Leicestershire Partnership NHS Trust

Risk Management Strategy and Policy

This Strategy and Policy sets out the Trust's approach to managing risk.

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
V1	August 2019	This Strategy and Policy is new. It replaces the former Risk Management Strategy and Framework version 11, 2018 and the Board Assurance and Escalation Framework 2017.
V1.1	December 2019	The Trust Board approved risk appetite statement has been appended. Update to reflect change in wording from corporate risk register / board assurance framework to organisational risk register.

For further information contact:

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

An analysis on the impact on equality' (Due Regard) has been included in the development of the policy, please refer to Appendix 8.

Definitions that apply to this Strategy and Policy

Board assurance framework	The Board Assurance Framework (BAF) is a tool used by the Board to collate relevant information on the risks to the board's strategic objectives
Organisational risk register	The term used to describe the merged board assurance framework and corporate risk register.
Directorate risk register	Is the document used to detail risks that cannot be controlled at a team/service level or other risks to the overall directorate identified from other sources, for example a business or staffing risk.
Local risk register	Is the document used by team / service level managers to register risks at that level that need addressing, and detail actions arising from the risk assessment process in their areas. The document is also recognised as an action plan.
Risk	A risk is something uncertain which, if it happens, will have an effect on the achievement of objectives. The more likelihood of harm occurring or the higher the impact of consequences the higher the risk is.
Risk management	Is the process of identifying, quantifying, and managing the risks that an organisation faces.
Risk	Is consideration of what may cause harm to people or the function

Assessment	of the Trust and whether or not precautions to prevent harm or loss are possible.
Current	Is the level of risk based on existing controls and sources of assurance
Action	Is putting controls in place to manage risks that have been identified and assessed. These measures are; avoidance and prevention, reduction, transfer and sharing.
Residual	Is the level of risk remaining once additional controls are applied.
Monitoring	Is putting checks in place to evaluate whether the controls are effective and still applicable and to evaluate possible changes in the risk level.
Terminate	Avoid the risk by making the likelihood of its occurrence totally impossible.
Operational risk	Operational risks emanate from day-to-day operations of the business.
Corporate risk	Refers to the risk that the Trust may fail to deliver its strategic objectives.

1.0 Purpose of the Strategy and Policy

This Strategy and Policy sets out the approach for the Trust's vision in relation to the management of risk, detailing the systems and processes in place, and highlighting roles and responsibilities.

Summary and Key Points

Local Risk Registers – locally identified operational risk held at local level.

Operational risks emanate from day-to-day operations of the business. Those risks requiring further controls are managed in a local risk register by the relevant teams and services and are discussed at service line governance groups. Where any significant risks and/or where risks require action outside of the remit of the local team or service, these are highlighted at the directorate governance groups to consider the appropriateness of escalation onto the relevant directorate level risk register.

The addition of risks onto local risk registers is gate-kept by the risk team and the directorate governance leads.

Directorate Risk Registers - locally identified operational risk held at directorate level.

Operational risks emanating from day-to-day operations of the business managed at directorate level. For the clinical directorates, these are discussed at directorate governance meetings. For enabling services, these will be discussed at relevant, service line team meetings.

The relevant governance / team meetings will approve the inclusion of all new risks on the directorate risk register.

Organisational Risk Register (ORR) - operational risks which cannot be resolved at directorate level, and/or are significant to the Trust's objectives. This also includes any corporate risk determined by board decisions concerning the objectives and direction of the Trust.

Executive Directors are responsible for ensuring that any local risks that cannot be resolved at directorate level, and/or have a significant impact on the Trust's objectives, are included in a risk register report submitted to the Executive Management Team for recommended addition to the Organisational Risk Register.

2.0. Strategy

Introduction

The achievement of strategic, directorate and clinical objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined.

Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.

The Strategy and Policy seeks to ensure that:

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

Standards

The over-riding principle is that the Trust will have in place an effective risk management system. This can be defined as the effective and systematic application of management policies, procedures and practices to the tasks of establishing the context of, identifying, analysing, evaluating, treating, monitoring and communicating risk.

The Trust has embraced the Australian/New Zealand Risk Management Standard (AS/NZS ISO 31000:2009 – see Appendix 1). The standard defines risk as "the effect of uncertainty on objectives ". It is measured in terms of consequences and likelihood (see Appendix 2).

The Trust is using the principles of the National Patient Safety Agency (NPSA) model risk matrix to inform the grading of impact (see Appendix 2).

Duties

Chief Executive

Accountable for ensuring that the Trust discharges its legal duty for all aspects of risk and has delegated effectively the responsibility for implementation of risk management.

Head of Nursing, Quality and AHP's

Delegated responsibility for the assurance of systems to ensure effective risk management within the Trust.

Other Executive Directors

Delegated responsibility as per director portfolios.

Service/Clinical Directors

Responsible for ensuring that appropriate and effective risk management processes are in place within their Directorate, and that all staff are aware of the risks within their work environment, together with their personal responsibilities. They ensure that risks are captured on local and directorate risk registers, risks are reviewed at least quarterly, and will ensure appropriate escalation of risks from local to directorate level.

Service Directors are responsible for ensuring that all staff receive the relevant elements of risk management training.

The Trust Secretary has a specific responsibility to advise the Board in order to ensure that its corporate risks are managed effectively.

Senior and Line Managers

Must ensure that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility, including:

- Identifying a co-ordinator for risk management within their designated area to facilitate the risk management process.
- Ensuring compliance with Trust Policies.
- Ensuring that all staff, subcontractors, volunteers, visitors and members of the public 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.
- Preparing specific directorate/departmental policies and guidelines to ensure that risk assessments are carried out as necessary.

Head of Assurance and Risk Management Leads

There are specialists within the Trust to advise and support others in the management of risk.

All Employees, Agency and Contractors

Recognise, act on and report risks in the Trust. In addition, all staff are expected to know and understand the risk management systems within the Trust, to follow the

Trust's policies, guidelines and procedures, use correct documentation and ensure that their training in risk management is up to date. Staff are expected to recognise and act within their own skills and competencies in the management of risks. Staff should be encouraged to develop skills in risk management as part of their personal development plan. Such skills and competencies should be monitored through the appraisal process.

- Be familiar with the Trust's Risk Management Strategy and Policy together with all directorate/department and Trust policies, relevant to their role and comply with these.
- Comply with all Trust rules, regulations and instructions to protect health, safety and welfare of anyone affected by the Trust's business.
- Comply with Trust and professional codes of conduct.
- Comply with statutory and mandatory risk management training.
- Contribute to and assist in the risk assessment/risk register process in the Trust.
- Embrace and embed learning from outcomes such as incidents, complaints, claims, aggregated data and risk assessments to improve safety and quality.
- In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risk to the attention of their director if local resolution has not been satisfactorily achieved. If the director assesses the risk as significant, the lead director for risk will be notified for update to the Organisational Risk Register and Trust Board of Directors.

Trust Board of Directors (The Board)

The accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing risks.

The responsibility for managing risk across the Trust has been delegated by the Board to the following committees:

- Audit and Assurance Committee
- Quality Assurance Committee
- Finance and Performance Committee

Audit Committee

Responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical); to support the achievement of the Trust's strategic framework. The committee will monitor and gain assurance on the timely implementation of internal audit report actions. The Executive Team also reviews outstanding internal report actions and ensures appropriate follow up takes place.

Quality Assurance Committee

Oversee all aspects of the Trust's quality management and to provide assurance to the Board and to have oversight of and assurance on those corporate level risks assigned to it.

Finance and Performance Committee

Oversee all aspects of the Trust's financial and performance management and to provide assurance to the Board and to have oversight of and assurance on those corporate level risks assigned to it.

Other Trust operational committees

There are a number of sub-groups reporting into committees in relation to risk management; these responsibilities are detailed with group terms of reference and the Trusts governance structure.

The committees/groups have the responsibility, through the Directors, for the risk of their services and for the putting in place of appropriate arrangements for the identification and management of risks.

Governance

The merged BAF/CRR maps risks, controls and assurances to the Trust's strategic framework. This provides the Board with information on a timely basis to support the Annual Governance Statement. Disclosures within the Annual Governance Statement are consistent with the self-declaration on compliance with regulatory requirements.

There is a monthly business cycle for reviewing, managing and monitoring risk on the BAF/CRR:

- Week 1. The Trust Board will receive the latest version of the BAF/CRR.
- Week 2. The Head of Assurance will meet with Executive Directors; this will provide an opportunity for reflection on existing risks, with any changes to risk scoring, controls and assurances being updated. New risks and any potential escalations can be discussed.
- Week 3. An updated BAF/CRR report will be presented to the Executive Team.
- Week 4. The BAF/CRR will be presented to the Board Sub-Committees.
- The Audit and Assurance Committee will receive the BAF/CRR each quarter; the covering report will include narrative pertaining to any changes to the systems and process underpinning the management of risk within the Trust.

The Board of Directors receives minutes and reports from its sub-committees. These will be discussed and progress with management actions will be noted as necessary. The Board, in exercising its responsibility, will also consider key indicators capable of showing improvements in risk management and/or providing early warning of risk (e.g. incident and complaints statistics, Care Quality Commission inspection report findings).

Trust Board of Directors will review and approve annually the Trust's Risk Management Strategy and Policy.

A Board committee structure is in place which supports the risk management accountability arrangements within the Trust and ensures that all significant risks are properly considered and communicated to the Board. The structure is devised to ensure a co-ordinated and holistic approach to risk management with committee cross- membership arrangements in place to ensure risk management activities are integrated.

Each service line and directorate governance meetings consider risk, quality and performance information alongside the risk registers for their relevant areas.

Risks that can be managed at department level will be under local management control. Where risks are estimated as significant or high within local risk registers, or where resources are inadequate to address risks at directorate level they will be brought to the relevant Director's attention. This includes enabling and hosted services risk.

Risk Appetite Statement

The risk appetite statement will be updated every six months and will be made available on the Trust's website.

The Trust is not risk averse and recognises that decisions with the potential to improve services can also carry risks. This should not deter from making the decision, but is considered before making an informed decision based on risk assessment and a decision on the level of tolerance of any risks. Decisions or actions that may have consequential high risks will be discussed by the Board and if relevant the Board will agree how the risk(s) will be proactively managed and contained.

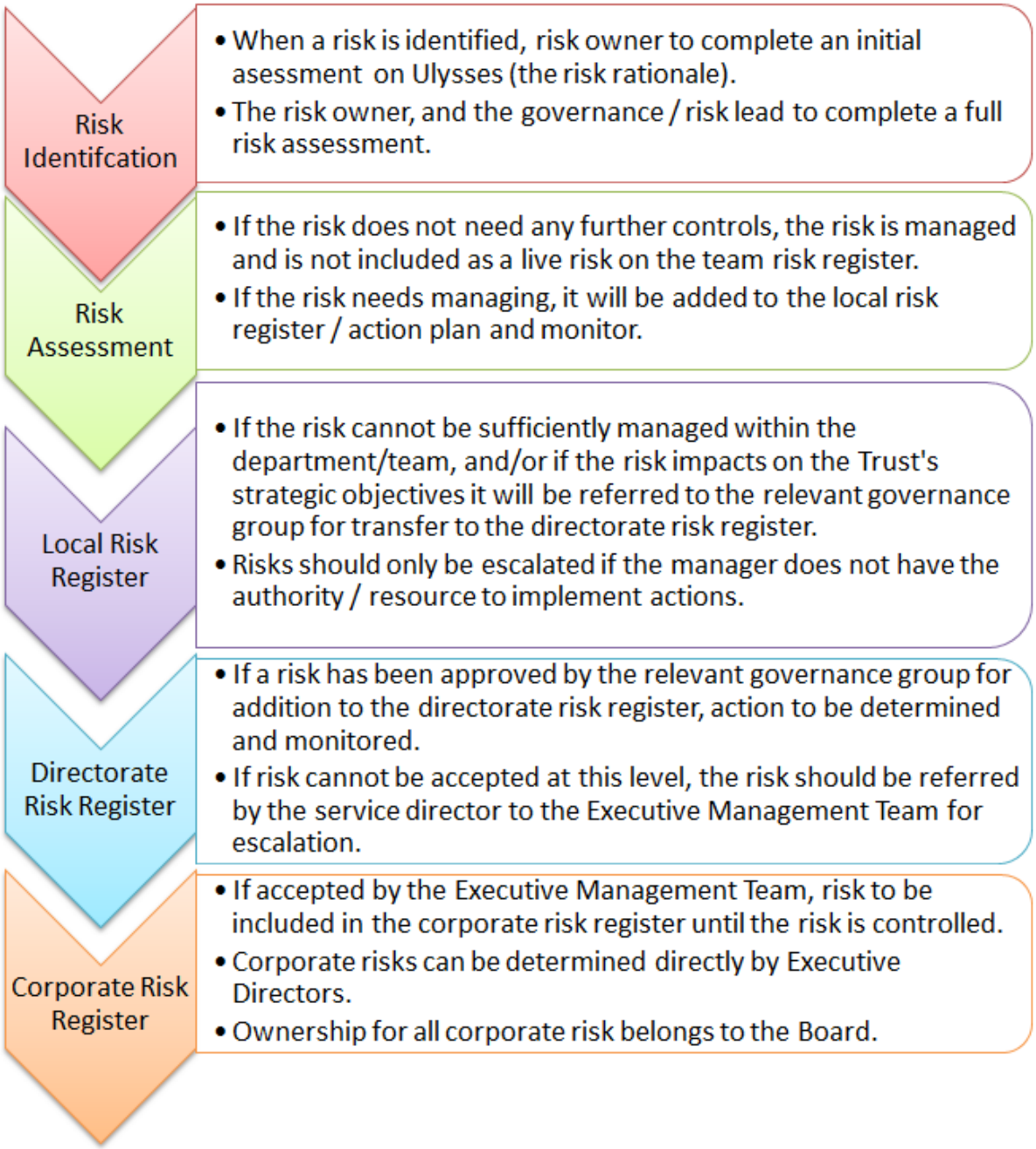
The Trust accepts that no system can be totally risk-free and that there are occasions when the Trust will have to accept a degree of risk in the course of its undertakings. For each assessed risk, the managed risk level must be considered for acceptability and risk registers should be populated and reviewed regularly in accordance with the Strategy and Policy.

New developments and business proposals that the Trust is planning will be risk assessed and included in all relevant levels of risk registers and the Trust's agreed risk appetite for the management of risks will be applied.

3.0 Policy

Risk Registers

This section details the hierarchy of the process of risk registers in the Trust. The flowchart below illustrates the process.



Local risk register

- Members of staff identify a risk and enter a risk rationale onto the Ulysses System.
- The governance / risk teams work with the risk owner to complete a full risk assessment. Risks that need further controls are entered onto the local risk register.
- The local risk register is review and maintained through service line governance meetings / enabling service team meetings.
- Significant risks and risks requiring action outside the remit of the local team/service are flagged at directorate governance meetings for consideration and inclusion onto the directorate risk register.

Directorate risk register

- As part of the review of the directorate risk register, the reviewer considers the content of all local risk register to identify potential overall risks to the service. This could be an amalgamation of a cluster of the same low level risk in local areas, but on a grouped basis poses a risk to the service.
- The directorate risk register is reviewed and monitored by the departmental/service management groups. Each service will be supported by the governance and risk teams to manage the process.
- Updated directorate risk registers are regularly submitted to the risk review group and to the relevant Executive Directors.
- Significant risks and risks requiring action outside the remit of the service are referred to the Executive Team for potential inclusion onto the organisational risk register.

Immediate escalation of significant risks

Uncontrollable risks which are significant to the Trust should be referred directly to the Trust's Executive Team for consideration to resolve immediately or to enter onto the organisational risk register.

Risk Assessment (Describing a risk and assigning controls)

The risk assessment process for risk registers considers all identified risks within the Trust inclusive of internal and external risk factors and from all sources including clinical and non-clinical risks, and those risks that could impact on the delivery of safe, high quality services.

For a consistent approach to risk assessment the following sections below must be addressed. The Ulysses System must be used to record risks identified and how they are being controlled.

Initial risk rational

In the first instance, the risk rational will be submitted prior to a full risk assessment being undertaken with relevant governance / risk leads.

Controls

Only controls that are in place and working must be considered when first evaluating the risk. Where controls exist they must always meet the minimum legal standards and there must be procedures in place to ensure they remain effective.

If the controls in place are not controlling and lowering the risk as far as is reasonably practicable and acceptable then recommendations must be put forward to do this.

This is the point at which the risk and required control measures should be entered onto the risk register. Note, if the risk is sufficiently controlled it will not be entered onto the risk register.

The register should provide the source of the identified risk, description of the risk, action required including interim control measures, risk score, deadline and review date, cost, identify the person responsible for implementing the control and show a residual risk rating after implementation of controls.

When implementing controls, the Trust can consider 3 options;

- Treat. Work is carried out to reduce the likelihood of the risk (this is the most common action).
- Transfer – Shift the responsibility or burden for loss to another party e.g. the risk is insure against or subcontracted to another party.
- Terminate - Avoid the risk by making the likelihood of its occurrence totally impossible.

Assurance

Assurance may be provided by inspection of areas, clinical processes, work, financial controls, planned preventative maintenance, regular testing of equipment, relevant board reports, performance indicators, 3rd party assurance e.g. internal/external audit. This should be recorded on the risk assessment form.

Evaluate and Record the Findings

The risk assessment form provides a mechanism and evidence that a risk assessment has taken place and whether this risk is immediately controlled or requires further action(s).

The overall risk depends on the likelihood of the unsafe event occurring, the number of people who might be exposed and the impact of the consequences. The overall risk is the most likely outcome not worst case scenario.

Risk = Likelihood of Occurrence X Impact of Consequences

The overall risk should be considered in term of low, moderate, high or significant and justification for the rating must be given. The risk level is calculated using the risk scoring matrix see Appendix 3.

Risk Review

All risk registers must be reviewed formally on a quarterly basis as a minimum, to ensure risks are being identified and controls/action plans are in place. The governance and risk teams will co-ordinate and undertake the review. Hosted services are required to undertake their own review.

The risk register is a ‘live’ working document to be considered as part of the management of each area. It is recommended that risk forms part of the standard governance / service line team meeting agenda with regular discussion on progress with actions required to mitigate the risks.

Review of the risk register also includes a review of the risk assessment forms and consideration of any new potential risks. Risk assessments should be reviewed

periodically either 6 monthly, on implementation of new controls or when there are changes to the working environment. This is to ensure that the focus does not remain on the risk register alone and therefore have the potential for other risks to be missed.

4.0. Training needs

Knowledge of risk management is essential to the successful embedding and maintenance of effective risk management. Training required to fulfil this Strategy and Policy will be provided in accordance with the Trust's Training Needs Analysis.

- E-learning modules and local, tailored training courses are available for all staff.
- Specific training will be provided in respect of high level awareness of risk management for the Board and senior staff.
- Risk Awareness Sessions are included as part of the ongoing development programme for the Board and the Audit and Assurance Committee.

A record of any training and any names of attendees / non attendees will be recorded and passed to the training department for recording on the training database. The training department will alert managers of any non –attendees and managers will be responsible for following this up.

Only competent persons can carry out risk assessments. Therefore anyone who is to carry out risk assessment must have successfully completed the risk register training

A manager may delegate this duty to a member of the team. However, it is required that managers also complete the training.

5.0. Monitoring Compliance and Effectiveness

The table below outlines the Trust's monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational need.
This document is uncontrolled once printed. Please refer to the Trust intranet for the current version.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
1.	Local risk registers	Review of local risk registers		Governance / risk leads	Quarterly
2.	Directorate risk registers	Review of Directorate risk registers		Governance / risk leads	Quarterly
3.	Organisational risk register	Review of organisational risk register		Trust Board	6 monthly
5.	Staff have completed the training associated with	Training will be monitored in line with the training policy.		Governance / risk leads	6 monthly

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	this Strategy and Policy in line with the TNA				

6.0. References and Bibliography

The Strategy and Policy was drafted with reference to the following:

Northamptonshire Healthcare NHS Foundation Trust:

- Policy and guidance for the use of risk registers – HSC002
- Risk Management Strategy – CRM001v1.5 July 2019

Appendix 1 Risk Management Process (AS/NZS ISO 31000:2009)

The elements of the AS/NZS ISO 31000:2009 risk management process in more detail:

- **Establish the Context**: It is necessary to fully understand the external and internal aspects of the organisation or organisational part which is subject to risk management.
- **Identify Risks**: This step shall uncover risks, their location, timeframe, root causes, and scenarios.
- **Analyse Risks**: The output of risk analysis is the likelihood of a risk and the consequence in case of risk occurrence.
- **Evaluate Risks**: Risk analysis provides an outcome which is basis for decision making which risks need treatments and in which priority.
- **Treat Risks**: Treatments are responses to risks. Alternative treatments need to be identified, assessed, selected, planned, and implemented.
- **Monitor and Review**: This step shall ensure that the risk management plan remains relevant and all input data, including likelihood and consequence, are up-to-date. Monitor and review relates to all of the above five elements of the risk management workflow.
- **Communication and Consult**: Successful risk management relies on communication with all stakeholders. Communication will improve the level of understanding and treating risks. Communication is important throughout the entire risk management cycle.

Appendix 2 Risk impact matrix

Identify the highest consequence of this risk, taking account of the controls in place and their adequacy, how severe would the consequence by of such an incident? Apply a score according to the following scale:

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient harm / outcome / experience	▪ No obvious harm. ▪ Patient dissatisfaction.	▪ Minimal harm. ▪ Experience readily resolvable. ▪ 1-2 people affected	▪ Some harm. ▪ Mismanagement of patient care. ▪ Short-term effects <week. ▪ 3-15 people affected.	▪ Permanent harm. ▪ Serious mismanagement of care. ▪ Misdiagnosis/poor prognosis. ▪ 16-50 people affected. ▪ Increased level of care *(> 15 days)*	▪ Death/life threatening. ▪ Totally unsatisfactory outcome/experience. ▪ > 50 people affected *(e.g. screening concerns, vaccination errors).*
Staff / Visitor etc. Injury / Psychological / Social	▪ No injury/illness not requiring first aid.	▪ Minor Injury/Illness requiring first aid/minimal treatment or care. ▪ Short-term staff sickness *(< 3 days)* ▪ 1-2 people affected.	▪ Moderate injury/illness requiring medical intervention. ▪ Staff sickness *(> 3 days)* - RIDDOR ▪ 3-15 people affected	▪ Major injury/illness requiring long-term treatment/incapacity/disability. ▪ Long-term sickness ▪ > 15 people affected.	▪ Death. ▪ Life threatening injury/illness. ▪ Permanent injury/damage/harm.
Health Inequalities *(Equity of access to care and/or inequity in wider public health)*	▪ Possible/minor loss of potential for reducing health inequalities,	▪ Unable to investigate, develop/pilot future improvements in services/activities that are likely to reduce health inequalities.	▪ Unable to implement intended developments in services/activities that have significant potential to reduce health inequalities.	▪ Reduced effectiveness of existing service/activity that is targeted at reducing health inequalities.	▪ Probability of increase in health inequalities OR permanent loss of existing service/activity targeted to reduce health inequalities.
Complaint/Litigation	▪ Locally resolved complaint.	▪ Justified complaint peripheral to patient care. ▪ Litigation unlikely.	▪ Justified complaint involving lack of appropriate care. ▪ Litigation/enforcement action possible. ▪ Below excess.	▪ Multiple justified complaints. ▪ Claim above excess level. ▪ Litigation/enforcement action expected.	▪ Multiple claims or single major claim. ▪ Unlimited damaged. ▪ Litigation/prosecution certain.
Business/Service Loss	▪ Minimal impact. ▪ No service disruption.	▪ Minor loss/interruption *(> 8 hours)*	▪ Moderate loss/interruption *(> 1 day)*	▪ Significant loss/interruption *(> 1 week)* ▪ Temporary service closure.	▪ Permanent loss of service/facility. ▪ Impact in further areas.
Staffing & Skill Level	▪ Short-term low staffing level that temporarily reduces service quality.	▪ On-going low staffing level reduces service quality.	▪ Late delivery of key objectives/service due to staffing levels. ▪ On-going unsafe staffing level, skill level ineffective.	▪ Uncertain delivery of key objective/service due to staffing levels. ▪ Unsafe staffing levels, skill levels inadequate.	▪ Non-delivery of key objective/service due to lack of staff. ▪ Serious incident due to insufficient training.
Financial	▪ Small loss	▪ Loss > 0.1% of budget.	▪ Loss > 0.25 of budget. ▪ £500,000 loss of contractual income.	▪ Loss > 0.5% of budget. ▪ £1M loss of contractual income.	▪ Loss > 1% of budget. ▪ £2M loss of contractual income.
Reputation/Publicity	▪ No adverse publicity or loss of confidence in the Trust.	▪ Local Media – short term low impact on confidence and effect on staff morale.	▪ Local media – long term relations with public affected. ▪ Moderate loss of confidence in the Trust and significant effect on staff morale.	▪ Widespread adverse publicity. ▪ National Media *(< 3 days)* ▪ Major loss of confidence in the Trust.	▪ National Media (> 3 days) ▪ MP concern – questions in the House. ▪ Major loss of confidence in the Trust. ▪ Viability of the Trust threatened.
Governance *(Inspection/Audit & Policy Compliance)*	▪ Minor non-compliance with standards. ▪ Minor recommendations.	▪ Non-compliance with standards. ▪ Recommendations given.	▪ Reduced rating. ▪ Challenging recommendations. ▪ Non-compliance with core standards, legislation.	▪ Low rating. ▪ Enforcement action. ▪ HSE intervention. ▪ Critical report. ▪ Major non-compliance with core standards, legislation.	▪ Zero rating. ▪ Prosecution. ▪ Severely critical report. ▪ Loss of contracts. ▪ Public enquiry.
Objectives & Projects	▪ Insignificant cost increase/schedule slippage. ▪ Barely noticeable reduction in scope or quality.	▪ < 5% over budget/schedule. ▪ Minor reduction in quality/scope.	▪ 5-10% over budget/schedule slippage. ▪ Reduction in scope or quality.	▪ 10-25% over budget/schedule slippage. ▪ Failure to meet secondary objectives.	▪ > 25% over budget/schedule slippage. ▪ Doesn't meet primary objectives.
Estates & Environmental	▪ Inconsequential damage to buildings/environment/historic resources that requires little or no remedial action.	▪ Recoverable damage to 'non-priority' buildings/environment/historic resources.	▪ Recoverable damage to 'priority' buildings, or loss of 'non-priority' buildings/environment/historic resources.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting part of the site.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting the whole site.

Appendix 3 Likelihood and consequence

How likely it is that such an incident could occur.

From the descriptors below determine the likelihood of the incident recurring or the risk identified actually occurring.

N.B when deciding on the likelihood always remember to consider the risk controls you already have in place.

Likelihood descriptors

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
or					
Probability	<1% Will only occur in exceptional circumstances	1 – 5% The event is not expected to happen	6- 20% The event may occur occasionally	21 – 50% The event is likely to occur	>50% A persistent issue

Use the Matrix below to Grade the Risk. (i.e. 2 x 4 = 8 = Orange or 5 x 5 = 25 = Red)
Risk scoring = consequence x likelihood (C x L)

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

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

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Significant risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Use question 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

Use question 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome

occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score, as per question 3, by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Identify the level at which the risk will be managed in the Trust, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the Trust's risk management system. Include the risk in the risk register at the appropriate level.

Appendix 4 Training Needs Analysis

Training topic:	Risk
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ✓ Personal development
Division(s) to which the training is applicable:	✓ Adult Mental Health & Learning Disability Services ✓ Community Health Services ✓ Enabling Services ✓ Families Young People Children ✓ Hosted Services
Staff groups who require the training:	All clinical and non-clinical staff. Emphasis on training provision for Governance and Risk Staff.
Regularity of Update requirement:	Annual
Who is responsible for delivery of this training?	Risk Team
Have resources been identified?	Risk Team
Has a training plan been agreed?	Training plan subject to on-going refinement
Where will completion of this training be recorded?	✓ ULearn ✓ Other (please specify) tailored training to be recorded by the Risk Team.
How is this training going to be monitored?	In regular reports to the Audit and Assurance Committee

Appendix 5 The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 6 Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Kate Dyer	Head of Assurance

Circulated to the following individuals for comment

Name	Designation
Anne-Maria Newham	Director of Nursing, Quality and AHP's
Frank Lusk	Trust Secretary
Anna Pridmore	Interim Associate Director of Governance
Fern Barrell	Risk Manager
Heather Darlow	Governance Lead
Jennie Palmer-Vines	Governance Lead
Chris Brookes	Governance Lead

Appendix 7 Due Regard Screening Template

Section 1	
Name of activity/proposal	Development of a Risk Management Policy
Date Screening commenced	August 2019
Directorate / Service carrying out the assessment	All
Name and role of person undertaking this Due Regard (Equality Analysis)	Kate Dyer, Head of Assurance
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This Policy sets out the Trust's approach to managing risk.	
OBJECTIVES: This Policy sets out a clear approach for the Trust's vision in relation to the management of risk, detailing the systems and processes in place, and highlighting roles and responsibilities. The objective of this Policy is to promote an integrated and consistent approach across all parts of the Trust to managing risk.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No
Disability	No
Gender reassignment	No
Marriage & Civil Partnership	No
Pregnancy & Maternity	No
Race	No
Religion and Belief	No
Sex	No
Sexual Orientation	No
Other equality groups?	No

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Full statement of commitment to policy of equal opportunities is included in the policy.			
Signed by reviewer/assessor	Kate Dyer	**Date**	19 August 2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 8 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	Risk Management Policy		
Completed by:	Kate Dyer		
Job title	Head of Assurance		**Date** August 2019
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	The only data collection relates to the list of staff attending training. This will be held securely and staff will not be named in committee reports.
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:	**n/a**		
Date of approval	**n/a**		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 9 Board Risk Appetite Statement

The Trust Board is responsible for setting and monitoring a collective appetite for risk when pursuing its 'Step up to Great' strategic objectives. This appetite allows Board members to take a corporate view on each organisational risk, to determine what additional assurance it requires. It reduces the likelihood of any inopportune risk taking which could expose the Trust to any risk it cannot tolerate, or to an overly cautious approach which may stifle growth and development. The level of risk that it is willing to accept is based on what it considers to be justifiable and proportionate to the impact for patients, carers, the public, members of staff, the wider health economy and the sustainability of the Trust.

Risk Element	Risk Appetite	Appetite Descriptor
Financial / VFM	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	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.
Compliance / Regulatory	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Limited tolerance for exposure to risk. Want to be reasonably sure we would win any challenge.
Innovation / Quality / Outcomes / Patient Benefit	Significant Appetite Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	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.

Reputation	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	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.

Matrix based on Good Governance Institute Risk Appetite Matrix for NHS organisations.