Milton Keynes University Hospital NHS Foundation Trust

# Risk Management Framework

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**Guideline to be followed by (target staff):**

**CQC Fundamental standards:**

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatmentRegulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

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## Executive Summary

Risk management is a crucial part of Milton Keynes University Hospital NHS Foundation Trust's (MKUHFT) approach to governance; and is a central part of the Trust's internal control processes, as well as its strategic and operational management. Risk management is the process through which the Trust identifies, assesses and analyses the risks inherent to and arising from its activities; whether clinical or non-clinical; including strategic, financial, operational, hazard / health and safety, compliance, or any other; and puts in place robust and effective controls to mitigate those risks.

The aim of risk management is to reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operational objectives, thereby safeguarding patients, staff and other service users, improve safety and quality, , and to ensure the Trust is making informed risk-based decisions in all levels of the organisation.

This strategy describes the systems and framework that the Trust will use to embed risk management throughout the organisation, in order to provide assurance that risks are being managed and that an effective internal control system is in place. The strategy is a Trust-wide document,and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation.

The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals to ensure the risk is at the optimal level. The optimal level of risk will depend on the type of risk and the Trust's risk appetite to that type of risk (as outlined later in this policy). Risk management is a fundamental part of both operational and strategic management in every part of service delivery within the organisation.

The Trust is committed to working in partnership with staff to make risk management a core organisational requirement, and to ensure that it becomes an integral part of Trust culture and activities. This will be achieved by building and sustaining an organisational culture which encourages appropriate risk taking, effective internal control systems and accountability for organisational learning in order to continuously improve the quality of services the Trust provides. In support of this aim, the Trust undertakes to ensure that adequate provision of resources; including a commitment to giving staff the time to discharge their duties around risk management, financial, training and information technology is made available in as far as reasonably practicable.

This framework is subject to annual review and approval by the Board of Directors (Trust Board).

# 1.0 Introduction

The aim of this framework is to set out the Trust's strategy and processes for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats; and maximise opportunities.

Risk is an inherent part of the delivery of healthcare. The risk management framework outlines the Trust's approach to risk management throughout the organisation.

This Board-approved framework for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

Successful risk management involves:

- Identifying and assessing risks
- Evaluating risks to identify whether further action is necessary or whether it is an acceptable risk.
- Ensuring effective contingency plans are in place.
- Monitoring risks and reviewing progress in order to be assured that risks are being managed effectively.
- Providing effective communication about risk

The framework applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels. Managers are expected to take an active lead to ensure that risk management is a fundamental part of the management of their operational area.

The Trust encourages an open culture of reporting and requires all its employees, contractors and third parties to operate within the systems and structures outlined in this framework.

## 2.0 Milton Keynes University Hospital Risk Statement

This framework describes a consistent and integrated approach to the management of all risk across the Trust.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust has an ongoing commitment to continually improving the management of risk throughout the organisation.

Where risk management is performed well it ensures staff are making effective risk-based decision, which can lead to improving the safety of patients, visitors, and staff. It also ensures that as an organisation, the Board and management are not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to explore growth and other opportunities.

Considered risk taking is encouraged – in line with the Trust's risk appetite statement - together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, as well as effectively managing financial, operational and reputational risks.

### 2.1 Risk Awareness

**Staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.**

There are three important elements to awareness:

- **Risk identification**: line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

- **Accountability**: staff will be identified as risk owners, with responsibility for controls/ mitigation, assurance and escalation of gaps.

- **Communication**: there will be active and frequent communication between staff, stakeholders and partners on the management of risk. There will also be regular communication to staff of the risks in their particular areas of work.

### *2.2* Competence

**Staff will be competent at managing risk.**

- **Training:** staff will have access to comprehensive risk guidance and advice. Those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided.

- **Behaviour and culture:** senior management will lead change by example; ensuring risks are identified, assessed and managed. Front line staff are encouraged to identify risks. Risks should be regularly reviewed and the information kept up to date on the Radar risk management system.

### 2.3 Management

**Activities will be controlled using the risk management process and staff are empowered to actively manage risks.**

- **Risk assessment and management**: risks will be assessed and acted upon (or tolerated at a certain level) to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks; escalating them where necessary. Contingency plans will be put in place where required.

- **Process**: the process for managing risk will be reviewed in order that it continually improves. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.

- **Measuring performance**: risk will be actively managed and management performance measured and reported. This will include cultural indicators.

### 2.4 Risk Appetite

#### 2.4.1 Definition of Risk Appetite

- The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time (HM Treasury, Orange Book, 2006)

Risk appetite is the level at which the Board of Directors determines whether an individual risk, or risks with a particular category, are acceptable (tolerable) or not. The Board may actively seek some risks, or categories of risk in pursuit of its strategic objectives. It may also determine other risks are to be avoided or to be approached with caution. Risk appetite should address several elements – the type and nature of the risk; the amount of risk; the balance of risk versus reward.

The Trust has adopted the Good Governance Institute's risk appetite matrix headings and adapted its risk categories in order to provide further guidance on risk tolerances (appetites).

### 2.4.2 Risk Appetite Matrix Scoring

| Matrix Scoring | 0 Avoid | 1 Minimal (As little as Reasonably Possible) | 2 Cautious | 3 Open | 4 Seek | 5 Mature |
|---|---|---|---|---|---|---|
| **Descriptor** | Avoidance of risk and uncertainty is a key Trust objective | Preference for ultra-safe delivery optionsthat have a low degree of inherent risk and only for limited reward potential | Preference forsafe delivery options that have a low degree of inherent risk and may only have limited potential for reward | Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money (VFM) | Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk | Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness are robust |
| **Radar Scoring** | Low | | Medium | | High | |

### 2.4.3 Risk Categories

The Trust is exposed to international and external risk across a wide range of activities. To assist in the setting of risk appetite, risk can be categorized using the definitions below – which have been adapted for use from the Good Governance Institute published guidance on risk appetite.

| Types of Risk | Definition |
|---|---|
| Financial | Risks that may adversely affect the Trust's financial position or viability |
| Compliance/ Regulatory | Risks that may adversely affect the Trust's ability to deliver care and services inaccordance with its license and registration and any relevant statute/ legislation/law/ regulation |
| Strategic | Risks that may threaten the Trust's ability to explore innovative/improved ways of working or delivering care/ services |
| Operational | Risks that may threaten the day-to-day delivery of safe, high-quality care and services |
| Reputational | Risks that may threaten public confidence in the Trust and its services or staff |
| Hazard (Safety) | Risks that may adversely affect the safety of its service users or staff |

### 2.4.4 General Risk Appetite Statement

Milton Keynes University Hospital recognizes that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with those it serves, the wider community, and the health and social care system in which it operates (both locally and nationally).

The Trust will not accept risks that materially impact on the safety (quality and outcomes) of the patients it provides care and services for. The Trust will consider risk in other categories if there is clear strategic or operational benefit. The Trust recognizes that it takes such decisions within a legal and regulatory framework.

### 2.4.5 Risk Appetite Statement by Category

| Type of Risk | Risk Appetite |
|---|---|
| Financial | **Open** - Willing to consider potential delivery options and choose while also providing and acceptable level of reward and VFM |
| Compliance/ Regulatory | **Cautious** - Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward |
| Strategic | **Seek** - Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk |
| Operational | **Minimal/ ALARP** (as low as reasonably practicable)- Preference for ultra-safedelivery options that have a low degree of inherent risk and only for limited reward potential |
| Reputation | **Open** - Willing to consider potential delivery options and choose while also providing and acceptable level of reward and VFM |
| Hazard | **Avoid** – Preference to avoid delivery options that represent a risk to the safety of patients, staff and member of the public. |

### 2.4.6 Risk Appetite Scores on the Board Assurance Framework

In addition to the general risk appetite statement and the category risk appetite statements; individual risks on the Board Assurance Framework will have a risk appetite score/ category. This will be set as risks are added to the BAF and reviewed at Board/ Committee level alongside the risk. A risk appetite profile by category/ objective will be produced annually as part of the Board's risk review processes.

## 3.0 Governance structures to support risk management

There are different operational levels of risk governance in the Trust:

- Board of Directors
- Assurance Committees
- Management Board
- Risk and Compliance Board (and other Executive Boards)
- Divisional or Corporate Management
- Clinical/Corporate Service Unit
- Department/specialty level
- All staff reporting risks

Risk Management by the Board is underpinned by a number of interlocking systems of control: The Board reviews risk principally through the following three mechanisms:

**The Board Assurance Framework** (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls. The BAF is used to drive the Board agenda.

**The Significant Risk Register** is a high level risk report used to ensure the Board are aware of all significant risks in the Trust.

**The Corporate Risk Register** is the operational risk register used to manage risks that cannot be managed at Divisional / CSU level and/or where the risk impacts multiple Divisions/CSUs and is therefore needs to be managed at an organisation-wide level.

**The Annual Governance Statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

Additionally the Audit Committee and other Board sub-committees (Finance and Investment, Workforce, Quality and Clinical Risk and Remuneration & Nomination) exist to provide assurance of the robustness of risk processes and to support the Board of Directors.

Each Division, clinical directorate, and corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation. Risks that cannot be managed by the Division, clinical directorate or corporate area should be escalated

onto the Corporate Risk Register until such a time that the risk has closed or has reduce such that it can be managed by the Division, clinical directorate or corporate area.

### 3.1 Horizon Scanning

Horizon scanning is about identifying and managing changes in the risk environment, before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services,taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scan, the Trust will be better able to respond to changes or emerging issues in a planned, structured and coordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers but is not limited to:

- Legislation
- Government white papers
- Government consultation
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health publication
- NHS Improvement/England publications
- Local demographics
- Seeking stakeholder views
- Trends in incidents, complaints and claims occurring a other similar organisations, or trends at other organisations that have the potential to impact the Trust (e.g. building cladding following the Grenfell Fire disaster).

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives or which may impact on patient safety. This will ensure that appropriate data/information can be collated and where required, risk assessments undertaken to formalise the risk. It is also essential that, where applicable, staff take immediate action to mitigate the risk and to ensure immediate staff/patient safety e.g.removing faulty equipment from use.

Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to areas of strategic and other potentially significant risk.

### 3.2 Process for managing risk

The following sections will lead you through the process for identifying and managing risks.

### 3.2.1 Stage 1: Clarifying objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process.

To understand whether something constitutes a risk it must first be understood what the objectives/outcomes are that you want to achieve.

**Strategic or Corporate Objectives:** identify and clarify which Trust strategic or local objective is relevant to the Division, directorate, service or area.

**Local Objective**s: as well as the above, think what the local team or area objectives are. By identifying the objectives it can be identified whether there is a risk to manage. Once the objectives have been identified it is then possible to identify what threats and opportunities there are to achieving the objectives. This enables to the risks and opportunities to be managed, increasing the likelihood of the objectives being achieved. If these steps are missed or omitted then the risk register will be neither relevant nor effective.

**Outcomes:** risk can also be linked to outcomes. These can be broad (e.g. 'delivering safe care'); or narrow/specific (e.g. the safe use of a specific piece of equipment).

### 3.2.2 Stage 2: Defining and recording risks

According to the ISO standards, a risk is the effect of uncertainty on objectives. The effect can be negative (threats) or positive (opportunities).

Therefore, a key aspect of a risks is uncertainty and how that uncertainty affects us achieving our objective. risk is something that has not yet occurred (uncertainty) but has potential to do so and will have an impact on our objectives.

This is in contrast to an incident relatesto a situation that has already happened.

Risk reporting can be seen as proactive whereas incident reporting is reactive.

Once objectives/ outcomes and potential harms have been identified then risks can start to be identified, with due consideration to following questions.

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended on for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible, gather those staff together those who are able to assist with the identification of risk for the area and please refer to the Trust's Risk Manager for guidance on how to do this, if necessary. Be aware of the different hierarchies within the staff you have gathered and ensure

that all staff members feel confident that they can speak openly and honestly, that their opinion matters, and that it is equally important as other's opinions regardless of their role. If staff feel uncomfortable raising risks and concerns with their line manager present, have the discussion without the manager and provide anonymised feedback to the line manager at a separate. This will help ensure all risks and concerns are raised without staff being concerned about recrimination.

As part of the Trust's health and safety management a statutory legal requirement exists to audit and review compliance with the Health and Safety at Work etc. Act 1974 and its supporting regulations and guidance. This is to ensure that the arrangements we have are in place, staff are aware of them, and they are being implemented and managed. This in turn ensures a safe place work, reduces the chances of personal injury and enforcement action for not meeting legal requirements.

As part of this process managers with responsibility on an operational level for a ward or department (and the staff employed there) need to complete a Workplace Health and Safety Self-Assessment checklist. The questionnaire requires a YES / NO / N/A response to a range of questions covering legal issues established in health and safety laws and Trust policies that are minimum standards which should be met by the Trust and its management teams. There is also a section for ward/department specific concerns that you may wish to raise. Responses are reviewed by the Health and Safety Advisor and feed into the annual Health and Safety Inspection and work programme.

### 3.2.3 Stage 3: Defining and recording risks

Before any entry onto the Risk Register a risk assessment must be documented. Once the riskhas been identified then:

- **Describe it so that others understand what the risk is. What is the event that** couldhappen? What is the uncertainty that is causing concern?
- **Assign an owner** to the risk
- List the **key controls** (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact
- For the BAF, list the **assurances** that enable you to test whether the controls are working
- If it is a severe moderate or above (red or orange) then consider what is needed as a **contingencyaction plan**, i.e. what will you do should the risk happen (see escalation)
- **Rate the likelihood** of the risk materialising
- **Rate the consequence** of the risk happening

All these things should be recorded on a Risk Register following risk assessment and completionof risk assessment template. The following sections describe in detail how to complete the risk register.

### 3.2.4 Stage 4: Completing a Risk Register

Adding a risk to the Risk Register can seem daunting, however the aim is to have a simple process to allowthe monitoring of actions and aid decision making.

Headings in the register (which is on the Radar system) that need to be completed are:

**Category:** Use this to identify whether the risk is financial, operational, strategy, a hazard (including health & safety), or a compliance risk.

**Description:** this section is used to describe the risk, including its cause. It is important that risks are clearly articulated. If not it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans.

Use the IF, THEN headings to help you describe the risk. For example:

***IF*** *there is insufficient staff to care for the patients in the ward*
***THEN*** *patients may not be given their medication at the prescribed time, patients observations will not be completed in a timely manner*

**Impact: Use the LEADING TO heading to describe the impact. For example:**

***LEADING TO*** *patients receiving sub-optimal care and a poor patient experience*

**Risk owner:** the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many action owners. The risk owner must know, or be informed, that they are the owner, and accept this **before** they are allocated the risk on Radar.
**Scope:** When first adding a risk to the Risk Register select Region in the scope dropdown. If the risk is significant and is likely to need to go onto the Corporate Risk Register, escalate this to the Risk & Compliance Board (RCB). If approved by RCB, the scope will be adjusted accordingly.

**Region:** Select the relevant CSU or Corporate Department from the list. This will ensure that the risk goes onto the correct Risk Register.

**Initial Risk Rating**: enter the level of risk when the risk was first identified. Once the risk is saved, this rating cannot be changed.

**Next Review Date:** Identify when the risk needs to be reviewed again. The review date must be

at least annually and will depend on:

- The level of risk. E.g. significant risks should be reviewed monthly, whereas controlled low risks may be reviewed bi-annually or annually
    - The proximity of the risk. E.g. when the risk is likely to materialise or the anticipated timescale is within three months
    - Between three and twelve months
    - Twelve months or longer
- If something is expected to happen that could impact the risk. E.g. an upcoming change to legislation/policy etc.

**Risk Appetite:** This is the amount of risk the Trust is willing to take in pursuit of its objectives (see Risk Appetite section earlier in this document).

Use the Risk appetite matrix scoring to select Low / Medium / High

Low = Avoid (0) or Minimal (1)
Medium = Cautious (2) or Open (3)
High = Seek (4) or Mature (5)

**Risk Response:** Not all risks can be dealt with in the same way. The *'5 T's* provide an easy list of optionsavailable to anyone considering how to manage risk:

- **Tolerate**: the likelihood and consequence of a particular risk happening is accepted i.e. the risk is down to the lowest practicable/cost-effective level. Therefore within risk appetite.
- **Treat**: work is carried out to reduce the likelihood or consequence of the risk (this is the most common action). I.e. the risk is above the tolerable level and requires appropriate cost-effective preventative measure to be put in place.
- **Transfer**: shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party i.e. the risk is above the tolerable level and a decision has been made to insure against or outsource/contract theservice to another provider. Transferring the risk does not mean, moving the risk from one risk register to another.
- **Terminate**: an informed decision not to become involved in a risk situation, e.g. terminate the activity i.e. the risk is above the tolerable level and a decision has been made to stop the activity or close the services etc.
- **Take the opportunity**: an informed decision to accept the risk and take the opportunity the risk presents. e.g. constructing a building to provide radiology services will present financial risks (among others), however you may make a informed risk-based decision to take the opportunity as the benefits outweigh the other risks.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision.

The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people inways which they need to be informed about.

**Target Risk Rating:** is the amount of risk that is accepted or tolerated, or the level that has been decided to manage the risk down to. When deciding the risk target, consider the following:

- What risk rating should a risk be managed down to in an ideal world?
- What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
- Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?
- What are the defined tolerance and escalation thresholds for the level of risk?

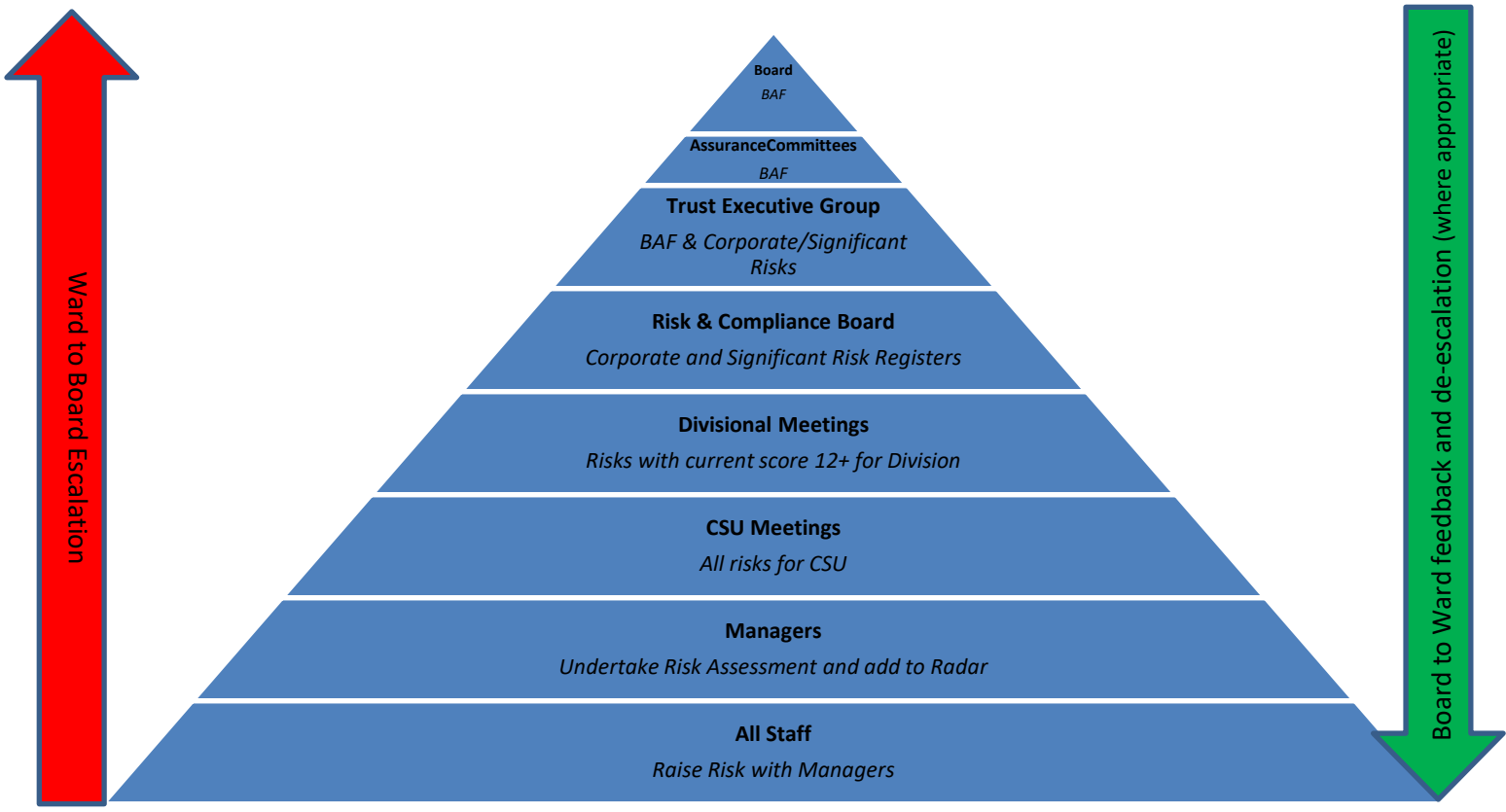
### 3.2.5 Stage 5: Reviewing risks

All risks are to be regularly reviewed. The frequency of the review will depend on the current risk rating, whether the risk is within risk appetite, or whether the risk has changed / due to change soon.

As a guide:

- All green/yellow risks (graded 1 – 6) should be reviewed at least annually unless otherwisedictated by the risk assessment, or when there is significant change to process/the identified hazard, accident incident
- All amber/moderate (graded 8 -12) risks should be reviewed monthly
- All red/significant risks (graded 15+) best practice should be for a review two weekly, unless appropriate actions are in place and there is agreement that the risk can be tolerated atthat level. Significant risks must be reviewed no less than monthly.

### 3.2.6 Stage 6: Escalation and De-escalation




he consequences of some risks, or the action needed to mitigate them, can be such that itis necessary to escalate the risk to a higher management level, for example from Clinical Support Unit risk register to a Divisional register, or from a Divisional register to the Significant Risk Register reviewed by the Trust Executive Group, Finance and Investment Committee, Workforce Committee and Quality and Clinical Risk Committee, and finally the Trust Board.

If a risk is reviewed by a Division and either they do not have the ability (e.g. financially, capacity, insufficient level authority) to manage the risk, it should be escalated to the Risk & Compliance Board (RCM) via the Risk Manager. RCB will review the risk and either accept that the risk is managed through the Corporate Risk Register, or that the risk should remain on the Divisional Risk Register. Where a risk impacts multiple areas, it may also require escalation onto the Corporate Risk Register in the same way.

Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e. a risk rated 25 (red, or extreme) at Divisional level will be re-evaluated and may not be rated 25 at Trust level.

Once an escalated risk has reached the accepted target for the risk, following mitigating actions or a change in the nature of the risk, it will be de-escalated. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

Risk Registers at Divisional level will also be reviewed to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is available. This will aid in identifying lower risk issues which may be common across many areas. Registers will also be reviewed to identify high impact but low frequency risks which

may pose a threat. These will be included in the reports to the Risk and Compliance Board for review.

### Risk Profile

A summary of risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be shown. If exposure to risk is above this, and therefore the tolerance set at that level, managers can see that they must take prompt action such as upward referral of relevant risks. Risk tolerances are defined by the Trust Board and Management Board (and may be devolved to the Risk and Compliance Board within its terms of references).

## 4.0. Project and Programme Risk

Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk Register or logs will still be maintained for risks to programmes or projects as part of the programme documentation.

## 4.1 Project and Programme Risks

Project and programme opportunities and threats are generally identified:

- If a programme, through the escalation of risks from projects within the programme
- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with this project or programme
- By operational areas affected by the project or programme

Although a project or programme should adhere to the Trust Risk Management Strategy it should also have its own risk management guidelines, which should:

- Identify the owners of a programme and individual projects within the programme
- Identify any additional benefits of adopting risk management within this project or programme
- Identify the nature and level of risk acceptable within the programme and associated projects. This should remain in line with the risk appetite outlined in the Trust Risk Strategy
- Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level
- Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects

- Identify how inter-project dependencies will be monitored and managed
- Clarify relationships with associated strategies, policies, and guidelines.

Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

### 4.2 Costing of project and programme risks

In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising. This should be recorded in the Risk Register. The cost of mitigating the risk should also be recorded, if this can be determined. Both these figures will be relevant to thecalculation of risk targets. If, for example, a risk will have a big financial impact and it islikely to actually happen, how much are you prepared to spend to counter it?

## 5.0 Regulatory Framework for Risk Management

### 5.1 Care Quality Commission Essential Standards of Quality and Safety

In April 2015, the Care Quality Commission Fundamental Standards Regulations replaced the 2010 Essential Standards as the regulatory framework by which the quality of health and social care providers is assessed. The CQC use a risk-based approach to decide on whether the essential standards are being complied with so it is essential thatthe trust can also make a connection between quality and risk.

All regulations are relevant, but Regulation 17: Good Governance, is particularly relevant in the context of effective risk management and governance.

This Strategy supports compliance with CQC fundamental standards by providing a framework by which risks are linked to Regulations and for sources of assurance to be monitored.

### 5.2 The NHS Foundation Trust Code of Governance

This strategy will support the continued development of an environment which will enable the trust to demonstrate compliance with the NHS Foundation Trust Code of Governance, and in particular principle F.2 Internal Control:

- **Main principle – F.2:** The Board should maintain a sound system of internal control to safeguard public and private investment, the NHS Foundation Trust's assets, patient safety and service quality.
- **Code Provision – F.2.1:** The Board should conduct, at least annually, a review of the effectiveness of the NHS Foundation Trust's system of internal control and should report to members that they have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems.

### 5.3 NHS Improvement/England's) Single Oversight Framework

The Single Oversight Framework replaced the Monitor *Risk Assessment Framework* in September 2016. NHS Improvement monitors performance in five broad key areas and issues Trust's with a segmentation rating in line with that performance – 1 being the best (maximum autonomy) and 4 being the worst (special measures). Effective risk management and governance processes are an important contributor to a positive rating.

As part of the Annual Governance Statement, NHS Improvement/England requires all Foundation Trusts to declare that all significant risks have been identified, that effective risk management processes are in place and that all issues raised by external audits and assessments have been addressed. This strategy describes the processes that the trust will put in place to achieve this.

### 5.4 NHS Resolution (previously the National Health Services Litigation Authority (NHSLA))

The Risk Management Strategy will be underpinned by specific policies which cover all the key elements of risk and which incorporate, as a minimum, the requirement of the NHS Resolution Risk Management Standards for NHS Foundation Trusts.

### 5.5 Health & Safety Legislation

The Health & Safety at Work etc. Act 1974 places a legal duty on the Trust (managers) to ensure the risks to their staff and others are assessed and managed within the boundaries of the duties placed in statutory documents. This is made explicit in the Management of Health & Safety at Work Regulation 1999 – Regulation 3. It is also made explicit in other supporting regulations, approved codes of practice and guidance.

Further details in relation to Health & Safety risk management processes can be found in the Trust Health & Safety Policy and Trust Risk Assessment Procedures & Guidance or by contacting the Trust Health & Safety Advisor.

## 6.0 Responsibilities and accountabilities for risk management

### 6.1 Individual Responsibilities

Risk management is the responsibility of all staff. Ultimately everyone who works at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in the day to day to of members of staff in many different ways.

The following sections define the organisational expectations of particular roles or groups.

#### 6.1.1 Chief Executive

The Chief Executive is the responsible officer for the Milton Keynes University Hospital NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management as outlined below.

### 6.1.2 Director of Finance

The Director of Finance has responsibility for financial governance and associated financial risk.

### 6.1.3 Medical Director

The Medical Director has responsibility for clinical governance and clinical risk, including incident management, and has joint responsibility with the Director of Patient Care & Chief Nurse for quality. Director of Patient Care and Chief Nurse

The Chief Nurse has responsibility for patient safety and patient experience and has joint responsibility with the Medical Director of quality.

### 6.1.4 Director of Corporate Affairs

The Director of Corporate Affairs leads on the management of internal control and strategic risk within the organisation and the Board Assurance Framework and has responsibility for ensuring the processes for governance risk management across the organization are effective. He/She is also the executive lead for health & safety within the Trust and will therefore ensure robust arrangements for the management of health & safety risk in line with statutory duties is identified and implemented.

### 6.1.5 Executive Directors

Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

### 6.1.6 Trust Secretary

The Trust Secretary is accountable to the Director of Corporate Affairs for the overall performance of governance functions, including the assurance systemof internal control to ensure effective management of risk; including health & safety; including the system and supporting processes for risk management.

### 6.1.7 Risk Manager

Supporting the Trust Secretary with the development and reviews of the BAF including the transposition of the risks from the Corporate Risk Register.

They will have oversight of, maintain and develop the Trust's Risk Register process; advising the corporate risk leads, Divisional and CSU risk leads in the continued maintenance and development of Risk Registers, to ensure the effective management of risksto their area.

Facilitating the Division and CSU reviews of their risks, supporting them to identify and manage risks, and to ensure actions are developed and followed through to implementation.

To provide ongoing Risk Management training to staff as required.

### 6.1.8 Divisional Directors

Divisional Directors are accountable for ensuring that appropriate and effective risk management processes are in place within the Divisions, and that all staff are aware of the risks within their work environment, together with their personal responsibilities.

They must ensure that risks are identified, assessed, and acted upon. They must ensure that where appropriate captured on local risk registers, ensuring that risks are reviewed by an appropriate divisional group at least quarterly as part of performance monitoring, to consider and plan actions being taken. They must ensure appropriate escalation of risks from service or directorates to divisional level within the defined tolerances. Divisional Directors have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this strategy and related documentation.

The Divisional Directors are responsible for ensuring that staff receive the relevant elements of risk management training and then non-attendance is followed up.

### 6.1.9 CSU Leads

CSU Leads are responsible for ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk register; and ensuring that local groups review risk registers on a regularbasis to consider and plan actions being taken.

### 6.1.10 Senior Managers

Senior managers take the lead on risk management and set the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Sending a message to staff that they can be confident that escalated risks will be acted upon.
- Ensuring risks are updated and regularly acted upon.
- Identifying and managing risks that cut across delivery areas.
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focused approach.
- Communicating downwards what the top risks are, and doing so in plain English.
- Escalating risks from the front line.
- Linking risks to discussions on finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in risk management.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.
- Ensuring that people are not blamed for identifying and escalating risks, and fostering a culture which encourages them to take responsibility in helping to manage them.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Senior staff are expected to be aware of and adhere to the risk management best practice:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front-line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Is there an opportunity to benefit from the risk or the work done to mitigate against the risk materialising?
- Record risk on a risk register.
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks, and use it.

### 6.1.11 Risk Owner

Risk owners are responsible for:

- Reviewing and updating their risks within the set review date for each risk
- Taking risks to the relevant Clinical Improvement Group (CIG) for initial approval and upload onto the risk register and when escalation or downgrade of the riskrating requires discussion and approval
- Ensuring that actions allocated to risks are implemented and monitored

### 6.1.12 All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they should be aware and encouraged to followthe Whistleblowing Policy incorporating guidance on raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

### 6.1.13 Clinical Governance Leads

Supporting staff in completingrisk assessments/reviews of risk assessments as required.

### 6.1.14 Health & Safety Advisor/Manual Handling Advisor/Fire Advisor

These individuals are deemed the competent persons for the Trust (as identified in health & safety legislation) and will provide advice and support to managers in relation to the identification and management of health and safety risks. Advising and training staff on the completion of risk assessments in relation to health & safety legislation.

## 6.2 Committee Duties and Responsibilities

### 6.2.1 Board of Directors

The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has been delegated by the Board to the following interrelating committees:

- Audit Committee
- Finance and Investment Committee
- Quality and Clinical Risk Committee
- Workforce and Education Committee
- Remuneration and Nomination Committees

The Trust Management Board in its role as the Executive decision-making committee of the Trust maintains oversight of the operational risk.

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

### 6.2.2 The Audit Committee

The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system for internal control by means of independent and objective reviews of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

- To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.
- To review the Trust strategic risk register at each meeting or as the Board determines.
- To monitor the Board Assurance Framework, and ensure its presentation to the Trust Board at intervals that the Board determines.
- To assess the overall effectiveness of risk management and the system of internal control.
- To challenge on the effectiveness of controls, or approach to specific risks.

### 6.2.3 The Finance and Investment Committee

The Finance and Investment Committee is responsible for providing information and making recommendations to the Trust Board on financial performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.

### 6.2.4 The Quality and Clinical Risk Committee

The Quality and Clinical Risk Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research & development issues; and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Trust Board as appropriate.

### 6.2.5 Workforce and Development Assurance Committee

The Workforce and Education Committee is responsible for providing information and making recommendations to the Trust Board on workforce and education issues, and for providing assurance that these are being managed safely and effectively. The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.

### 6.2.6 Trust Executive Committee

The Trust Executive Committee is responsible for the operational management and monitoring ofrisk, through the Significant Risk Register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring their delivery.

### 6.2.7 Risk and Compliance Board (RCB)

The Risk and Compliance Board is responsible for ensuring there is an appropriate and robust risk management system in place and working throughout the organisation.

It is responsible for moderating new risks and escalating risks to the Corporate Risk Register and Board Assurance Framework and recommending and advising the Trust Executive Group on the escalation and de-escalation of risks. In addition, they can commission reviews with appropriate individuals to help them work through their risks.

It will also ensure that risks are clearly documented with clarity on controls and assurance, reviewed within agreed timescales and that similar risks are merged to make the risk register easier to manage. There will a scheduled rolling programme of review dates for each corporate and Divisional risk register with dashboards created on Radar to help effectively monthly oversight monitoring.

Risks management and escalation also occurs at other executive-led Boards.

### 6.2.7 Health & Safety Committee

The Health and Safety Committee receive and review information relating to identified health & safety risks which may require further specialist input, escalation or decision to ensure legal compliance is met and continued safety of services, premises and people .

### 6.2.8 Corporate Risk Review process

All corporate related risks will be centrally managed through the Corporate Risk Register and reviewed on alternate months atthe Risk and Governance meeting (chaired by the Director of Corporate Affairs).

### 6.2.9 Clinical and Corporate Divisional Risk Management Arrangements

Divisions both corporate and clinical will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.

The Divisional forums have the responsibility, through the Divisional Directors, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. The Divisions will develop, populate and review their risks, drawing on risk processes within the services, to ensure that Service, Directorate and Divisional Risk Registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular Division and its services. Directorate meetings similarly will review the risk registers and contribute to the development of the Directorate and Divisional Risk Registers and ensure risk registers are in place and operating within the defined tolerances and escalation processes.

Directorate and Divisional management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

# 7.0 Supporting processes

## 7.1 Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training requirements to fulfil this strategy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Learning and Development Policy. This information can be accessed on the Learning and Development pages of the Trust intranet.

Specific training will be provided in respect of high-level awareness of risk management for the Board. Risk Awareness Sessions are included as part of the Board's Development Programme.

Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register.

The specific training required by staff group is outlined in Appendices 3 and 9 along with a description of how the training is managed.

## 7.2 Review

This strategy will be reviewed every three years or sooner if circumstances dictate.

## 7.3 References

Home Office Risk Management Policy and Guidance, Home Office (2011)
A Matrix for Risk Managers, National Patient Safety Agency (2008)
Single Oversight Framework, Monitor, August 2016
The NHS Foundation Trust Code of Governance, Monitor, December 2013; Updated July 2014
Quality Governance Framework, Monitor, March 2010
Fundamental Standards of Quality and Safety, Care Quality Commission, 2015
Integrated Governance Handbook: 2006
The NHS Audit Committee Handbook, Department of Health (2011)
Board Assurance Frameworks: A simple rules guide for the NHS 2009
The Health NHS Board Principles for Good Governance, National Leadership Council, 2010
Taking it on Trust, Audit Commission 2009
Defining Risk Appetite and Managing Risk by Clinical Governance Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
Risk Management Assessment Framework, HM Treasury (2009)
Health & Safety at Work etc Act 1974
Management of Health & Safety at Work 1999
Trust Health & Safety Policy
Trust Health & Safety Risk Assessment Procedure & Guidance

## 7.4 Equality Impact Assessment

The Trust is committed to promoting equality of opportunity for all its employees and the population it serves. The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.

# 8.0 Governance

## 8.1 Document review history

| Version number | Review date | Reviewed by | Changes made |
|---|---|---|---|
| 1.0 | March 2009 | Healthcare Governance Manager | Separated from Risk Mgmt Strategy to comply with risk management (NHSLA) requirements and □tandardize risk management systems and processes in a single document |
| 1.1 | 10 March 2009 | | Version for Audit Committee |
| 1.2 | March 2009 | | Minor update following Audit Committee meeting |
| 1.3 | April 2009 | | Minor updates from comments |
| 1.4 | May 2009 | | Minor updates from comments |
| V2 Draft 0.1 | October 2010 | | Reviewed as part of PwC requirements from action plan, re-structure of governance committees and NHSLA requirements |
| V2 Draft 0.2 | February 2011 | | Update to cover new Trust governance structures and revised policy template |
| V2 Draft 0.3 | August 2001 | | Update to include further recommendations |
| V2.0 | October 2011 | | Document published following TDC minor comments and approval |
| V3.0 | July 2012 | | Update in line with CEAC comments and realignment of Committee work Phase 3 |
| V4.0 | May 2013 | | Major amendments including addition of definitions, revisions to committee structures, job titles, expansion and clarification of responsibilities and accountabilities e.g. Non-Executive Directors |
| V5.0 | September 2014 | | Amendments following comments from Deloittes and PwC recommendations. Amendments to reflect revised governance structure and executive accountabilities |
| V 9 | December 2021 | | Revisions made to reflect current practices in Risk Management in the Trust |

## 8.2 Consultation History

| Stakeholders Name/Board | Area of Expertise | Date Sent | Date Received | Comments | Endorsed Yes/No |
|---|---|---|---|---|---|
| Risk Manager | Risk Management | December 2021 | December 2021 | Current practices | Yes |
| | | | | | |

## 8.3 Audit and monitoring

| Audit/Monitoring Criteria | Tool | Audit Lead | Frequency of Audit | Responsible Committee/Board |
|---|---|---|---|---|
| Risk Management Policy includes audit and monitoring criteria | N/A | N/A | N/A | N/A |

### 8.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact onthe grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identifiedbarriers or discriminatory practice.

| Equality Impact Assessment | | | |
|---|---|---|---|
| Division | Corporate Affairs | Department | Trust Secretariat |
| Person completing the EqIA | | Contact No. | 86234 |
| Others involved: | N/A | Date of assessment: | 04/02/2022 |
| Existing policy/service | Yes | New policy/service | No |

| | |
|---|---|
| Will patients, carers, the public or staff be affected by the policy/service? | Yes |
| If staff, how many/which groups will be affected? | *N/A* |

| Protected characteristic | Any impact? | Comments |
|---|---|---|
| Age | NO | Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff |
| Disability | NO | |
| Gender reassignment | NO | |
| Marriage and civil partnership | NO | |
| Pregnancy and maternity | NO | |
| Race | NO | |
| Religion or belief | NO | |
| Sex | NO | |
| Sexual orientation | NO | |

What consultation method(s) have you carried out?

*N/A*

How are the changes/amendments to the policies/services communicated?

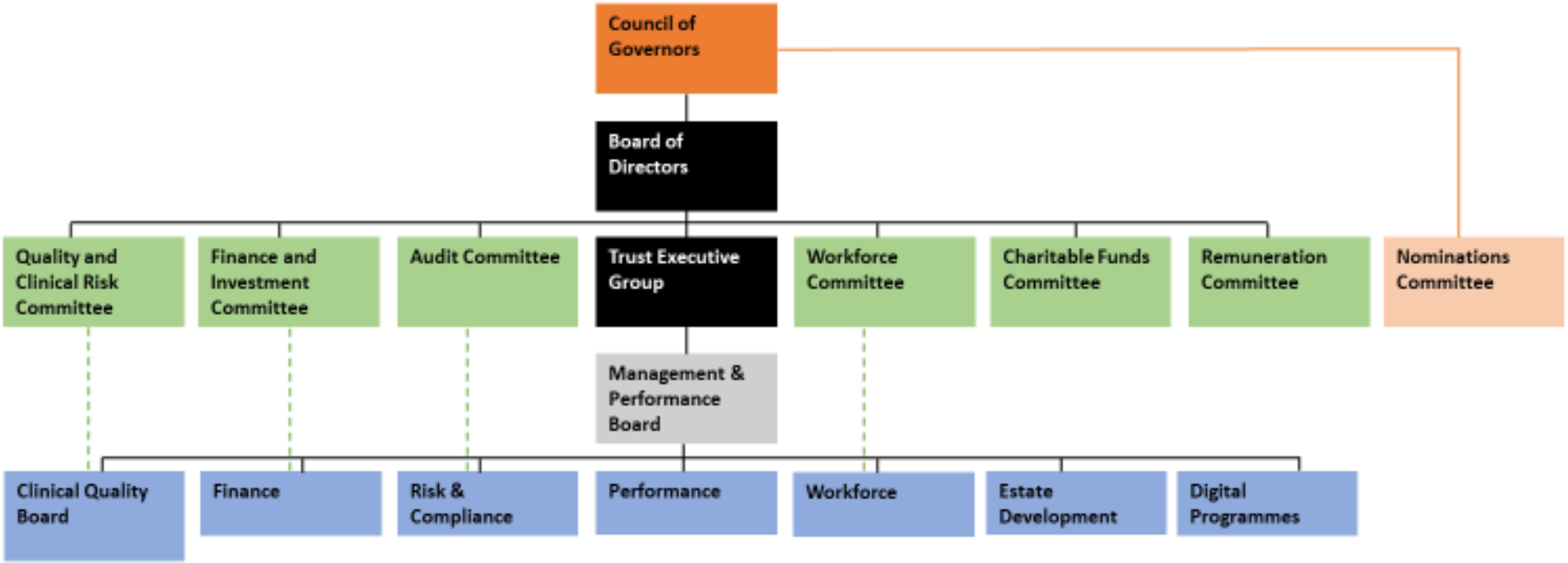
*Email*

What future actions need to be taken to overcome any barriers or discrimination?

| What? | Who will lead this? | Date of completion | Resources needed |
|---|---|---|---|
| N/A | N/A | N/A | N/A |
| N/A | N/A | N/A | N/A |
| N/A | N/A | N/A | N/A |
| Review date of EqIA | March 2025 | | |

Milton Keynes University Hospital NHS Foundation Trust

# Appendix 1: Board Governance Structure



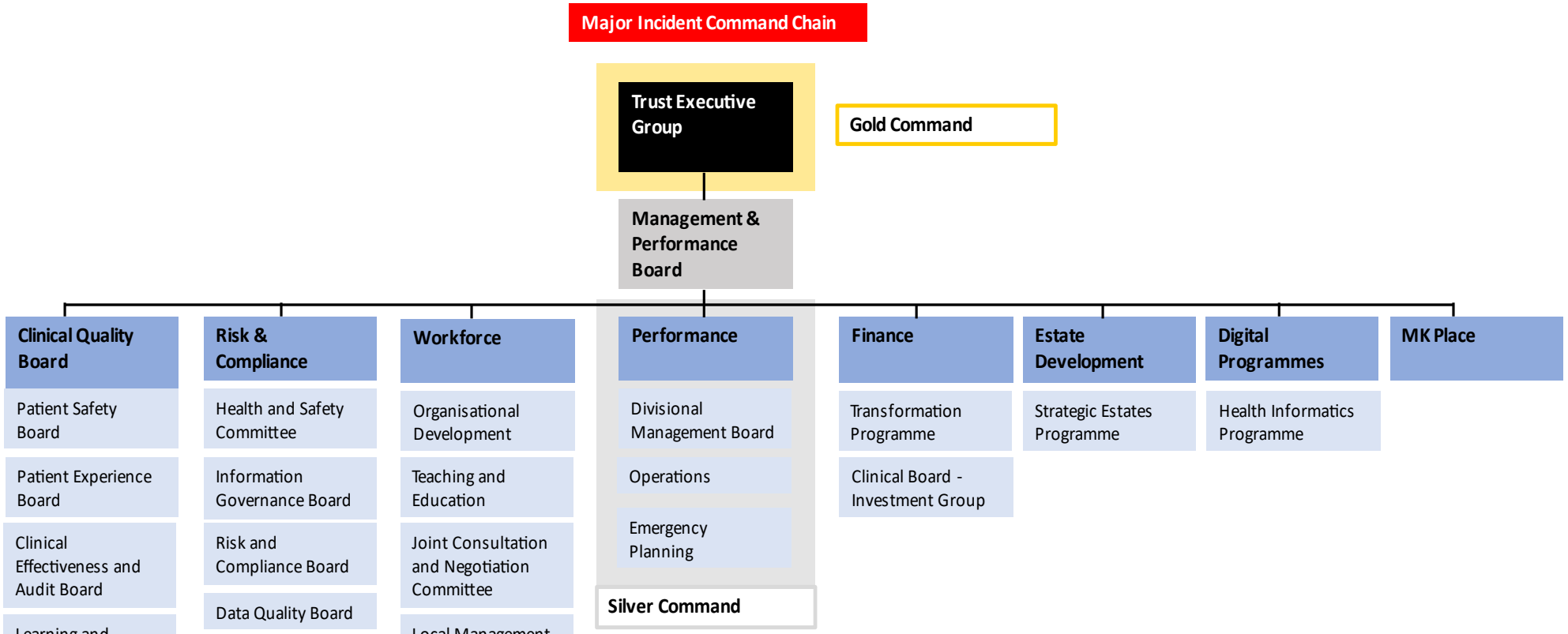

This is the Trust's corporate governance structure at Trust Board (Board of Directors) level.

The role of the Trust Board is to:

- Set the strategy for the hospital
- Ensure accountability (hold the organisation to account for delivering the strategy and seek assurance that the systems of control are robust and reliable
- Shape the culture of the organisation

In an NHS Foundation Trust the Trust Board is held to account by an elected Council of Governors. The Council is made up of elected staff and public members, representing constituencies. Nominated stakeholders also sit on the Council of Governors. This increases public scrutiny, oversight and accountability.

Milton Keynes University Hospital NHS Foundation Trust




**This is the Trust's corporate governance structure at Trust Executive Group level.**
**You can see the main reporting lines and groups to the Trust Executive Group, which retains oversight and management of the hospital and its operational, financial and clinical quality performance.**

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

# Appendix 2: Assurance Map

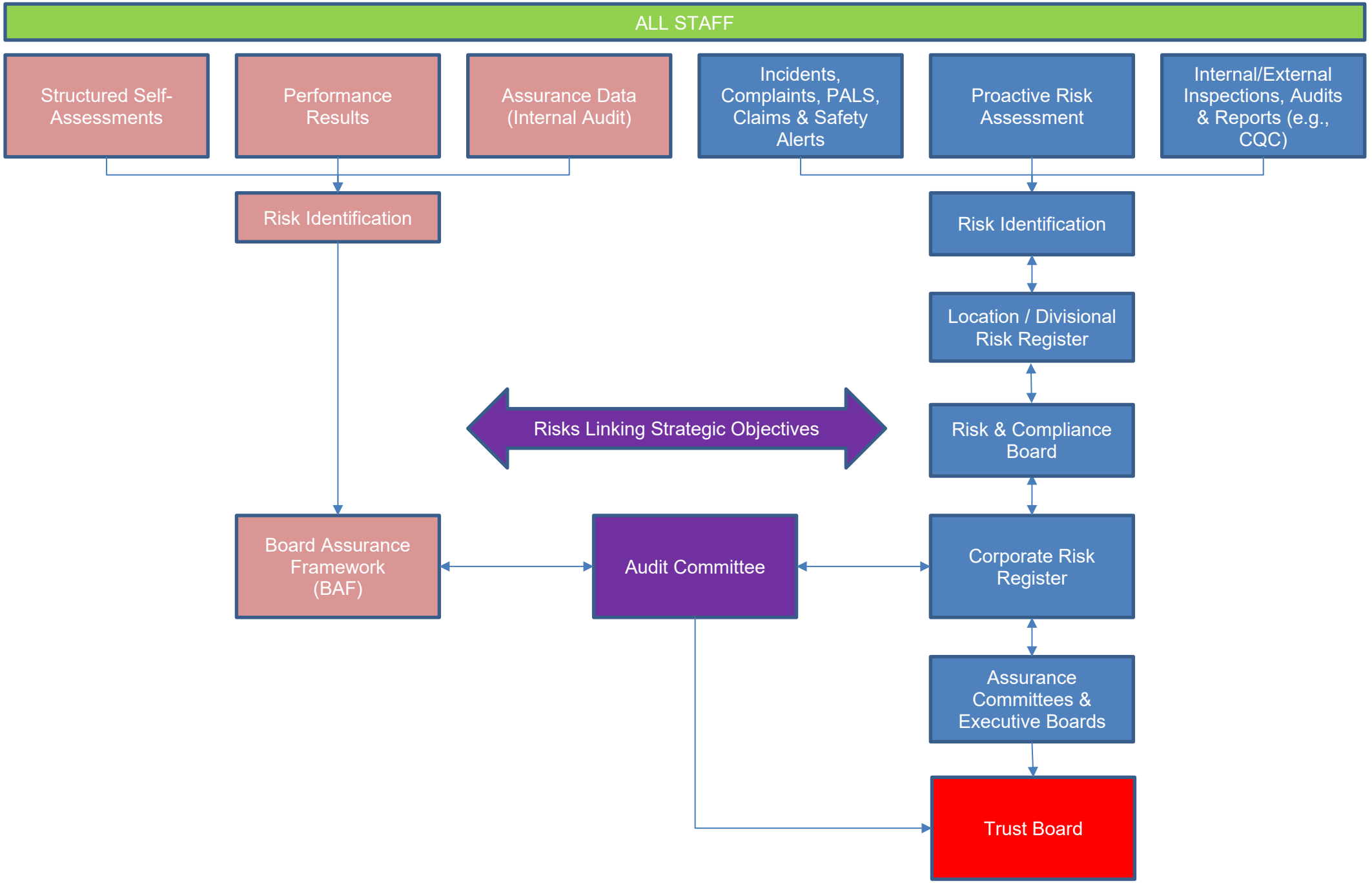
## Assurance Map - Board to Ward/Floor Visibility of Risk Management Process Outline

| Report | Purpose | Reviewed by | Frequency | Sourcing Risk from: |
|---|---|---|---|---|
| Board Assurance Framework | Identify, assess and manage all risks to the Trust's strategic objectives<br><br>Delegate sub-committees with responsibility for managing and tracking actions<br><br>Feed all risks rated as 15 or more and/or have a consequence of 5 into the Significant Risk Register<br><br>Address any risks flagged as RED | Board<br>&<br>Board Committees | Board - Monthly<br><br>Sub Committees - In line with committee cycle | Board discussion, Monitor, Quality Assurance Framework, Leadership Walkarounds<br>Escalation from sub-committees<br>Performance data (IPR)<br>Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc.)<br>Trust wide risk assessments/Clinical Audits<br>Patient & Staff Experience Surveys |
| Risk Profile Summary | Receive and manage exceptions from the Significant Risk Register (new risks, increased risks, actions outstanding, risks which remain RED) and Corporate Risk Register | Board | Monthly | Significant Risk Register and BAF |
| Significant Risk Register | Identify, assess and manage all risks across the Trust<br><br>Accept risks and associated actions where these are rated 15 or more<br><br>Report and manage exceptions (new risks, increased risks, actions outstanding, risks which remain RED)<br><br>Address any risks flagged as RED | ED<br>Risk & Compliance Board | Bi-monthly<br>Monthly | Committee discussion, Serious Incident Review Group<br>Escalation from sub-committees and Divisional Boards<br>Performance data<br>Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc.) Reporting (Complaints, Litigation, Incidents & PALs)<br>Risk Assessments<br>Patient & Staff Experience Surveys |
| Corporate Risk Register | Departments/divisions escalate:<br><br>• risks affecting multiple areas that are not already subject to corporate oversight e.g. Sharps, Violence & Abuse and Staffing etc.<br>• risks where the action required to control the risk does not fall within the full control of the ward/department/division and should therefore be escalated to the Trust for oversight e.g. Suicide, Self-Harm, Supply Chain Disruption (including medications, medical equipment) etc.<br>• risks which are overseen by specialist groups due their nature e.g. health & safety, infection control, information governance etc.<br>• Risks that have a significant impact on the Trust objectives. | ED<br>Risk and Compliance Board | Bi-monthly<br>Monthly | Same as above |

| | | | | |
|---|---|---|---|---|
| | | | | |
| Other Risk Registers - IM&T. H&S, HR | Identify, assess and manage all risks across the responsibility<br><br>Accept risks and associated actions where these are rated less than 15<br><br>Escalate risks and recommended actions where these are rated 15 or more<br><br>Submit Register to Trust Secretary quarterly<br><br>Address any risks flagged as RED | Corporate teams, Divisional Directors and ED's | Team discussion - Monthly<br><br>Submission of refreshed register - Quarterly | Management, operational and clinical team discussion<br>Performance data<br>Clinical Audit<br>Compliance Reporting (CQC, NHSLA, Audit, NICE Guidelines Compliance etc.)<br>Reporting (Complaints, Litigation, Incidents & PALs)<br>Risk Assessments<br>Patient & Staff Experience Surveys |

Milton Keynes University Hospital NHS Foundation Trust

# Appendix 3: Risk Information Flow



# Appendix 4: Risk Evaluation Tool

This risk evaluation tool is to be used for the evaluation of risks across the Trust. The range of risk categories covered will include clinical risk, health and safetyrisk, service risk, project risks and strategic business risk. The tool will help you to decide the level of **residual** risk that you have identified.

**Step 1**
Consider the possible consequence of the identified risk if it happens.Think broadly across the domains of:

- *Injury (physical/psychological) to patients, staff, visitors & contractors*
- *Adverse publicity*
- *Patient experience*
- *Quality*
- *Finance*
- *Human Resources, staffing and competence*
- *Business Objectives/projects*
- *Business/service interruption*
- Statutory duty/inspection
- Environment

**Step 2**
Choose a description of how serious the consequence might be from the following, taking into consideration any controls that are in place. The descriptions intable 1 on the following page should be used to obtain a consequence score, it should be noted these are illustrative only and other descriptions can be used.

***Consequence scoring***

| | |
|---|---|
| 1 | Insignificant |
| 2 | Minor |
| 3 | Moderate |
| 4 | Major |
| 5 | Catastrophic |

Many issues need to be factored into the assessment of consequence. Some of these are:

- Does the organisation have a clear definition of what constitutes a minor injury?
- What measures are being used to determine psychological impact on individuals?
- What is defined as an adverse event and how many individuals may be affected?

**Step 3**
Consider how likely it is that a risk with a consequence of this seriousness will actually happen. Table 2 on the following page should be used to obtain a likelihoodscore.
Choose a description from the following:

| | | |
|---|---|---|
| 1 | Rare | *Extremely unlikely to happen* |
| 2 | Unlikely | *Unlikely to happen* |
| 3 | Possible | *Reasonable chance of happening* |
| 4 | Likely | *Likely to happen* |
| 5 | Almost certain | *More likely to happen than not* |

**Step 4**
Once the risk consequence and likelihood have been determined use the matrix at Table 3 on the following page to identify the degree of risk. The matrix showsboth numerical scoring and colour bandings.

# Appendix 5: Risk Matrix and guidance

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

| **Likelihood score** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Frequency** How often might it/does it happen | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur,possibly frequently |

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

### Risk scoring = consequence x likelihood (C x L)

| | **Likelihood** | | | | |
|---|---|---|---|---|---|
| **Likelihood score** | **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 | Very Low Risk |
| 4 - 6 | Low Risk |
| 8 - 12 | Moderate Risk |
| 15 - 25 | Significant Risk |

## Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

| | Consequence score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| **Descriptor** | **Insignificant 1** | **Minor 2** | **Moderate 3** | **Major 4** | **Catastrophic 5** |
| **Injury (physical & psychological) to patient / visitor/ staff** | No Injury sustained | Minor injury or illness requiring minor intervention | Moderate injury requiring: Medical treatment, Counselling, Surgical intervention, and/ | Major injuries / long term incapacity or disability (loss of limb) requiring medical | Incident leading to death or major permanent incapacity |
| | | Incident requires patient to have extra observations<br><br>Requiring time off work for <3 days<br><br>Increase in length of hospital stay by 1-3 days | or<br>Cancelled treatment<br><br>Requiring time off work for 4 – 14 days<br><br>Agency reportable, e.g. Police (violent and aggressive acts)<br><br>Increase in length of hospital stay 4 – 15 days<br><br>An event which impacts on a small number of patients | treatment and/or counselling<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days | An event which impacts on a large number of patients |
| **Quality / Complaints/ Audit** | Locally resolved verbal (informal) complaint<br><br>Peripheral element of treatment or service suboptimal | Justified written complaint peripheral to clinical care (overall treatment or service suboptimal)<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Justified complaint involving lack of appropriate care – treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2)<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major patient safety implications if findings are not acted on | Multiple justified complaints/ independent review<br><br>Non-compliance with national standards with significant risk to patients if unresolved.<br><br>Low performance rating<br><br>Critical report | Complex justified complaint – totally unacceptable level or quality of treatment / service<br><br>Gross failure of patient safety if findings not acted on<br>Inquest / ombudsman inquiry<br><br>Gross failure to meet national standards |
| **Human Resources / Organisational development / Staffing & Competence** | Short term low staffing level temporarily reduces service quality (<1 day). Short term low staff level (>1 day) where there is no disruption to patient care | Ongoing low staffing level reduces service quality<br><br>Minor error due to ineffective training / implementation of training | Late delivery of key objective / service due to lack of staff.<br>Unsafe staffing level or competence (>1 day).<br><br>Low staff morale<br><br>Poor staff attendance for mandatory / key training.<br><br>Ongoing problems with staffing levels. | Uncertain delivery of key objective / service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory / key training | Non-delivery of key objective / service due to lack of staff<br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>No staff attending mandatory training / key training on an ongoing basis. |

| Descriptor | Insignificant 1 | Minor 2 | Moderate 3 | Major 4 | Catastrophic 5 |
|---|---|---|---|---|---|
| **Statutory duty / inspections** | No or minimal impact or breach of guidance / statutory duty<br><br>Small number of recommendations which focus on minor quality improvement issues | Breach of statutory legislation<br><br>Reduced performance rating if unresolved<br><br>Recommendations made which can be addressed by low level of management action | Single breach in statutory duty<br><br>Challenging recommendations that can be addressed with appropriate action plan / improvement notice | Enforcement action<br><br>Multiple breaches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breaches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse Publicity/ Reputation** | Rumours, no media coverage but potential for public concern | Local media coverage – short term reduction in public confidence. | Local media coverage – long-term adverse publicity<br><br>Significant effect on staff morale and public | National media / adverse publicity, less than 3 days<br><br>Service well below | National / International media / adverse publicity, > 3 days MSP/MP concern (Questions in |
| | Little effect on staff morale | Elements of public expectation not being met.<br><br>Minor effect on staff morale / public attitudes. | perception of the organisation | reasonable public expectation<br><br>Public confidence in the organisation undermined<br><br>Use of services affected | Parliament)<br>Court Enforcement<br>Public Inquiry/ FAI<br><br>Service well below reasonable public expectation<br><br>Total loss of public confidence |
| **Business objectives / projects** | Insignificant cost increase/ schedule slippage, reduction in scope or quality | <5% over project budget; minor reduction in scope, quality or schedule | 5-10% over project budget; reduction in scope or quality of project; project objectives or schedule. | Non-compliance with national 10-25% over project budget; significant project over-run; key objectives not met | Incident leading to >25% over project budget; Inability to meet project objectives; reputation of the organisation seriously damaged |
| **Financial (including damage / loss/ fraud) and Claims** | Negligible organisational / personal financial loss (£<1k) (NB. Please adjust for context)<br><br>Small loss risk of claim remote | Minor organisational / personal financial loss (0.1 – 0.25% of budget)<br><br>Claim(s) less than £10,000 | Significant organisational / personal financial loss (0.25 – 0.5% of budget)<br><br>Claim(s) between £10,000 and £100,000 | Major organisational / personal financial loss (0.5 – 1% budget)<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Severe organisational / personal financial loss (>1% of budget)<br><br>Failure to meet specification / slippage<br><br>Loss of contract / payment by results<br><br>Multiple claims or single major claim > £1 million |
| **Services / Business Interruption Environmental impact** | Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service<br><br>Minimal or no impact on the environment | Short term disruption to service with minor impact on patient care<br><br>Minor impact on the environment | Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.<br><br>Moderate impact on the environment | Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked<br><br>Major impact on the environment | Permanent loss of core service or facility<br><br>Disruption of facility leading to significant 'knock-on' effect<br><br>Catastrophic impact on the environment |

# Appendix 6: Definitions

| | |
|---|---|
| Hazard | Anything that has the potential to cause injury, loss, damage or harm |
| Likelihood | A measure of the probability that the predicted harm, loss or damage will occur |
| Consequence | A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected |
| Risk | The effect of uncertainty on objectives |
| Risk Assessment | The process by which hazards are identified and the risk rated using tools implemented by the Trust for use by all employees. Assessments can either be general or specific, but will be undertaken by competent persons who have received appropriate degree of information, instruction and training |
| Risk Management | Risk management is a set of practices and processes supported by a risk-aware culture and enabling technologies, that improves decision making and performance through an integrated view of how well an organisation manages its unique set of risks This includes the application of Health and Safety Regulations in every day working activity |
| Risk Matrix | The tool that is used to "score" each risk and determine its place on the Trust Risk Register, levels of authority are determined through the matrix and this will provide a priority list for managers to use within their respective area of control |
| Risk Register | Is a log of all risks that threaten the organisationssuccess in achieving its objectives |
| Strategic Risk Register | The highest-ranking risks assessed at 15 and above from the Directorate level will be used to populate and inform the Trust's Strategic Risk Register |
| Corporate Risk Register | The operational risk register used to manage risk across the Trust and provide executive support to managing risks outside the control/capability of the Divisions/corporate Departments. |
| Control | The control of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures |
| **Original Risk** | The level of risk identified when the risk was assessed and approved onto the risk register. |
| Current Risk | Are those which remain after considering the controls in place to reduce the risk and the implementation of any additional controls that may have been identified as necessary |
| Target Risk | The level of risk the Trust deems to be tolerable. |
| An incident | An event of circumstance that did or could have led to unintended/unexpected harm, loss or damage to a patient, staff, visitor |

# Appendix 7: How to do a risk assessment

**Purpose**
The purpose of this document is to assist the trust staff in conducting a risk assessment. The guidance is intended to encourage greater consistency in the way risk assessment is applied across the trust and promote vigilance in identifying risk and the ways in which it can be reduced.

**Introduction**
The Management of Health and Safety at Work Regulations 1999, Regulation 3 place a legal duty on all employees to assess all significant risks in the workplace. This includes all clinical tasks, activities, situations and risks. The Regulations also state that risk assessments should be suitable and sufficient, taking account of the work tasks, activities and situations undertaken and the environment in which these take place.

The assessment should identify the hazards associated with the task, activity or situation and establish control measures to minimise the risk. This in turn, based upon the risk levels, allow you to prioritise actions.

There is also a legal duty to monitor and review the risk assessments to ensure they remain suitable, (appropriate to the task, activity or situation), effective and sufficient (continue to meet the needs of the task, activity or situation).

The important thing that needs to be considered is, **does the hazard pose a significant risk?** If so, have you implemented control measures to reduce the risk to an acceptable level?

If there is a lack of or 'gap in control' to reduce the risk, then further actions and precautions, 'controls' may be required.

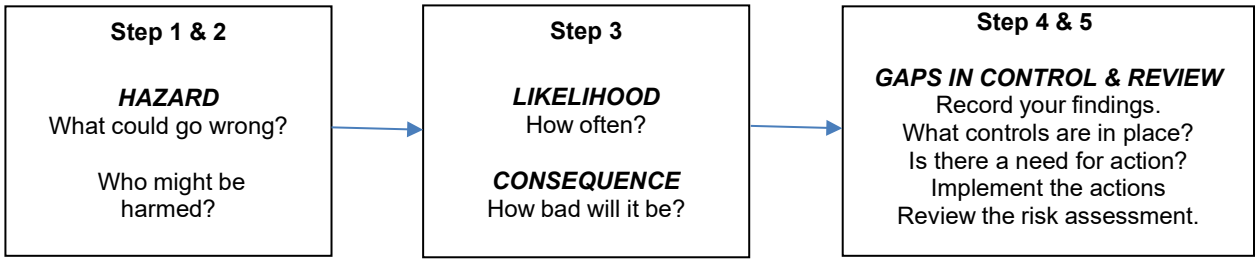
It is not usually possible to eliminate all risks, but the trust has a duty to protect patients, staff and visitors as far as 'reasonably practicable'. This means you must avoid unnecessary risk.

**Definitions:**

| | |
|---|---|
| **Hazard:** | Anything that has the probability or may cause harm (what could go wrong) |
| **Likelihood:** | The chance of harm occurring as a result of exposure to a hazard |
| **Consequence:** | The level of harm that may occur as a result of exposure to or contact with a hazard |
| **Risk:** | Risk is the chance high or low that an event/hazard will occur or may prevent the trust from achieving its objectives |

**What is a risk assessment?**
A risk assessment is simply a careful examination of the hazards associated with work tasks, activities, or situations in the trust, that could have the potential to cause harm to patients, staff and visitors. It allows you to consider and evaluate if there are 'suitable' (appropriate to the task, activity or work situation) and 'sufficient' (meet the needs of the task, activity or work situation) controls in place to reduce the level of risk to the lowest possible level. In other words have you taken enough precautions (controls) or should you do more to prevent potential harm from the hazard?

Using a methodology of the Health and Safety Executives *5 Steps to Risk Assessment* and the NPSA *Guide to Healthcare Risk Assessment* shown in the diagram, a risk assessment seeks to answer the following key questions:




**How to carry out a risk assessment**

The steps below will enable you to complete the risk assessment form. A template form can be found at **Appendix 10**.

| | |
|---|---|
| **Step 1** | **Identify the Hazards (what could go wrong)**<br>• Walk around your workplace and look at what could reasonably be expected to cause harm. Ignore the trivial and concentrate on significant hazards, things that could result in serious harm or affect numerous people e.g. Medicines not stored or locked away/trailing electrical lead causing a trip hazard.<br>• Ask those involved with the task, activities or situation for their opinion. They may have noticed things, which are not immediately obvious to those not involved with the task on a regular basis<br>• Look at and provide a description of the hazards associated with a task/activity/situation, include any hazards associated with any equipment, substances or processes used in the task/activity/situation<br>• Remember to prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong<br>• Take into account things that have gone wrong in the past and near miss incidents<br>• Check manufacturer instructions for equipment or data sheets for chemicals as they can also help you spot hazards and put risks in their true perspective<br>• Check if individual's health has been affected e.g. sickness absence due to skin problems caused by using a particular chemical/complaints of feeling unwell when working in a certain environment |
| **Step 2** | **Who might be harmed and how?**<br>• Identify those individuals or groups of people who may be at risk of harm if exposed to the hazard<br>• Remember the most vulnerable patients are more likely to suffer harm<br>• When considering people who, potentially could be harmed don't forget to consider new workers or trainees, young workers, new and expectant mothers and people with disabilities<br>• Cleaners, visitors, contractors or maintenance workers who may not be familiar or in the work place all the time |
| **Step 3** | **Evaluate the risks** (how bad – consequence and how probable (often) – Likelihood) and decide on the actions required<br>• Having spotted the hazards, detail the existing control measures already in place to prevent harm occurring<br>• Are these controls adequate?<br>• Intelligence data such as incident reports many indicate that a control you have in place is not effective<br>• Are controls reducing risk or harm to its lowest level?<br>• Is there a 'Gap in Control' and therefore a need for additional action and controls to reduce the risk? Look at the hierarchy of risk control |

| | |
|---|---|
| **Step 4** | **Record your findings and proposed actions then implement them**<br>• Complete the risk assessment form and action plan<br>• The actions required should be detailed in the action plan section of the risk assessment form, summarising how the controls are to be achieved. A responsible person is then allocated the responsibility of ensuring the actions are completed within a targeted date<br>• Using the Trust risk matrix, quantify the level of risk by choosing the level of consequence and likelihood of the harm occurring based on all the information you have gathered<br>• Evaluate the risks and decide whether the existing control measures are adequate or if more could be done<br>• Consider how likely it is that each hazard could cause harm. This will determine whether or not you need to do more to reduce the risk. Even after all precautions have been taken, some risk usually remains. What you have to decide is , whether the remaining level of risk is acceptable, if not then further action is required<br>• When writing the results of the risk assessment keep it simple, for example 'tripping over rubbish: bins provided, staff instructed, weekly housekeeping checks instigated'<br>• It is important that you can show that:<br>A thorough check was make to identify all the hazards and treat all the significant risks;<br>The controls are reasonable and the remaining risk is acceptable<br>The solutions are realistic, sustainable and effective<br><br>NB it may be reasonable to accept some degree of preventable risk, if the benefits to be gained outweigh the risk |
| **Step 5** | **Review your risk assessment and update if necessary**<br>• Risk assessments and action planning should be reviewed and monitored regularly<br>• Risk levels that are medium or high should be placed on the risk register. So that the action plans can be monitored regularly. Decide if you have a 'local risk' or 'Corporate risk'<br>• Once an action on the plan has been completed and the new or additional control implemented the risks should be re-evaluated and the results recorded<br>• Remember, research and new developments increase the pace of change, and those changes can alter existing and/or introduce new hazards<br>• Review your risk assessment regularly and at least on an annual basis:<br>Regularly and at least on an annual basis<br>When learning from incidents which may indicate a control is not working or needs to be changed<br>When you are planning a change to a task, activity or situation<br>When there has been a significant change to a service or way of working |

Risk assessment doesn't need to be overcomplicated and identifying hazards is common sense. However, risk assessment should only be carried out by a competent person, that is, someone who is familiar with the task, activity or situation, the environment is which the activity takes place and who has sufficient knowledge and understanding that they can identify those hazards present. Additionally, the competent person should recognise their limitations and be prepared to seek advice as necessary.

**Risk Evaluation Tool**

In order to separate those risks that are unacceptable from those that are acceptable the risks should be evaluated.

**Control Measures**
Once the risk assessment has been completed and the risk level indicates further actions and controls are necessary to ensure that the risk is reduced to as low as is reasonably practicable then consider the following:

a) Can the hazard be removed altogether?
b) If not, how can I control it?

When controlling risk, try applying the principles below:

Use **ERIC PD**

**E**LIMINATE get rid of the hazard; replace it with something less hazardous
**R**EDUCE the level of risk by reducing the nature of the hazard e.g. use similar quantities, lower voltage etc
**I**SOLATE the hazard from people, for example by putting up barriers or guarding
**C**ONTROL exposure to the hazard by controlling who has access or limiting exposure time
**P**PE issue Personal Protective Equipment
**D**iscipline and Culture

Improving risk management need not cost a lot of money, however failure to carry out suitable and sufficient risk assessments and not controlling significant risk in the workplace can cost the Trust in more ways than one.

If a task, activity or situation remains the same then a generic risk assessment can be produced. However, the assessment must be reviewed when the environment changes affecting the task, activity or situation and/or the process changes.

**Risk Assessment Action Plan**
The actions required should be detailed on the action plan section of the risk assessment form, summarising how the additional controls required to close the gap are to be achieved. A key individual is then allocated the responsibility of ensuring the actions are completed. A target date must be set and activity against the action monitored.

Unless the risk level is specified as 'acceptable' where only actions necessary are to monitor and review the assessment and established controls for effectiveness, all of risk levels will require further actions applied to reduce them to the lowest acceptable level. Once completed, the action is implemented and closed.

**Monitor and Review**
All risk assessments must be reviewed not less than annually and/or if:

- There is a significant change in equipment or process
- There is a change to the task activity or situation process or environment
- After an incident or accident

- There is a change to the people who are affected by the task, activity or situation
- There is a change in legislation
- There is a change to or introduction of new equipment
- The routine, process, system or procedure is no longer valid

If you have any questions regarding the completion of the risk assessment please contact the Trust Risk Manager.
Training on the risk assessment process is available from the Risk Team

**References:**

HSE Guide Five Steps to Risk Assessment IND163 (rev3), revised 06/1
NPSA Healthcare Risk Assessment Made Easy, March 2007

# Appendix 8: Identifying Risks

- The Trust will review compliance with the Care Quality Commission requirements on an ongoing basis to identify any risks
- Effective health and safety audits and inspections and implementation of resulting action plans
- Each Director will be responsible for ensuring that departmental risk assessments are carried out, producing directorate risk registers and taking action to manage the risk
- Regular multi-disciplinary review of incidents, complaints and claims data
- Patient and staff feedback surveys
- Public perceptions of the NHS e.g. media reviews
- Root Cause Analysis following serious adverse incidents
- Underlying root causes of incidents, complaints and claims
- Concerns raised by Trade Unions
- Whistle blowing
- Coroners' reports
- Financial forecasting and reports
- Board Quality walkabouts
- New legislation and guidance
- Recommendation and reports from assessment/inspections from internal and external bodies
- Safety alerts e.g. Central Alerting System, NHS Protect
- Non-Clinical/Generic Risk Assessments completed by staff
- Incident Reports
- Serious Incident Reports
- Risk Registers
- Health and Safety Audits
- Regular Health and Safety Checks e.g. Window checks, Fire Inspections
- National Guidance/Reports
- Patient's conditions (e.g. inherent risk of falls in people with dementia)
- Major incident (drill or live)
- Deficiencies with effective controls assurance standards
- Deficiencies with various elements of the CQC standards
- Recommendations and reports from external agencies such as NHSLA, Health and Safety Executive, Patient-led Assessments of the Care Environment (PLACE) etc.
- Actions taken to reduce risks which could not be or were not implemented for various reasons such as resource limitations
- Any other sources of information that could be considered to be a threat to patient, staff visitors, environmental safety or the organisations wellbeing
- Estates risk profile
- Financial/business plans/IT reports
- Underlying causes related to poor trends identified from key performance indicators
- Considerable deficiencies in non-compliance with staff mandatory training

# Appendix 9: Trust training for the management of risk

| Staff groups | Training need | Frequency | Format |
|---|---|---|---|
| Executive and Non-Executive Directors of the Board | Board Risk Awareness training | Annual | Workshop session as part of Board Development Programme |
| Trust senior managers | General Risk Awareness Training<br><br>Risk assessment training<br><br>Risk register training<br><br>Management of risk for senior managers | Every 3 years<br><br>Every 3 years<br><br>Every 3 years<br><br>Every 3 years | PowerPoint presentation/workshop<br><br>PowerPoint presentation/workshop<br><br>PowerPoint presentation/workshop |
| All new staff | Risk awareness training and an understanding of the role of risk management in the organisation | Once only<br><br>Completed as part of induction | PowerPoint presentation/workshop |
| Existing staff | Ad hoc bespoke training<br><br>Risk assessment training | As required<br><br>Ad hoc / as required | Variable according to need PowerPoint/workshop |
| Staff involved in risk management | Individually addressed according to individual needs | Dependent on individual needs | As required |

# Appendix 10 – Risk Assessment Form

**Type of Risk Assessment** *(tick any that apply)*:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Compliance** | | **Legal** | | **Financial** | | **Health & Safety** | | **Environmental** | |
| **Patient Safety** | | **Operational** | | **Medical Equipment** | | **Strategic / Business** | | **Project** | |

| **Location/Department:** | **Name of Assessor:** | **Job Role:** | **Date of Risk Assessment:** |
|---|---|---|---|
| | | | **Next Review date :** |

**Review Period** *(tick the relevant option)*:

**Risk assessments should be reviewed at least annually or when significant change to scenario being assessed, legislative update, incident/accident or when prompted.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Monthly** | | **Quarterly** | | **Bi-Annual** | | **Annual (minimum)** | | **Other (specify)** | |

| **Approving Manager:** | **Job Role:** | **Date:** | **Datix Risk Register Reference** *(where appropriate)*: |
|---|---|---|---|
| | | | |

| **Describe the task/environment/hazard being assessed:** |
|---|
| |

| **Hazard Number** | **Step 1. Identify the hazards** | | **Step 2. Risk without controls** | | | **Step 3. What is already in place?** | **Step 4. Current Risk** | | | **Step 5. Action required** | **Risk Register** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hazard Number** | **CAUSE What are the hazards?** | **IMPACT Who might be harmed and how?** (include anyone at special risk, patients, staff, visitors, the Trust) | **Inherent Risk Grading** *The level of risk if the controls fail?* | | | **CURRENT CONTROLS** What are you already doing to control the risk? | **Current Risk Grading** *The level of risk now* | | | **GAPS IN CONTROL** What further action do you need to consider to control the risk? These actions need to be transferred to the action plan below. | **Escalate onto Risk Register?** Yes/No |
| | | | **Consequence** | **Likelihood** | **Risk C x L** | | **Consequence** | **Likelihood** | **Risk C x L** | | |
| | | | | | | | | | | | |

## ACTION PLAN

| Hazard number | Action required | By whom | By when | Date completed |
|---|---|---|---|---|
| | | | | |

| Grading the Risk | | | |
|---|---|---|---|
| **Risk Rating** | **Consequence** *(How bad it may be?)* | **Likelihood of Harm** *(The chance it may occur)* | **Rating** *(R=C x L)* |
| Decide the applicable **Consequence** and **Likelihood** for the risk:<br>a) without any control measures in place (Inherent)<br>b) taking into account existing control measures (Current) | 1 Negligible<br>2 Minor<br>3 Moderate<br>4 Major<br>5 Catastrophic | 1 Rare<br>2 Unlikely<br>3 Possible<br>4 Likely<br>5 Almost Certain | 15-25 = High / Significant<br>8-12 = Moderate<br>4-6 = Low<br>1-3 = Very Low |

| | | **CONSEQUENCE** *(I.e. the Impact/Severity)* | | | | |
|---|---|---|---|---|---|---|
| | | **1** | **2** | **3** | **4** | **5** |
| **LIKELIHOOD** *(i.e. frequency)* | **5** | 5 | 10 | 15 | 20 | 25 |
| | **4** | 4 | 8 | 12 | 16 | 20 |
| | **3** | 3 | 6 | **9** | 12 | 15 |
| | **2** | 2 | 4 | 6 | 8 | 10 |
| | **1** | 1 | 2 | 3 | 4 | 5 |