Portsmouth Hospitals NHS Trust

RISK MANAGEMENT STRATEGY 2018 - 2021

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Name of responsible (ratifying) committee	Trust Board
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Document Manager (job title)	Head of Risk Management
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Version Tracking

VERSION	DATE RATIFIED	BRIEF SUMMARY OF CHANGES	AUTHOR
3.2		Removal of divisional risk register review at Quality & Performance Committee. Update Corporate Risk Register to Board Risk Register	Head Of Risk Management
3.1	05 July 2018-	Risk scoring matrix updated to mirror Datix version	Head Of Risk Management
3	5 July 2018	Strategy rewritten, to replace 2015 – 2018 Strategy	Director of Governance and Risk

CONTENTS

1. INTRODUCTION

An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services. The business of healthcare is, by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Portsmouth Hospitals NHS Trust's Board of Directors with assurance that services are delivered safely, effectively and in line with corporate strategic objectives.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but that risks can be minimised by making sound judgments from a range of fully identified and assessed options.

The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

This strategy applies to all Trust staff, agency staff and contractors, engaged on Trust business in respect of any aspect of that work. It is recognized that actions contain inherent risks.

2. STATEMENT OF INTENT

The Trust Board is committed to leading the organisation forward to deliver a high quality, sustainable service, achieving excellent results and making the very best use of public funds.

The Board recognises that to deliver these objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: these are cornerstones of building safer, effective, and efficient care for the future.

The Trust uses a web based risk management system, Datix, for the recording, management and reporting of incidents and risks at caregroup, divisional, corporate and strategic levels.

This Risk Management Strategy/Policy is underpinned by a suite of policies guiding staff on the day to day delivery of effective risk management processes. These linked policies are listed in section 12.

3. WHOSE RESPONSIBILITY IS RISK MANAGEMENT?

The success of the risk management programme is dependent on defined and demonstrated support and leadership offered by the Trust Board as a whole.

However, the day-to-day management of risk is the responsibility of everyone in our organisation at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

4. AIMS AND OBJECTIVES

The aim of this strategy is to strengthen the existing risk management framework, further embed risk management at a divisional and local level, and ensure appropriate escalation of the risks through the organisation to the Board. In addition, greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements will support delivery of improved risk management. The strategy is supported with an implementation plan, with objectives to support the achievement of the aims, as outlined below. Both the strategy and implementation plan will be monitored by the Quality & Performance Committee.

The key objectives of the Risk Management Strategy are to:

I. Embed risk management at all levels of the organisation
II. Create a culture which supports risk management
III. Provide the tools and training to support risk management
IV. Embed the Trust's risk appetite in decision making
V. Measure the impact of implementation

5. EMBED RISK MANAGEMENT AT ALL LEVELS OF THE ORGANISATION

One of the key aims of this strategy is to ensure greater local ownership of risks. To achieve this, we will continue to strengthen risk registers at Divisional, Care Group and specialty level, supported by clear criteria and timeframes for escalation of risks.

To support this greater local ownership of risks, the roles and responsibilities for risk identification, assessment, management and monitoring will be clarified and clearly articulated in relevant role and job descriptions in the Trust's revised structure. This will help to ensure clear escalation of risks between the different levels of the organisation, from 'ward to board'.

5.1 Wards and Departments

Wards and clinical Departments will be required to identify, assess and monitor risks as they arise or are anticipated in accordance with the Risk Assessment Policy. Risks may be identified as a result of

- Incidents
- Complaints
- Claims
- Serious Incidents Requiring Investigation and Never Events
- Risk Assessments
- External and internal reviews, inspections and assessments
- External and internal audit activity

All such risks will be referred to and recorded on Speciality Risk Registers, which will then be used to ensure the effective management of those risks.

5.2 Specialty Risk Registers

Specialty Risk Registers will be comprised of all risks identified in the wards and clinical departments included in that Specialty. They will be reviewed at Specialty Governance Committee meetings.

5.3 Care Group Risk Registers

Care Groups will be required to maintain Risk Registers, comprised of all risks on the Specialty Risk Registers in that Care Group, plus such other risks as have been identified as relevant to the Care Group as a whole. Speciality Risk Register risks may be amalgamated on the Care Group Risk Register if their management will be more effective when addressed at Care

Group, rather than Speciality, level. Care Group Risk Registers will be owned by, and reviewed at, Care Group Governance Committee meetings.

5.4 Divisional Risk Registers

Each Division will have a Risk Register which reflects the risks it faces as a whole, plus the Care Group and Specialty level risks which require Divisional management, in accordance with the Trust Risk Appetite (see section 8 below). Divisional Risk Registers will be owned at, and reviewed by, Divisional Specialty Governance Committees.

5.5 Corporate Services Risk Registers

The Corporate services (Human Resources, Finance (including Estates), Integrated Governance, Corporate Nursing and Medical Director) will also be required to develop and maintain Risk Registers which reflect the risks relevant to their services which are not incorporated into any of the other Risk Registers identified at paras 5.2 to 5.4 above. The Corporate Services Risk Registers will be owned by the Service Management teams and reviewed at Performance & Accountability meetings.

5.6 The Board Risk Register

The Board Risk Register will be comprised of all risks on the Divisional and Corporate Services Risk Registers which score 15 and above, plus other risks which are identified as likely to affect the organisation as a whole or as best managed at a Board level. Divisional and Corporate Services Risk Register risks may be amalgamated on the Corporate Risk Register where appropriate for effective oversight and/or management.

Lower scoring risks which occur across the Divisions or Corporate Services may also appear on the Board Risk Register if they are unlikely to be managed effectively if they are not addressed at a Board level.

The draft Board Risk Register will be produced by the Integrated Governance Directorate for consideration by the Quality & Performance Committee on a quarterly basis. The Committee will recommend the draft Board Risk Register, with amendments, as required, to the Board of Directors for adoption.

Appendix 1 describes these arrangements in diagrammatic form.

6. CREATE A CULTURE WHICH SUPPORTS RISK MANAGEMENT

6.1 Roles and responsibilities

A key component of an effective and mature risk management framework is a culture of knowledge and understanding of risk management and leadership. This means that roles and responsibilities need to be clearly defined so that risk management is ‘owned’ by appropriate members of staff, and that all staff are encouraged to be more risk-aware through promotion of openness and support for local management of risk where possible. It also means visible and supportive leadership from the Board in ensuring effective systems and processes for the management and escalation of risks.

The Trust has board level leadership for risk management and a clear committee structure that supports the aggregation and escalation of risk at Divisional level through the Performance & Accountability.
We have already identified and strengthened the leadership within the risk management framework by aligning the management of operational and strategic risk under an Executive

Director (Director of Governance and Risk) and ensuring Non-Executive level input and challenge into the Quality & Performance Committee.

Appendix 2 describes individual roles and responsibilities in connection with risk management.

Divisional Risk Registers will be used by the Executive team to inform discussion at Divisional Performance and Accountability meetings to ensure that risk is considered collectively and holistically, along with financial and operational performance. These meetings will be the mechanism by which Divisional Management Teams are held to account for the management of all aspects of the division, including the management of divisional risks.

The Quality & Performance Committee will review the Board and Corporate Services risk registers on a quarterly basis to ensure that risks are being managed effectively and that lessons and risk information are being shared across the organisation. These reviews will inform the Committee's decisions in respect of the recommendation of the draft Board Risk Register to the Board for adoption.

Other Board committees (see Appendix 3) play a role in risk management, as outlined in Appendix 1.

6.2 Interface Between Board Risk Register and Board Assurance Framework (BAF)

The BAF is a tool via which risks to the achievement of the Trust's strategic objectives are managed and reported to the Board. Risks recorded on the Board Risk Register may also appear on the BAF if they have the potential to compromise delivery of corporate strategic objectives. Not every high scoring item of the BoardRisk Register will appear on the BAF, and not all BAF entries will appear on the Board Risk Register, which is a tool for the management of operational risk.

The Director of Governance and Risk produces the BAF and oversees the relationship between the BAF and the Board Risk Register.

6.3 Board engagement in risk management

As well as structure, a mature risk management culture requires risk management to be at the heart of board level discussion. To enhance the maturity of existing conversations at board level, one of the aims of this strategy is to create a clear link between assurance, risk management, corporate governance and regulation. Using the agreed risk appetite matrix, the Board can set out a framework within which all risk should be considered, linking objectives, business planning and risk appetite. This will also help to develop an approach that engenders risk forecasting.

The Board will receive a quarterly Board Risk Register for consideration and adoption, as recommended by the Quality & Performance Committee. The Board will also receive a quarterly Board Assurance Framework, proposed by the Director of Governance and Risk. The Board will use both of these documents to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources.

To this end, each adopted iteration of both the Board Risk Register and the BAF will be sent by the Board to

- the Finance and Investment Committee to inform financial decision making and budget setting
- the Audit Committee to inform the planning of audit activity

- the Workforce and Organisational Development Committee to inform human resources and training and development decisions

7. PROVIDE THE TOOLS AND TRAINING TO SUPPORT RISK MANAGEMENT

In order to develop a culture for risk management and to ensure successful implementation of this strategy, there needs to be a targeted training programme for staff to supplement existing training provision.

Risk management training and awareness already occurs in a number of different methods. The Board will have a training and awareness raising session on risk management once a year as part of the board development programme, and risk, governance and quality feature in a number of leadership development programmes. The training and development programmes for Divisional Management teams will include significant amounts of risk management training.

We recognise that in order to implement this strategy successfully we will need to develop a more structured risk management training programme to increase staff knowledge and understanding of risk management for specific staff groups. That training will help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances and target risk. This will enhance the quality of conversation and consistency of approach. We will therefore review the existing training programme and training materials to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

Management of risk at Operational levels is supported by Governance Leads. We aim to further standardise, develop and support these roles to ensure the delivery of this strategy. We will also create local ownership of risk management through involvement of staff in designing the tools to manage risk and training programmes.

Increasing transparency of the Divisional, Care Group and Corporate Services risk registers will support all risk management activity, and will be achieved by utilising the risk register module within the DatixWeb incident reporting system. This will allow for ease of transference of risks and enable incidents, claims and complaints to be linked to specific identified risks.

8. EMBED THE TRUST'S RISK APPETITE IN DECISION MAKING

Considered risk taking is encouraged in order to support innovation, research & development within authorised and defined limits. The priority is to mitigate those risks that impact on safety, and reduce our financial, operational and reputational risks.

8.1 Acceptable Risk

The Trust acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, patients and others. The Trust will therefore make all efforts to eliminate risk or ensure that risks are contained and controlled so that they are as low as reasonably practical.

However it is not always possible to reduce or mitigate an identified risk completely and it may be necessary to make judgments about achieving the correct balance between benefit and risk. A balance needs to be struck between the costs of managing a risk and the benefits to be gained.
A decision must therefore be made regarding the level at which a risk would be deemed tolerable. A risk is considered acceptable when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable.

Where a risk has been reduced to the point where the cost of further controls to reduce the risk outweigh the benefit they may provide, it may not be considered reasonably practicable to

implement those controls. However, such position must be fully demonstrated before it can be accepted.

8.2 Risk Appetite.

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take.

The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

The Trust's risk appetite is expressed in two key ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

8.3 Risk impact scores.

The Trust uses a risk matrix which is common across the NHS and based on AS/NZS 4360:1999, a globally recognised standard for risk measurement and management.

Risk Grading Matrix	IMPACT				
LIKELIHOOD	1.Insignificant	2.Minor	3.Moderate	4.Major	5.Extreme
5. Almost Certain: Will undoubtedly happen	5	10	15	20	25
4. Likely: Will probably happen	4	8	12	16	20
3. Possible: Might happen occasionally	3	6	9	12	15
2. Unlikely: Do not expect it to happen	2	4	6	8	10
1. Rare: This will probably never happen	1	2	3	4	5

Describing the types of impact which attract each of the scores from 1 to 5 is another key way that the Trust can indicate its risk appetite. A table of example risk impacts is set out at Appendix 4 and will be included in the Risk Assessment Policy to ensure that staff are guided by the Trust's Risk Appetite in attributing impact scores to reported risks.

Very low and low risks (1-8)

Most risks will be graded into these less serious categories and can normally be managed through local action by line managers and local risk registers.

Risk	Further Action	By Whom
Very low Score 1-3	Acceptable • Inform all appropriate stakeholders • Take action to reduce risk where necessary and within authority • Maintain electronic records via Datix	All staff
Low Score 4-8	Acceptable risk. As above plus: • Discuss whether any further action should be taken to reduce future risk • Report to local governance group for management	Departmental Lead/Supervisor/Ward Manager/Team Leader

Moderate risks

Those risks classed as moderate will be addressed by a Clinical Director of the service area, Deputy Directors or Associate Directors. Where risks are complex, separate risk assessments and action plans must be recorded on Datix for all identified moderate risks to determine the most appropriate way of dealing with the risk. This will be reported to the appropriate group e.g. Divisional Governance Group, and Performance & Accountability meetings.

Risk	Further Action	By Whom
Moderate Score 9-12	Considerable risk • For complex risks, complete and record full risk assessment and action plan on Datix • Inform all appropriate stakeholders • Take action to reduce risk within authority • All risk updates recorded on Datix • Discuss further actions to be taken to reduce risk • Upload all supporting information to Datix e.g. reports, business cases • Report to Divisional Governance Group for management • Place on to Specialty risk register and Divisional risk register if requires divisional management	Clinical Directors Deputy Directors Associate Directors General Manager

	• Risk to be managed/monitored at specialty/divisional governance group • Risks to be discussed with the Divisional Management Team and at Performance & Accountability on a monthly basis	

High risks (15+)

All high risks will be recorded on the Board risk register and reported 4 times per year by the Director of Governance and Risk to the Board to approve action plans and monitor progress.

Risk	Further Action	By Whom
High Score 15-25	Significant risk. As above plus: • Board risk register will be reviewed 4 times a year at Q&P Committee • Board risk register will be reviewed by the Trust Board 4 times a year.	Executive Directors Divisional Directors/Management Team Deputy/Associate Directors Associate Director of Governance and Risk/Quality

8.4 Risk Registers

Speciality Risk Registers

All specialities are required to maintain a risk register of identified risks; these can be proactive or reactive risks pertinent to the service or area and monitored at least monthly by the responsible team. Risks scoring 10 or below can be managed at speciality level.

Care Group Risk Registers

These are held by each Care Group and monitored monthly by the responsible team. Speciality risk registers are reviewed regularly by the Care Group governance committee where high level risks (scoring 12 or above) identified at local level can be discussed and agreed for inclusion on the Care Group risk register.

Divisional Risk Registers

These are held by each Division and monitored monthly by the responsible team. Any risk that the Care Group cannot manage, that has the potential to affect the Division as a whole, or scores 15 or above should be discussed and potentially be escalated to the Divisional risk register.

Board Risk Register

Divisional Risk Registers will be appraised monthly at the Performance & Accountability meetings where management of risks will be assessed. Risks scored 15 or above will be discussed and consideration given to whether escalation to the draft Board Risk Register is required.

9. MEASURE THE IMPACT OF IMPLEMENTATION OF THE RISK MANAGEMENT STRATEGY/POLICY

There is a need to measure the impact of the strategy, to measure its effectiveness in developing the maturity of the Trust's risk management framework. We will therefore review the strategy on an annual basis and its implementation plan on a quarterly basis, via the Quality & Performance Committee.

In order to measure the impact of implementation of this strategy, we will complete an annual risk maturity assessment to evaluate performance and progress in

- developing and maintaining effective risk management capability, and
- assessing the impact on delivering effective risk handling and required/planned outcomes.

Amongst the measures we will use to measure the impact of the implementation of the strategy are

- Audit of Committee minutes to show risk is discussed
- Audit of risk review dates to ensure timely review
- Audit of whether risk scores change at appropriate rates and how quickly risks appear on, and are removed from, risk registers
- The extent to which risk is cited in decision making at divisional and corporate levels
- Audit of incidents and complaints to identify whether
  - they feed through into risk registers
  - the identification and management of a risk leads to a decrease in associated incident and complaints
- Audit of whether learning about / from risks is shared across divisions and specialties

Tools to measure implementation of the strategy may vary from year to year to reflect other audit and governance activity in hand.

10. EQUALITY IMPACT STATEMENT

Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

Our values are the core of what Portsmouth Hospitals NHS Trust is and what we cherish. They are beliefs that manifest in the behaviours our employees display in the workplace. Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.
We are committed to promoting a culture founded on these values which form the 'heart' of our Trust:

Respect and dignity ----
Quality of care
Working together
Efficiency

This policy should be read and implemented with the Trust Values in mind at all times.

11. MONITORING COMPLIANCE WITH THE RISK MANAGEMENT STRATEGY

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Leads for Acting on Recommendations
Risk Management structure and committee functions are operating as per this Strategy	Head of Risk Management	• Internal Audit	Annually	Reported to: • Trust Board • Audit Committee • Quality & Performance Committee	Head of Risk Management
Local management of risk (risk registers) is operating as set out in this strategy	Head of Risk Management	• Internal Audit	Annual	Reported to: • Trust Board • Audit Committee • Quality & Performance Committee	Divisional Management Teams

12. ASSOCIATED DOCUMENTATION

The following internal and external documents support the implementation of the Risk Management Strategy

Internal – these can be found on the Trust's Intranet site.

- *Duty of Candour and Being Open Policy*
- *Claims Management Policy*
- *Transformation Programme Development (Including Quality Impact Assessment)*
- *Health and Safety Policy*
- *Major Incident Response Policy*
- *Maternity Risk Management Strategy*
- *Adverse Event and Near Misses Management Policy*
- *Serious Incident Requiring Investigation Management Policy*
- *Complaints Concerns Comments and Plaudits Management Policy*
- *Risk Assessment and Monitoring Policy*
- *Raising Concerns (Whistleblowing) Policy*

If, for any reason, a member of staff does not have access to the Trust Intranet a hard copy can be made available by their line manager or the Risk Management Department

External:

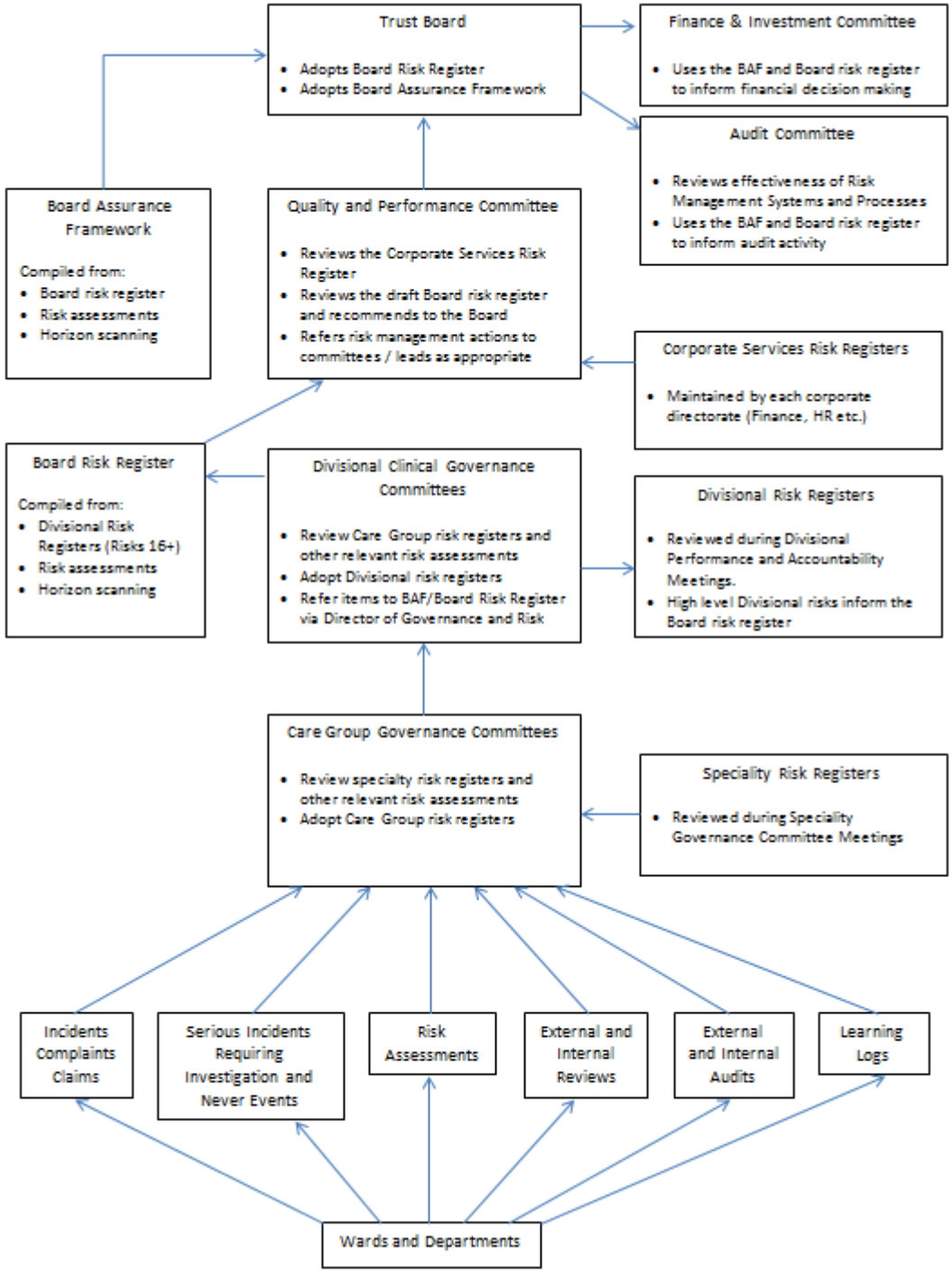
- An Organisation with a Memory: *Department of Health 2000 www.dh.gov.uk*
- Building a Safer NHS: *Department of Health (2002) www.dh.gov.uk*
- Building a Memory: preventing harm, reducing risks and improving patient safety: *National Patient Safety Agency (2005) www.npsa.nhs.uk*
- Being Open: *National Patient Safety Agency (2005) www.npsa.nhs.uk*

- National Standards, Local Action, Health and Social Care Standards and Planning Framework: *Department of Health (2004)* *www.dh.gov.uk*
- Assurance: The Board Agenda: *Department of Health*. *(2002)* www.dh.gov.uk
- The Handbook to the NHS Constitution www.dh.gov.uk
- Acute Hospitals: Provider Handbook www.cqc.org.uk
- The NHS Outcomes Framework 2013/14 – DoH *www.dh.gov.uk*
- Equity and Excellence: Liberating the NHS – DoH 2010 *www.dh.gov.uk*
- Assurance: The Board Agenda – DoH 2002
- Management of Risk: A Strategic Overview – HM Treasury 2000

13. REVIEW

This Strategy will be reviewed in 2021, unless requirements change.

APPENDIX 1: DIAGRAMMATIC REPRESENTATION OF ROUTE FROM WARD TO BOARD



APPENDIX 2: DUTY OF KEY INDIVIDUALS IN THE RISK MANAGEMENT FRAMEWORK

Chief Executive: is the Accountable Officer for the Trust and has overall responsibility for the management of risk. The Chief Executive has delegated this responsibility to an Executive Lead for Risk Director of Governance and Risk The Executive Lead for Risk is responsible for reporting to the Trust Board on the development and progress of Risk Management, and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

Executive and Non-Executive Directors:
The Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

Non-Executive Directors: have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

Director of Governance and Risk: is the Executive lead for clinical and corporate governance, and operational and strategic risk. In partnership with the Medical Director and Chief Nurse, the post holder ensures organisational arrangements are in place, which satisfy legal requirements of the Trust with regard to the quality and safety arrangements for patients and staff; including delivery of processes to enable effective risk management and clinical standards. The Director of Governance and Risk is also responsible for the work of the Board and its Committees and for ensuring integration of their activities with respect particularly to their governance and regulatory responsibilities, and for management of the Board Assurance Framework.

Chief Operating Officer: has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation.

Chief Financial Officer: has executive responsibility for the financial governance arrangements throughout the organisation, including overseeing financial performance management at corporate and Directorate level

Associate Director of Governance and Risk supports the Director of Governance and Risk, Chief Nurse and the Medical Director with regard to their safety and risk management responsibilities. This includes overseeing the risk management function, encompassing the Trust Risk Register, Statement on Internal Control and compliance with the requirements of the CQC standards.

Risk Management Team: has responsibility for the operational delivery and implementation of the Risk Management Strategy/Policy and associated policies/processes.

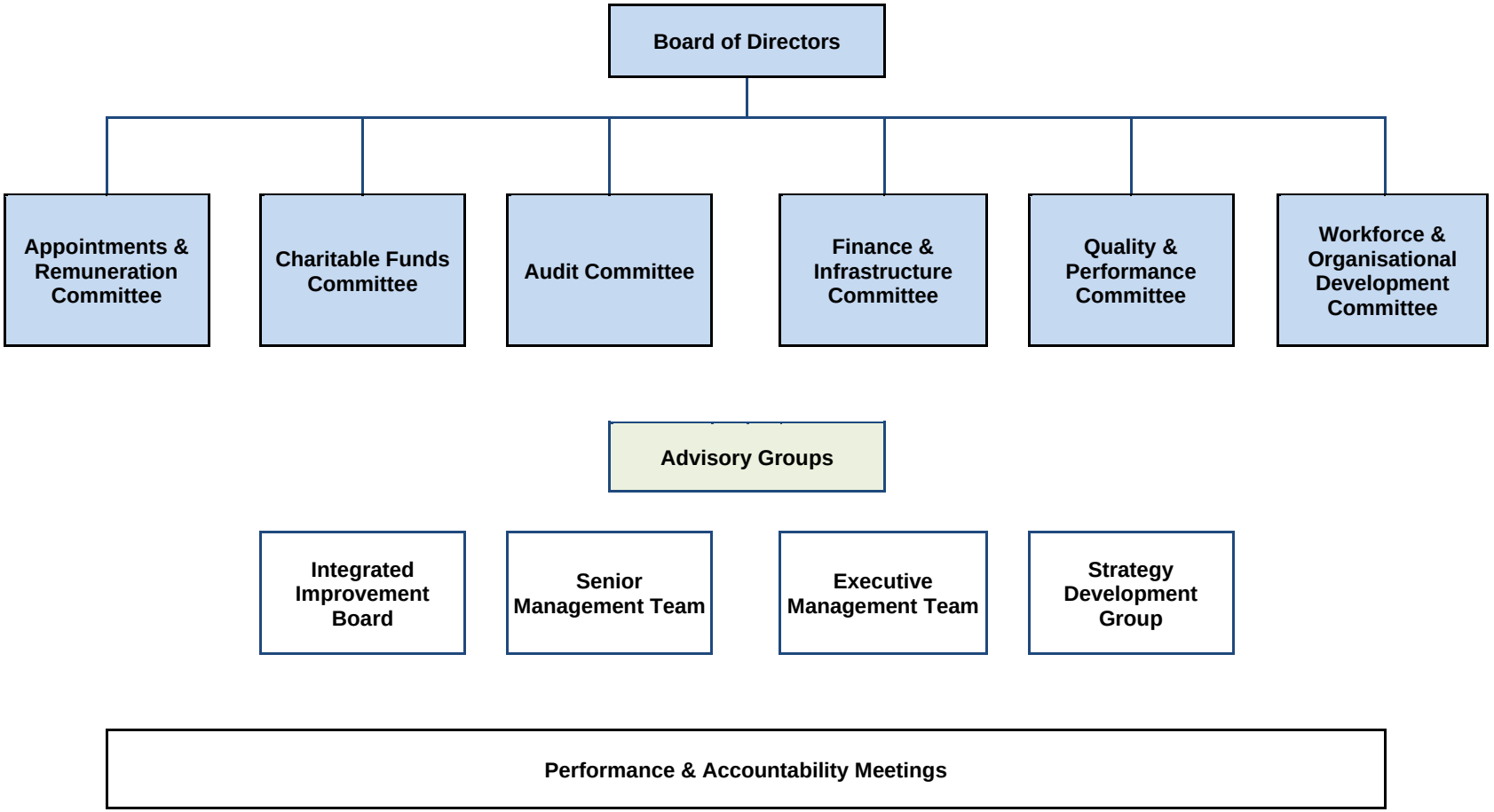
Divisional Management Teams: the teams comprise a Divisional Director (Clinical), Divisional Operational Director and Divisional Nursing / Medical Director, who have delegated authority and responsibility for: directing governance activity; managing risk and developing monitoring systems for providing assurance that activity is being carried out appropriately. This includes approving the provisional addition of new risks to the Divisional Risk Registers, prior to their formal consideration by Divisional Clinical Governance Committees. The Teams are also responsible for escalating any issues up through the governance structure.

Managers: have delegated responsibility and authority with regard to the management of quality, risk and performance within their specific spheres of activity included in their job descriptions. Managers are also responsible for escalating issues up through their designated governance structures.

Governance Leads: Governance Leads support the Divisional Management Teams in the day to day identification, assessment, management and reporting of risk.

All Staff: are responsible for their own and others health and safety within their immediate workplace and for participating in the wider governance, quality and risk management activities, as appropriate, and have these responsibilities included in their job descriptions. Staff are also responsible for escalating issues and risks up through their designated line management structures.

APPENDIX 3: ORGANISATIONAL COMMITTEE STRUCTURE



APPENDIX 4 – RISK IMPACT DESCRIPTORS

Descriptor	Insignificant	Minor	Moderate	Major	Extreme
Score	**1**	**2**	**3**	**4**	**5**
Impact on individual Patient/ Employee/Visitor Safety	Minor injury not requiring first aid.	No permanent injury (psychological, emotional, physical) Minor injury or illness, first aid treatment required.	Semi-permanent injury (psychological, emotional, physical). increase in treatment for a patient i.e. return to surgery, an unplanned readmission RIDDOR/Agency reportable.	Permanent injury, serious disability, reduced life expectancy (psychological, emotional, physical).	Unexpected death.
Patient Experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
Complaints/Claims	Locally resolved complaint.	Justified complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim.
Objectives/ Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality.	<5% over budget/schedule slippage. Minor reduction in quality/scope.	5-10% over budget/schedule slippage. Reduction in scope or quality.	10-25% over budget/schedule slippage. Doesn't meet secondary objectives.	>25% over budget/schedule slippage. Doesn't meet primary objectives.
Clinical Service/ Business Interruption	Local interruption with back up.	Local interruption.	Loss/interruption > 1 hour.	Loss/interruption > 8 hours.	Loss/interruption > 24 hours.
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1 day).	On-going low staffing level reduces service quality.	Late delivery of key objective/ service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level.	Uncertain delivery of key objective /service due to lack of staff. Serious error due to poor training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. Critical error due to insufficient training.
Financial	Less than £100.	<£1000 but >£100.	<£10,000 but >£1000.	<£100,000 but >£10,000.	<£100,000 to reduce the risk.
Inspection/Audit	Minor recommendations. Minor non-compliance with standards.	Recommendations given. Non-compliance with standards.	Reduced rating. Challenging recommendations. Non-compliance with core standards.	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours.	Local media – short term. Minor effect on staff morale.	Local media – long term. Significant effect on staff morale.	National media < 3 days.	National media >3 day. MP concern (Questions in the House).
Counter Fraud	Interception of non-recurring fraud with no losses.	Small losses incurred from fraud/error but no evidence to support sanctions.	Investigation leading to minor disciplinary sanction only.	Criminal investigation and possible dismissal. Local press coverage.	Criminal investigation. National press coverage. Poor systems exposed.

EQUALITY IMPACT SCREENING TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval for service and policy changes/amendments.

Stage 1 - Screening			
Title of Procedural Document: Trust Risk Management Strategy/Policy			
Date of Assessment	12.07.2018	**Responsible Department**	Risk Department
Name of person completing assessment	Annie Green	**Job Title**	Head of Risk Management

Does the policy/function affect one group less or more favourably than another on the basis of :	**Yes/No**	**Comments**
• Age	No	
• Disability	No	
• Gender reassignment	No	
• Pregnancy and Maternity	No	
• Race	No	
• Sex	No	
• Religion or Belief	No	
• Sexual Orientation	No	
• Marriage and Civil Partnership	No	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		
More Information can be found be following the link below www.legislation.gov.uk/ukpga/2010/15/contents		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions (what needs to be done to minimise / remove the impact)**	**Responsible Officer**

Monitoring of Actions

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level

Specialty Procedural Document:	Specialty Governance Committee
Clinical Service Centre Procedural Document:	Clinical Service Centre Governance Committee
Corporate Procedural Document:	Relevant Corporate Committee

All actions will be further monitored as part of reporting schedule to the Equality and Diversity Committee