comprising of the Principal Risks with the potential to impact upon strategic and business delivery

- Reviewing and escalating risks unable to be mitigated to the Executive Leadership Team, for acceptance on to the Board Assurance Framework.

3.4 Assurance Committees

The committees are responsible for seeking assurance on behalf of the Board in relation to the risks relevant to that committee, in order to assure the Board that the Trust is on course to deliver against its strategic objectives. The Board Assurance Framework highlights which committee is responsible for the oversight of which risks.

The Committees are also responsible for receiving and reviewing key risks and actions in place to mitigate those risks, highlighted through the assurance and escalation process set out in the Governance and Assurance Strategy and Framework.

3.4.1 Audit Committee

The Audit Committee is responsible for providing an independent overview on the effectiveness of the Trust's risk management and internal control systems, in order to assist in assessment of the way in which the Trust is implementing the Risk Management Strategy.

The Audit Committee is also responsible for considering evidence from other areas of the business to enable the provision of robust assurance to the Board that the Trust has a robust and effective risk management system in place – this includes evidence from areas such as internal audit and counter-fraud.

3.5 Executive Leadership Sub-groups

The Sub-Groups of the Executive Leadership Board are responsible for considering all risks relevant to their Terms of Reference. The remit is to seek assurance that controls and actions in place are successful in risk mitigation, and escalating risks unable to be managed at that level to the Senior Leadership Board.

The Sub-Groups are also responsible for providing assurance to the relevant Committees on the management and mitigation of the risks pertaining to their Terms of Reference.

3.6 Chief Executive

The Chief Executive has overall responsibility for ensuring that an effective risk management system is in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance. The Chief Executive is also accountable to the Board and has responsibility for maintaining a sound system of internal control and will be responsible for preparing the Annual Governance Statement (AGS) that supports the achievement of the organisation's policies, aims and objectives.

The Chief Executive is the Accountable Officer for ensuring that the Trust has a programme of risk management that includes:

- A process for identifying and quantifying risks and potential liabilities engendering among all levels of staff a positive attitude towards the control of risk
- Management processes to ensure all risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
- Contingency plans to offset the impact of adverse events
- Audit arrangements including; internal audit, clinical audit, health and safety reviews
- Decisions on which risks shall be insured
- Arrangements to review the risk management programme

Whilst the strategic development of risk management and its associated activities lies with the Chief Executive, this responsibility is discharged through the Senior Leadership Board and respective directors and senior managers as described.

3.7 Executive Directors

The Directors are responsible for owning, monitoring and acting upon the Strategic Risks with the intention of mitigating the risks to an acceptable level, in order that the Trust is able to achieve its Strategic Objectives. Directors will take individual ownership for the Strategic Risks based upon the Strategic Objective the risk most relates to. Directors are also responsible for ensuring that Strategic Risks are discussed and key decisions are taken as a collective, as it is recognised that these risks often impact across the Trust and are interdependent.

The Directors are responsible for ensuring their respective Directorates comply with the Risk Management Strategy and Policy.

3.8 Heads of Department and equivalent

Staff at all levels must understand and implement the Trust's Risk Management Strategy and Policy. Additionally Sector Heads, Senior Locality Managers, Heads of Department and their equivalents are responsible for:

- Ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.
- Preparing specific directorate and departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with appropriate expert advisors where necessary.
- Implementing and monitoring any identified and appropriate risk management control measures within their designated areas and scope of responsibility through the maintenance of directorate and local risk registers.
- In situations where potential principal risks have been identified and where local control measures are considered to be potentially inadequate, they are responsible for bringing these risks to the attention of the relevant Director and the risk team, if local resolution has not been satisfactorily achieved.
- Ensuring that all staff are made aware of the risks within their work environment and of their personal responsibilities and that they receive appropriate information, instruction, and training

to enable them to work safely. These responsibilities extend to any one affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

- Ensuring all new staff attend relevant and timely induction programmes and, where appropriate, organising exit interviews, and reporting and addressing any risk areas identified.

3.9 Head of Portfolio Office

The Head of Portfolio Office is responsible for ensuring Risk Management training is appropriate to support delivery of the Risk Management Strategy, ensuring overall compliance with the Strategy and Procedure and escalating issues and non-compliance to the Senior Leadership Board and Executive Directors. Other responsibilities include:

- The provision of advisory and practical support to Directors and Managers in risk management issues, actions and policy.
- Administration and review support to the 4Risk system
- Conducting and supporting the risk assessment process for new schemes and changes
- Monitoring compliance with the Risk Management Strategy and Policy
- Coordination of the Board Assurance Framework for the Trust Board and associated sub-committees

3.10 Trust Specialists

Trust Specialists (for example Safeguarding Lead, Medicines Management Lead, Infection, Protection and Control Lead etc) are responsible for ensuring that relevant risks are escalated to the relevant Sub-Group of the Executive Leadership Board for review, discussion and action.

3.11 Safety and Risk Lead

The Safety and Risk Lead is responsible for providing Health and safety training, audits, advice to ensure compliance with Health and Safety at Work Regulations, advice on policy development, fire safety training, advice on fire hazards and on policy development They provide a coordination function for clinical risk assessment, management and reporting to the relevant Executive sub-groups and provide resilience to the risk remit of the Head of Portfolio Office.

3.12 All Staff

Staff must adhere to policy and ensure changes to policy or practice are implemented, to ensure safety of staff, patients and the public in all instances. Other responsibilities include:

- Reporting accidents/incidents and near misses in accordance with the Trust's Management of Incident Policy, to enable the Trust to learn and put improvements in place.
- Raising with their line manager, or via the Trust's 'risk' email address, any areas of potential risk that they have recognised.
- Being aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the Trust's business.
- Complying with Trust rules, regulations and instructions to protect the health, safety and welfare of anyone affected by the Trust's business.

- Being familiar with the Trust's Risk Management Strategy and Policy, together with other Trust policies and procedures, including health and safety and fire safety, and comply with these.

4. Definitions

Appropriate definitions in relation to risk management are important. This strategy will use certain phrases within this document and on 4Risk which are defined as follows:

4Risk: The software system currently utilised by the Trust for the documentation and storage of risk registers. This is populated by managers to demonstrate the risk, its score, controls in place and actions to be taken. This should be updated by risk leads and owners monthly to ensure currency.

Assurance: Assurance is the level of confidence the Board has in the Trust's ability to manage the risks to business delivery and achievement of the strategic objectives. Executive Directors and managers are required to provide assurance to the Board, which can be through a range of methods including internal audit, surveys and evidence based updates to action plans.

Board Assurance Framework: This term is used to describe the document which holds the Strategic risk register, or summary of all of the strategic risks, their scores and what mitigating actions are being taken. The Board Assurance Framework (BAF) is reviewed monthly by Directors, and submitted formally to every Board and sub-committee meeting for review and monitoring. It is a key governance tool that enables the Board to gain assurance that the strategic risks are being effectively managed.

Consequence: This phrase is used interchangeably with impact (below). This provides a score out of five which demonstrates the level of effect a risk will have, should it occur.

Control: A risk control is a system, process or other tangible thing which has been put in place to better manage a risk. Examples could be training, a procedure or equipment which reduces either the likelihood or the impact of a risk. If the control is not yet in place but is being developed, it is a risk action until implemented.

Downside Risk: The majority of risks assessed and managed by the Trust. Downside risks relate to the loss of something, harm, or not meeting a target.

Escalation: How a risk or issue is raised through the reporting structures of the organisation, in order to ensure sufficient oversight, scrutiny and action. In terms of risk management, risks from local and directorate risk registers can be escalated to the Senior Leadership Board. In turn, the Senior Leadership Board can escalate risks to the Executive Directors and the Board Assurance Framework.

Gap in assurance: This term relates to an inability to provide assurance that a risk is being suitably managed to minimise occurrence, or the impact of the risk. This often relates to either insufficient controls being in place, or a lack of evidence to demonstrate that controls are effective. This term can also relate to a lack of confidence in delivery of the actions required to create mitigating controls and manage the risk.

Governance: The mechanisms, systems and processes within the Trust that ensures robust control and management of the way in which the organisation goes about its business. This incorporates

specialist fields of governance, for example clinical, information, financial and project. Please refer to the Governance and Assurance Strategy and Framework for more information.

Hazard: A danger, or the source of a risk. It has the potential to cause harm if the hazard is not managed or removed. Whilst the term hazard is often used interchangeably with ‘risk’, a hazard is best described as the cause of a risk, rather than the risk itself.

Impact: This phrase is used interchangeably with consequence (above). This provides a score out of five which demonstrates the level of effect a risk will have, should it occur.

Incident: An incident is something which has occurred, for example a risk which has materialised. These should be reported by staff using the Datix incident reporting system so that an investigation can occur and action can be taken to prevent an occurrence.

Inherent Score: The score of the risk if there were no mitigating controls in place. This demonstrates the worst position that would be caused through the risk materialising.

Likelihood: The probability of the risk occurring. Based upon a percentage or ratio, for example the risk is likely to occur on 10% or 1 in 10 occasions. There are five levels of likelihood set out in the risk matrix.

Mitigation: to put in place something which reduces either the impact or likelihood of a risk occurring, through the adding of controls.

Operational Risks: Risks encountered in the everyday work of managers and staff. Operational risks may be linked to strategic risks if they could impact on the strategic objectives. They are not limited to service delivery but encompass all areas of the Trust and its business.

Principal Risks: The risks residing on the Senior Leadership Board Risk register. These are not identified by score, but by the nature of the risks and the required methods for mitigation. Principal risks can be described as risks that can effect achievement of the Trust’s priorities, which impact across directorates, and require collaborative working between directorates to resolve in an effective manner.

Project Management: A strict discipline of initiating, planning, controlling, and closing a specific piece of work that achieves specific goals. A project will result in a clear product or output that can then be utilised within the business as usual environment. These outputs often facilitate control of risks. Project management includes a clear risk management approach to maximise the likelihood of success of the project.

Programme Management: The process of managing several related projects together, in order to ensure that delivery is successful. Programmes are intended to improve an organisation’s performance. As with projects, programme management includes a clear risk management approach to maximise the likelihood of success of the programme.

Project and Programme Risks: Risks that are only associated with the specific project, programme, or delivery of the project output. As such, these risks do not impact the Trust’s business as usual state. Project risks are scored in regards to their impact upon the project rather than the Trust as a whole and

as such, can result in higher scores. As a result, they are not escalated beyond the project unless they have a direct impact upon the strategic objectives.

Red Risks: This is a term often used to describe the collective risks that the Trust has with a residual risk score of 15 or above, based upon assessment of the impact and likelihood

Residual Score: The score of the risk after controls have been identified and working effectively. This is the current score assigned to the risk, and demonstrates whether the controls that have been put in place are working effectively to reduce the risk

Risk: The chance of something happening that will have an impact on objectives. It is measured in terms of impact and likelihood. Risks may be strategic, operational, clinical, environmental, financial, economic, political or reputational. Simply put, a risk is the probability that exposure to a hazard – or risk cause – will result in a negative consequence occurring.

Risk Action: An action that is taken to reduce either the likelihood of the risk occurring, or to reduce the impact/consequence, should a risk occur. Actions put in place should be set out using SMART principles, with a clear action owner and timescale for completion. They must also be proportionate to the risk itself.

Risk Appetite: The amount of risk an organisation is prepared to accept in the pursuit of its strategic objectives. This is a complex concept to define within an organisation, and the Board will have a different appetite for different types of risk (for example finance, safety). The Trust's risk appetite is in the process of being defined. In the interim period, this is managed through regular reporting of risks impacting the strategic objectives via the assurance and escalation processes in place.

Risk Assessment: The systematic review of all strategic and operational activities to identify hazards and develop control measures that eliminate or mitigate the risk. The risk assessment process is a step by step method to ensure all factors are considered and to ensure that the correct actions are taken to help reduce or control the risk.

Risk Lead: The person that the Risk Owner feels is better placed to manage the risk on their behalf and to regularly update and report back on progress and mitigation. The Risk Owner ultimately has overall responsibility for the risk, but the Risk Lead takes day to day responsibility and has the most influence in terms of completion of the mitigating actions required.

Risk Management: The process of identifying, assessing, analysing and managing all potential risks.

Risk Matrix: The mechanism / chart through which all risks are rated and scored using a 5 x 5 matrix with definitions for the impact and likelihood (Appendix C).

Risk Owner: The person with overall responsibility for the management of a particular risk. Strategic risks (as per the definitions above) are always assigned to a Director with Principal risks to a Senior Leadership Board member.

Risk Register: A management tool that enables the Trust to understand its comprehensive risk profile and is the hub of the internal control system. It includes all strategic and operational risks and they are stored on an electronic risk management system called "4risk". The Trust Risk Register is sub-divided

into a number of directorate risk registers to ensure there is ownership and management of risks relevant to that area at a local level.

Strategic Risks: Risks that may prevent achievement of the Trust's strategic objectives. These are identified, assessed and managed by the Board and are reviewed at each Board meeting.

Upside Risks: The opposite of a downside risk. These relate to the uncertain possibility of gain and often relate to projects or commercial delivery. Upside risks describe the risk being taken to gain the benefit, or upside.

5. Risk Management Strategy and Aim

The overriding aim of the Risk Management Strategy is to maintain and continually seek to improve the quality of healthcare provided by the Trust through the minimisation of risk and harm. To do this, the organisation must ensure that all activities – planned or undertaken – are adequately assessed to ensure that risks have been identified and evaluated, and that appropriate controls and actions are in place to minimise either the likelihood or impact of the risk.

It is essential that the organisation not only considers the risks of carrying out an activity, but also those actions that the organisation decides not to take.

Objectives underpinning this aim are:

- Ensure that risk management is linked to the implementation and achievement of the Trust's Strategic aims and objectives.
- Identify and control risks which may adversely affect the Trust's operational ability
- Provide and maintain a safe and secure environment for patients, staff and visitors
- Encourage and support innovation and service developments within clear frameworks for risk management and governance
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer of risk. Otherwise ensure the organisation openly accepts the remaining risks
- Create awareness throughout the Trust about the importance of actively managing risk and how this improves safety for staff, patients and the public
- Ensure risk management systems and processes are clear and understood by all staff
- Provide a systematic approach to risk discussions to ensure a 'no surprises' culture from operational staff through to the Board

6. Implementation of the Risk Management Strategy

The Risk Management Strategy and Policy will be applied through a number of methods, including:

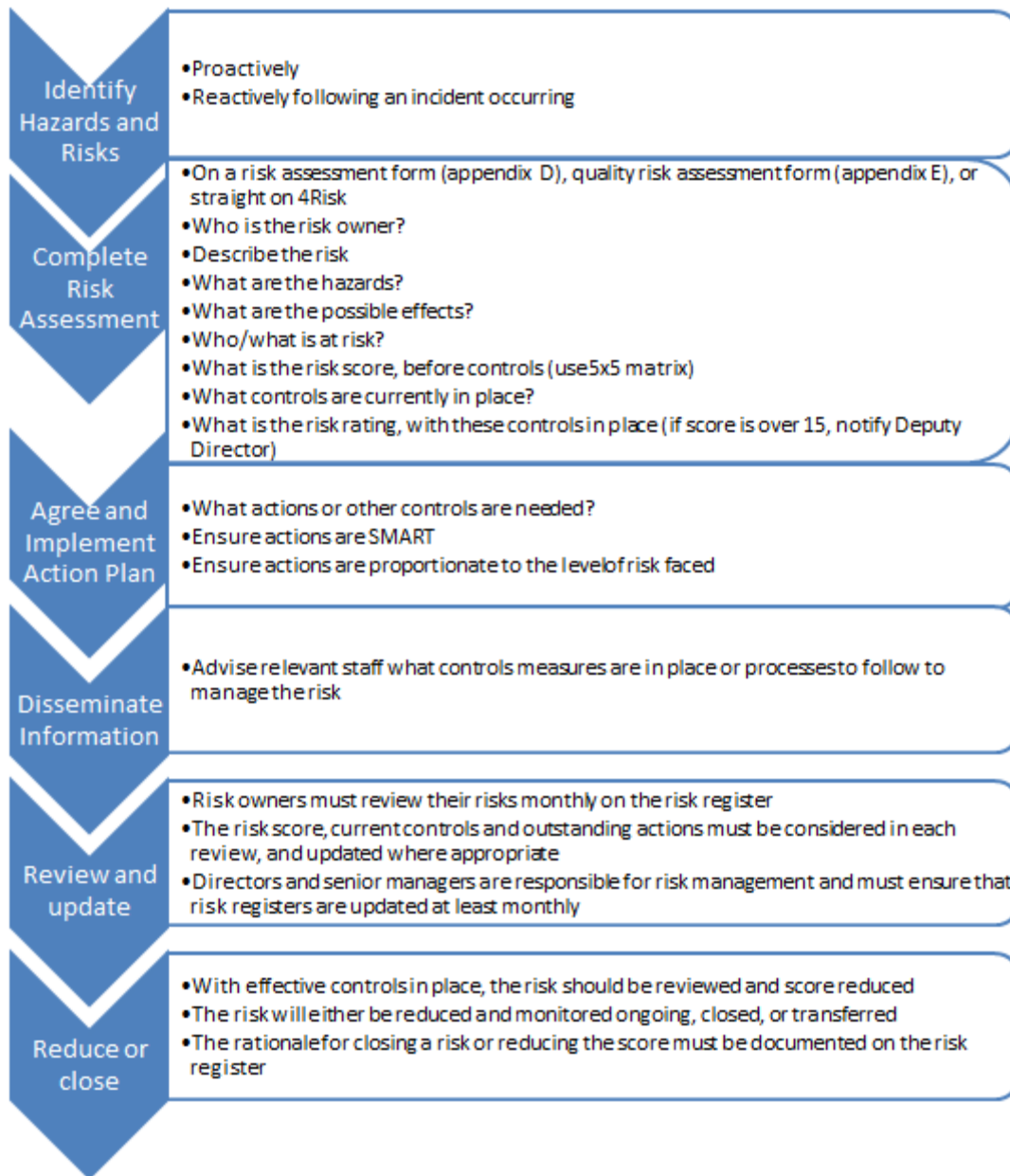
- Implementation of and adherence to the Risk Management Policy, as set out within this document
- Implementation and adherence to all policies in use in the organisation
- Establishment and application of a Risk Appetite statement by the Board

- Utilising the governance and assurance framework, ensuring flow of risk information through all groups and committees
- Ensuring that all formal Trust groups and committees discuss risks at each meeting
- Provision of risk management training according to the role of the staff member
- Ensuring that staff and managers have adequate knowledge and/or access to all legislation relevant to their area and, as advised by appropriate experts, ensure that compliance with such legislation is maintained.
- Ensuring that adequate resources are made available to provide safe systems of work. This will include making provision for risk assessments, appropriate control measures, raising outstanding concerns, ensuring safe working practices and continued monitoring and revision of same.
- Ensuring that all staff are aware of the system for the reporting of accidents / incidents and near misses. This includes ensuring that all incidents and near misses are appropriately reported, investigated, actioned and feedback provided to enable lessons to be learnt.
- Ensuring that concerns, complaints and claims are managed and investigated appropriately to enable lessons to be learnt
- Ensuring that staff attend all appropriate mandatory training e.g. Health and Safety, Fire Safety, Moving and Handling, Conflict Resolution, Resuscitation Training etc. and that mandatory updates are maintained.
- Ensuring that good practice is shared and disseminated across the organisation to facilitate the continuous improvement of services
- Utilising data from incidents, claims, complaints, concerns and other information to identify issues, risks and concerns and develop plans to resolve these within a timely manner.
- Promoting greater risk management health and safety awareness amongst all staff and ensuring that properly trained and competent staff are responsible for assessing risks and determining adequate control measures within the working environment.
- Making arrangements for the development and testing of procedures to ensure that fire and other emergency situations are appropriately dealt with.
- Monitoring clinical performance, health and safety standards including risk assessments, infection control measures; use of personal protective equipment etc and ensuring that these are reviewed and updated regularly, with appropriate actions taken.

7. Risk Management Policy

The following sections provide detail in relation to the Risk Management Policy, the Trust's approach and the way in which risks should be assessed, documented, managed and reported throughout the organisation. Adherence to the policy will ensure that a continual, systematic approach to the management of risks and issues is followed throughout the organisation.

The following flow chart provides an overview of the risk management process, which is broken down in more detail in subsequent sections:



7.1 Risk Identification

The first step in risk management is to identify the risks that could impact upon the objective intending to be met. Risk identification should be a continuous process, as new risks and hazards could become known at any given time. Risk identification can occur in two main ways – proactively and reactively.

- Proactive risk identification occurs through an individual actively considering all possibilities. A key part of this approach will be to 'horizon scan', reviewing trend data or national publications,

in order to estimate factors – or risks – that could have an adverse impact on the Trust. Organisations with a high level of risk maturity identify the majority of risks in this way, as they are invested in preventing an occurrence

- Reactive risk identification is when a risk is recognised after an incident has occurred – i.e., when a risk has materialised. Recognition that the incident could happen again initiates the risk identification and management process.

It is important to consider and document the source of the risk, as this enables the organisation to identify which risks have been identified proactively or reactively.

Examples of sources include:

- Discussions at team meetings
- Single incidents, serious incidents, complaints or claims
- Trends and themes demonstrated through analysis of data
- Internal and external audits
- Surveys
- New guidance or national best practice

7.2 Risk Assessment

The Trust requires that risk assessments are carried out in relation to the below types of risk:

- Strategic risks
- Operational risks
- Projects/programmes
- Clinical risks
- Non-clinical risks
- Any proposed service changes

By assessing these types of risk, the Trust can ensure all categories of risk are considered.

The risk assessment should include consideration of all questions highlighted in the risk assessment section of the flow chart in section 7.

The risk assessment is a fundamental step in successful risk management – if it is not undertaken in a detailed manner, incorrect actions or ineffective controls could be established which do not help to manage the risk, and can incur unnecessary cost. It is therefore essential that this stage of the process is conducted in an organised manner.

Key points to note:

- Ensure the risk is suitably described so that others can understand the problem
- Identify a clear owner for the risk
- Ensure that all hazards/causes of the risk are captured and considered, as these are required to determine what mitigating actions are needed
- Identify all of the effects that the risk would have if it materialised, in order to assist with the scoring of the risk. This must include detailing who, or what, is at risk

When carrying out a risk assessment the template at appendix D may be used to ensure a systematic approach is followed through the organisation; however it is recognised that all areas of a risk assessment are covered when entering a risk onto the Trust's risk register and as such, completion of the risk assessment template is not essential.

7.2.1 Determining the inherent risk score

It is important to note that the risk score must be based upon the impact to the organisation as a whole, not to a specific team. The exception to this relates to project risks, which are measured according to the impact upon the project.

The inherent risk score demonstrates the likelihood and consequence that a risk would have, before any controls are put in place. It is the level of risk that is apparent at the point of the first risk assessment. Determining the inherent risk score is important as it allows the organisation to understand how significant the risk is, how much effort and resource should be utilised to control the risk, and how effective management of that risk is over time.

The inherent risk score is calculated by giving a 1-5 score for both likelihood and consequence, and multiplying them together to give a score out of 25. Definitions for each level of likelihood and consequence can be found in the risk matrix in appendix C.

7.2.2 Determining Key Controls

Controls are the things put in place to reduce either the likelihood or consequence of a risk. There are a range of controls that can be applied to risks, designed to either prevent, treat, or direct the risk faced.

Preventive controls must either eliminate or remove the risk, or substitute it with something less risky to the organisation. Examples of preventive controls would be pre-employment screening, or use of pre-filled syringes to remove the ability for maladministration.

Corrective controls treat the risk, and most often reduce the likelihood. Examples of corrective controls include passwords and other access controls, or personal protective equipment.

Directive controls are system and processes put in place that are designed to give a specific outcome, through controlling the risk and evidence based practice. Examples would be training, policies and procedures.

It is important to note that a control is only in place if it is embedded in practice – for example, recognition that a policy is required is not a control – it is an action. Once the policy has been written, approved, disseminated to staff and implemented, it then becomes a control.

It may be necessary to have more than one control to successfully mitigate a risk to an acceptable level and this would be determined through the initial risk assessment, and regular monthly reviews of the risk. Controls can require change, or can become defunct as the risk or systems progress and so regular consideration of the effectiveness of each control should occur.

Similarly, controls may only be partially effective – for example implementation of a training course is only effective for those staff who have undertaken the course. Gaps in control should be considered



and actions put in place to fill those gaps and maximise the effectiveness of those actions. In the example of a training course, an action may be delivery against a clear training trajectory to ensure all staff are suitably trained.

If something is put in place that does not reduce the score of the risk in terms of either likelihood or consequence, it is not a control.

7.3 Mitigating Actions

Following a risk assessment and determination of the key controls in place, consideration should be given to the actions required in order to reduce the likelihood or consequences of the risk occurring.

Actions should be designed to form controls upon their completion, must be cost-effective and bring about a reduction in the risk score. Actions should follow the SMART principles of specific, measurable, achievable, realistic and timed.

7.4 Determining the Residual Risk Score

The residual risk score demonstrates the likelihood and consequence that a risk would have, at the current time. It is the level of risk that is apparent, with the existing controls currently in place. Determining the residual risk score is important as it allows the organisation to understand how effective management of that risk has been to date, and the level of further effort required to mitigate the risk.

The residual risk score is calculated by giving a 1-5 score for both likelihood and consequence, and multiplying them together to give a score out of 25. Definitions for each level of likelihood and consequence can be found in the risk matrix in appendix C.

8. Development and Management of Risk Registers

Risk registers are an essential tool the Trust employs to document, assess and manage risks the organisation faces. Risk registers are therefore in a consistent format using a standardised approach.

8.1 Risk Registers

The Trust Risk Management System (4Risk) is a tool used to effectively identify, prioritise, monitor and manage risk, and will comprise of the following parts:

- Strategic Risks (Board Assurance Framework)
- Senior Leadership Board risk register, comprising of the principal risks
- Directorate Risk Registers
- Local risk registers, as a sub-section of the Directorate register to better manage ownership and reporting

Projects have project-specific risk registers embedded within the project workbooks and associated documentation, in line with good project governance. As such, only project risks which impact upon business as usual will be entered onto and managed within the 4Risk system.

Each directorate within the Trust will establish a systematic approach to manage their own risks. Risk assessments will be carried out where hazards or risks are identified

All risks are recorded on the Trust's electronic risk management and are assigned to the relevant directorate or local risk register. All risk registers should be reviewed monthly.

Those risks deemed to be a principal risk (regardless of score) through the meeting of the following criteria are assigned to the Deputy Director for that area and are escalated to the Senior Leadership Board risk register, for greater pan-organisation oversight, action and scrutiny:

- Are likely to affect achievement of the Trust's priorities
- Impact across multiple directorates
- Require collaborative working between directorates to resolve in an effective manner

The directorates are responsible for the whole process of identifying, recording and managing their risks, taking suitable action within the scope of their responsibility, to ensure that these risks are constantly monitored and updated. In addition when a principal risk is identified they are responsible for escalating the issue to their Deputy Director and for alerting the Head of the Portfolio Office.

Each directorate is required to maintain their own risk register by monitoring actions taken to mitigate risks and reviewing risk assessments. On occasions where it may be possible that the risk has increased, the risk assessment should be reviewed.

Risks that are identified within one directorate but cross boundaries with more than one directorate or service, should be brought to the attention of those Deputy Directors and Heads of Department the risk may impact.

8.2 The Board Assurance Framework

The Board Assurance Framework (BAF) comprises of the strategic risks agreed by the Board, in regards to delivery against the Strategic Objectives. The BAF is an essential document which enables the Board and its associated sub-committees to gain assurance on risk management and progress towards strategic objective achievement, as well as to inform Board and Committee agenda planning.

Executive Directors own the Strategic Risks, with the Head of Portfolio Office responsible for coordinating and updating the BAF document. This is undertaken through monthly risk review meetings with Executive Directors and a core component of this function is to challenge quality of the controls and mitigating actions that have been put in place.

The Trust Board and each of its sub-committees will receive the BAF at each meeting.

8.3 Monitoring and Management of Risk Registers

The Directorate risk registers, as part of a living document, are subject to constant review and update; however directorates will be required to review and update their registers on at least a monthly basis.

Directors and those with delegated responsibility for maintaining Directorate Risk Registers are encouraged to seek advice from the risk team if there are any questions or clarifications required to assist in the maintenance of the risk register.

The BAF, Principal Risks and Directorate Risk Registers will be reviewed and monitored by the Senior Leadership Board on behalf of the Executive Leadership Board. The Audit Committee will review these documents to provide assurance to the Trust Board that the risk management system is in place and is effective.

8.4 Escalation, De-escalation and Removal of Risks

Risks are live; as such, it is important to recognise that risk scores, detail, causes, controls and actions are all subject to change. Risk register design is such that risks can be easily escalated, de-escalated or closed (and then reopened) at any point in time.

Options for movement in relation to risks are as follows:

- **Escalation** to another risk register – risks can be moved from a local or directorate register up to the Senior Leadership Board register, if deemed to be a principal risk. This decision is taken by the Deputy Director. Similarly, a principal risk can be escalated to the Board Assurance Framework, should Senior Leadership Board consider it to be a sufficient threat to delivery of Strategic Objectives. This decision is taken by the Executive Leadership Board
- **De-escalation** to another risk register – risks can be moved from the Senior Leadership Board register to a Directorate or local risk register, in cases where the risk has been controlled to an acceptable level, or when pan-organisation actions have been completed and the risk can be managed in a more local forum. This decision is taken by the Senior Leadership Board
- **Closure** of a risk – in scenarios where the risk has been terminated, or the risk is residually green or yellow with no further suitable action to be taken, the risk can be closed (score of 6 or below). Risks should only be closed when the risk owner has sufficient assurance to be confident that no further action can be taken to mitigate the risk further.
- **Ongoing monitoring** of a risk – there will be a number of risks that are unable to be mitigated further, but remain at a residual score of 8 or higher. These should remain open on the risk register and reviewed monthly to ensure no change, or no further actions are able to be taken/required

Only the Board can determine the need to remove a Strategic Risk from the Board Assurance Framework.

9. Responsibility for Managing Different Levels of Risk

Once a risk has been scored, it will be graded and managed in line with the grading process below:

- **Low Risks (green and yellow)** – are identified as those scoring 6 or less using the Risk Scoring Matrix and can normally be managed through local action by line managers who will be expected to agree control measures. Decisions should be taken and agreed locally as to the level of review required. All Directorates must keep a register of all their risk assessments, including those with a score of 6 or less.
- **Moderate Risks** – are any risks that score of 8 to 14 and must be reviewed/investigated by the appropriate Head of Department. All risks with a residual moderate score should be reviewed at every directorate meeting.
- **High Risks** – are any risks that score higher than 15. These must be owned by the Deputy Director and be reviewed at least monthly. All risks with a residual moderate score should be reviewed at every directorate meeting and the relevant Executive Director should be informed of the risk and what actions are being taken to mitigate it.
- **Principal Risks** – are any risks that reside on the Senior Leadership Board risk register regardless of score. These must be owned by a Senior Leadership Board member and be reviewed and updated at least monthly. They will be monitored at every SLB meeting.
- **Strategic Risks** – are the risks determined by the Board that could impact delivery against strategic objectives. Strategic risks will be owned by a pre-determined Executive Director, regardless of the score. Strategic risks must be reviewed and updated monthly by the Director.

10. Service Changes, Projects and Cost Improvement Programmes

All proposed service changes, projects and Cost Improvement Programmes should have a full risk assessment, taking into account the potential impacts upon quality, prior to approval and initiation. This risk assessment **must** be carried out on either a standard risk assessment template (service changes and projects – appendix D) or a Quality Risk Assessment template (Cost improvement programme – appendix E) and then submitted to the relevant governance group for approval:

- CIP Quality Panel (via the Consultant Paramedic) for Cost Improvement Programmes
- Clinical Quality and Safety Group for service changes impacting clinical care, operational delivery, pathway changes, or for proposed changes to medical equipment or medication products. This includes any changes within operations, EOC, Primary Care and Patient Transport.
- Senior Leadership Board for restructure proposals or new business
- If none of the above apply, discuss with the Safety and Risk Lead for the correct approval process

Please refer to the Governance and Assurance Strategy and Framework for greater clarity on the correct Executive sub-group pathway for the approvals process.

Projects, Cost Improvement Programmes or service developments should have their own individual risk registers that are managed within the process change, in line with project governance. Risks should be reviewed and monitored at every project planning meeting. However, if a project risk may impact upon business as usual, or prevent the overall delivery of the project then it will be necessary to escalate the risk to the appropriate directorate risk register.

For the full approval process for service changes, projects and Cost Improvement Programmes, please refer to the Governance and Assurance Strategy and Framework.

No service change, Cost Improvement Programme or Project should be initiated without documented approval from the relevant group. The project must have sufficient risk monitoring in place and have clear contingencies in place should it be unsuccessful, with an escalation process.

11. Key Performance Indicators

The Trust's performance in the management of risk will be monitored through:

- Internal and External Audit and Assessment reports, including a risk maturity audit
- Risk Register reports
- Board Assurance Framework reports
- Risk management key performance indicators (KPIs).

The aim of the risk management KPIs are to provide some measure of the total risk exposure of the Trust coupled with the effectiveness of the application of the risk management strategy. The Trust recognises that overall effectiveness will also be informed by other assurance arrangements, such as reviews by Internal Audit, and therefore the KPIs cannot be viewed in isolation. However, the set of KPIs determined below provide an immediate picture of risk and control at the Trust, which can be tracked and investigated further as required. The KPI's will be reported every six months to the Senior Leadership Board.

The following key performance indicators will be used:

- **KPI 1: Inherent / Residual Risk Profile** – how many of our inherent Red 15 + Risks have reduced to either amber / green scores due to mitigating controls and actions and how many remain as Red 15+ risks as a proportion of the total risks on 4Risk.
- **KPI 2: Strategic Risk Review** – the number / percentage of our Strategic Risks that have been reviewed and updated with Directors every month
- **KPI 3: Principal Risk Review** – the number / percentage of our Principal Risks that have been reviewed and updated by Senior Leadership Board members every month
- **KPI 4: Operational Risk Review** – the number / percentage of our operational risks on directorate risk registers that have been reviewed and updated by risk owners every month
- **KPI 5: Principal Risk Assurances** – the proportion of Principal Risk controls with recognised gaps in assurance.
- **KPI 6: Principal Risks Outstanding Actions** - the number of actions created for the Principal Risks that are overdue and outstanding on 4risk as a proportion of all actions created.

- **KPI 7: Operational Risks Outstanding Actions** – the number of total actions created that are overdue and outstanding on 4risk across the directorate risk registers as a proportion of actions created.
- **KPI 8: RIDDOR reporting** – the percentage compliance to the RIDDOR reporting timescales

Appendices

Appendix A	Monitoring Table
Appendix B	Equality Analysis
Appendix C	Risk Matrix
Appendix D	Risk Assessment Template
Appendix E	Quality Risk Assessment Template



Appendix A - Monitoring Table


What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Appropriate mitigation of the Principal Risks	The Board Quality Governance Committee	Review of the Board Assurance Framework	Three times per year (Board). Quarterly (Patient Safety and Clinical Standards Committee)	The BAF report and the Board/Committee minutes	The BAF report and the Board/Committee minutes	Head of Portfolio Office and Senior Leadership Board	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate.
Successful implementation of Risk Management and the BAF	Internal Audit (Deloitte)	Internal Audit	Annually	Audit Report	Analysis of the Audit Report by the Senior Leadership Board	Required actions will be identified and completed in a specified timeframe.	As above
Appropriate Committee and Group discharge of risk management related duties	Head of Portfolio Office	Review of the Terms of Reference for the Quality Governance Committee and the Senior Leadership Board	Annually	Committee and Group Minutes	Board approval of Terms of reference	Committee and Group will act accordingly as required	As above
Assessment of risk and control within the Trust	Head of Portfolio Office	Assessment of Risk KPIs	Bi-annually	KPI report	Reported to the Senior Leadership Board	The Senior Leadership Board will determine actions required	As above


Appendix B – Equality Impact Analysis

Equality Analysis

Initial Screening Form (Stage 1)

<p>1. Name of policy/procedures/guidelines being assessed:</p>	<p>Title: Risk Management Strategy and Policy</p>
<p>2. Is this a new or existing document?</p>	<p>New <input checked="" type="checkbox"/> Existing <input type="checkbox"/> <input type="checkbox"/></p> <p>Version being assessed (if existing): 1.0</p> <p>Last review date of document:</p> <p>Note – new document comprising of the merging of the former Risk Management Strategy and Risk Management Procedure</p>
<p>3. What is the Purpose of the document? (copy the purpose from the relevant document)</p>	<p>(a) What is it trying to achieve and why?</p> <p>Outline the risk management processes across the organisation. To ensure consistency and appropriate risk management processes are followed during the delivery of business by the Trust</p> <p>(b) Who is intended to benefit and how?</p> <p>All Trust staff and external stakeholders wishing to understand the risk management processes within the Trust.</p>

<p>4. Tick the boxes below to assess the potential for differential impact (negative or positive) on any of the protected characteristics?</p> <p> Tick Box for Positive Impact</p> <p><input type="checkbox"/> Age</p> <p><input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Gender Reassignment</p> <p><input type="checkbox"/> Marriage and Civil Partnership</p> <p><input type="checkbox"/> Pregnancy and Maternity</p> <p><input type="checkbox"/> Race</p> <p><input type="checkbox"/> Religion or Belief (including lack of belief)</p> <p><input type="checkbox"/> Sex</p> <p><input type="checkbox"/> Sexual Orientation</p>	<p><input checked="" type="checkbox"/> Cross Box for Negative Impact</p> <p><input type="checkbox"/> Age</p> <p><input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Gender Reassignment</p> <p><input type="checkbox"/> Marriage and Civil Partnership</p> <p><input type="checkbox"/> Pregnancy and Maternity</p> <p><input type="checkbox"/> Race</p> <p><input type="checkbox"/> Religion or Belief (including lack of belief)</p> <p><input type="checkbox"/> Sex</p> <p><input type="checkbox"/> Sexual Orientation</p>
<p>5. Is there the possibility of discriminating unlawfully, directly or indirectly, against people from any protected characteristic?</p> <p>Types of Discrimination:</p> <ul style="list-style-type: none"> - Direct - Indirect - Associative - Perceptive - Harassment - Third Party Harassment - Victimisation - Institutional 	<p>Yes <input type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>If yes, please state the reason:</p>
<p>6. Could there be an effect on relations between certain groups?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>If yes, please state the reason:</p>

7. Does the policy explicitly involve, or focus on a particular equalities group, i.e. because they have particular needs?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, please state reason:
8. PLEASE INDICATE BELOW ANY AMENDMENTS OR CHANGES TO THE POLICY/PROCEDURE: Creation of combined strategy and procedure. It should be noted that there are no material changes to the processes, this is the creation of a document that fully outlines the practices and expectations already in situ.	
9. Executive Summary Record Sheet Initial Screening - Equality Analysis (Stage 1)	
Document Reference: ST004	Document Title: Risk Management Strategy and Policy
Assessment Date: 25/05/2018	Document Type: Strategy and Policy
Responsible Director: Wayne Bartlett-Syree, Director of Strategy and Sustainability	Lead Manager: Emma de Carteret (Head of Portfolio Office)
Conclusion of Equality Analysis: The strategy and policy does not result in any discrimination to any group or protected characteristic, positive or negative	
Name of Committee/Board this document has been presented to: Trust Board Chairperson: Sarah Boulton, Trust Chair Date of meeting: Trust Board, via Audit Committee	
APPROVED: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Signature of Chairperson: 	Date: 25/05/2018

Appendix C: Risk Matrix

Purpose

The purpose of the risk matrix is to provide a consistent approach to the grading of risks arising within the Trust, however and from wherever, they are identified. This means that risks, whether identified from, e.g. a health and safety risk assessment or a clinical incident or a legal claim or a controls assurance self-assessment, may be graded in the same consistent manner against the same generic criteria. The Trust Board (and its sub-committees) can then be confident that, when considering risks within the same grading band, that these have been graded using the same method and the same criteria. This will allow for comparisons between different types of risk and for judgements and decisions to be made on that basis.

Method

The accepted formula for grading risk is: **Consequences x Likelihood**

This involves making a judgement both as to the **Consequences** to the person(s) involved and the Trust if the risk is realised, and the **Likelihood** (or probability) of the risk occurring, or recurring, and then allocating a number from 1 to 5 to reflect this. The numbers represent the following values:

Consequences:

- 1 = *insignificant*
- 2 = *minor*
- 3 = *moderate*
- 4 = *major*
- 5 = *catastrophic*

Likelihood:

- 1 = *rare*
- 2 = *unlikely*
- 3 = *possible*
- 4 = *likely*
- 5 = *almost certain*

(In the case of a 'near miss', by definition, no injury or damage has resulted. However, in slightly different circumstances, injury or damage could have resulted and it is the risk of this potential injury or damage which should be graded.)

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse impact that might arise from the risk;
2. Use **Table 1** (see below) to determine the **evidence based** Impact score(s) for the potential adverse outcome(s) relevant to the risk being evaluated;
3. Use **Table 2** (see below) to determine the **evidence based** Likelihood score(s) for those adverse outcomes. If possible score the likelihood by assigning a predicted frequency of the adverse outcome occurring. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of the project or the patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.
4. Multiply the Impact Score for each of the descriptors with the Likelihood Score to obtain the risk rating which should be a score between 1 and 25;
5. Use the risk matrix, shown below to determine the colour banding for the risk in respect of each descriptor (the highest score will determine the overall risk level).



RISK MATRIX – R (Risk) = C (Consequence) x L (Likelihood)

LIKELIHOOD	CONSEQUENCES (IMPACT)				
	1 - Insignificant	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

When assessing the risk of an adverse event occurring consideration should be given to using the likelihood and the *consequence* tables below.

	PROBABILITY	DESCRIPTION
RARE	1 in 100,000 chance	DO NOT BELIEVE WILL EVER HAPPEN
UNLIKELY	1 in 10,000 chance	DO NOT EXPECT TO HAPPEN
POSSIBLE	1 in 1000 chance	MAY OCCUR OCCASIONALLY
LIKELY	1 in 100 chance	WILL PROBABLY OCCUR
MOST CERTAIN	1 in 10 chance	LIKELY TO OCCUR



	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis

	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage -short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concern(questions in the House) Total loss of public confidence.
Business objectives/ projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule Slippage	Non-compliance with national 10-25 per cent over project budget Schedule slippage Key objective not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract/ payment by results Claim(s) >£1 million



Appendix D: Risk Assessment Template

Summary of task / hazard (Describe the hazard / activity giving cause to the hazard)
Title
<ul style="list-style-type: none"> Bullet point summary o

Risks associated with the task / hazard (Describe how harm may / will occur from the task / hazard. Include possible outcomes / consequences of the risks becoming realised)
<ol style="list-style-type: none"> Describe risk, bullet point potential harm <ul style="list-style-type: none"> Potential harm (e.g. patient harm, delay, reputation) Describe risk, bullet point potential harm <ul style="list-style-type: none"> Potential harm

Risk groups/areas (those most likely or especially at risk)			
Operational emergency staff		New/inexperienced staff	
EOC staff		Visitors	
Non-emergency services (PTS)		Service users/Public	
Critical Care/Air Ambulance		Lone workers	
First or Co-Responders (e.g. CFR)		Young or vulnerable persons	
Other emergency services		New/expectant mothers	
Other ambulance services		Contractors	
Other healthcare staff/organisations		Administration staff	
Information governance/Caldicott impact link here			

Existing controls (precautions in place)	Gaps in control
1. Reference risks above, bullet point controls <ul style="list-style-type: none"> Controls 	
2. Reference risks above, bullet point controls <ul style="list-style-type: none"> Controls 	
3. Reference risks above, bullet point controls <ul style="list-style-type: none"> Controls 	
4. Reference risks above, bullet point controls <ul style="list-style-type: none"> Controls 	

Risk rating (Risk rating with existing controls / precautions in place) – Refer to EEAST risk matrix									
Consequence score of incident (actual and potential)									
(5) Catastrophic		(4) Major		(3) Moderate		(2) Minor		(1) Insignificant	

Likelihood score of incident									
(5) Almost certain		(4) Likely		(3) Possible		(2) Unlikely		(1) Rare	

Detail reasons for giving this score
Enter rationale

Risk rating score			
Risk rating score (To attain risk rating multiply scores of consequence and likelihood)		Colour coded rating	

Are the current controls adequate?			
Yes or No with reason			
If No, what controls can be established to mitigate the risk?			
Risk rating score - following implementation of additional controls			
Risk rating score (To attain risk rating multiply scores of consequence and likelihood)		Colour coded rating	

Appendix E: Quality Risk Assessment Template

Project / CIP ref number:			
Descriptor: Describe the initiative / project to be implemented		Workstream	
Value of the CIP:			
Project Lead		PMO/CMO Support	
SRO		Service Line Lead	
	Risk 1	Risk 2	Risk 3
RISK: Describe the hazard / concern / harm or loss that could occur			
RISK OWNER: Which Director is the owner of this risk?			
RISK LEAD: Who is responsible for managing this risk?			
CAUSE: Why would this risk occur?			
EFFECT: If the risk occurred, what would be the effects? Reputational, Financial, Regulatory, Safety etc?			
EFFECT ON QUALITY: Describe the effects this risk will have on the quality of care we provide to our patients using each quality indicator below:			
1 Patient experience (include patient surveys, increases in complaints) i.e. how will this risk effect patient experience?			



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2	Clinical Outcomes (consider all, make specific reference if an individual AQI is affected, e.g. STEMI, ROSC, cardiac arrest to discharge, asthma, hypoglycaemia)			
3	Timed Clinical outcomes (consider AQIs such as the stroke 60)			
4	HEOC indicators (consider time to answer 999 calls, recontact rate, call abandonment rate, proportion of calls closed with telephone advice or managed without transport to A&E)			
5	Response times (consider A8, A19, time to treatment by a healthcare professional)			
6	Infection prevention and control (IPC)			
7	Patient Safety - increase in adverse events			
8	Nice Guidance			
9	NHSLA or CQC requirements			
10	Other external accreditation e.g. Royal College, OOH			
11	Impact upon staff (include staff survey)			
12	Mandatory Training			
13	Availability of essential medical equipment			
14	Back up delays			
	INHERENT IMPACT SCORE: How much impact would this have on the Trust? Please indicate 1 to 5 (See Impact Scoring Methodology below)			
	INHERENT LIKELIHOOD SCORE: How likely is this risk to happen? Please indicate 1 to 5 (See Impact Scoring Methodology below)			
	INHERENT RISK SCORE Impact X Likelihood = Total risk score (See Risk Classification Matrix)	0	0	0
	EXISTING CONTROLS: What controls are already in place to manage the risk?			
	RESIDUAL IMPACT SCORE: How much impact would this have on the Trust? Please indicate 1 to 5 (See Impact Scoring Methodology below)			
	RESIDUAL LIKELIHOOD SCORE: How likely is this risk to happen? Please indicate 1 to 5 (See Impact Scoring Methodology below)			
	RESIDUAL RISK SCORE Impact X Likelihood = Total risk score (See Risk Classification Matrix)	0	0	0
	ACTION REQUIRED: What further action is necessary to reduce risk score?			
	ACTION OWNER: Who is responsible for implementing the action?			
	ACTION DATE: When will the action be implemented?			

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KPI's: What KPI's are there that will help to monitor against this risk?			
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