Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Public

Date:	26 May 2021	**Item Ref:**	18c

TITLE OF PAPER	**Risk Management Strategy**
TO BE PRESENTED BY	David Walsh, Director of Corporate Governance
ACTION REQUIRED	For discussion and approval

OUTCOME	To approve the revised Risk Management Strategy
TIMETABLE FOR DECISION	Audit and Risk Committee 20 April 2021 Board of Directors 26 May 2021
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management Directorate Risk Registers Risk Management Strategy Trust Strategy Corporate Risk Register Care Network and Directorate Risk Registers
STRATEGIC AIM: STRATEGIC OBJECTIVE:	All
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	The Risk Management Strategy is the manual of how risk is managed within the organisation.
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	David Walsh
Designation	Director of Corporate Governance
Date of Report	18 May 2021

Sheffield Health and Social Care NHS Foundation Trust

Risk Management Strategy

1. Purpose

For approval	For assurance	For collective decision	To seek input from	To report progress	For information	Other (please state)
x			x			

2. Summary

It is good practice to review the Risk Management Strategy annually. More changes are proposed to the management of risks within the organisation and this document describes the proposed arrangements. The proposed Risk Management Strategy for 2021 is included as an appendix to this report, with tracked changes deliberately visible. A 'clean' version of the document can be circulated if required but it has been provided in this format to aid committee members in identifying the changes.

2.1 Changes to the Risk Management Strategy

The changes to the document are summarised below:

- **Revision of the Risk Appetite Statement** (pages 7-9). This follows on from the work that was initially undertaken during a Board Development session in February 2021, then revisited by Trust Board in a formal setting in March 2021. As well as amending the risk thresholds in line with the discussions that took place, the narrative has been changed to differentiate between risks that the organisation *tolerates* in relation to its general business and those for which it has an active *appetite* in relation to the pursuit of strategic objectives;
- **Responsibilities and accountabilities** (page 9 and Appendix 3). This has been revised to reflect current management arrangements but also to 'future proof' the strategy. The previous iteration utilised this appendix to detail the areas of portfolio responsibility associated with each Executive Director. The amended appendix consolidates this so the description relates more to the duties than the areas of responsibility. Other changes have been made to direct reports to Executive Directors (reflecting structural changes that have taken place);
- **Greater clarity around process for risk reviews at service level** (pages 16-17). Although the narrative which has been added is very procedural, this clarity was required arising from weaknesses identified in the processes previously;
- **Escalation of risks with a score of 12 or above** (pages 17-18 and page 23). It has been identified that there have been occasions when risks with a score of 12 or above have not always been considered for escalation to the Corporate Risk Register. This is not compliant with the strategy. Further

narrative has been added to make clear the requirement that this should take place;

- **Risk Review** (page 18). It is proposed that the ability to set a review date of six months for low level risks (six or below) be removed. The maximum length of time between reviews has been reduced to three months for these lowest risks. Accordingly, it is proposed to reduce the minimum review period for risks with a score of 8-10 from quarterly to monthly. This responds to poor review compliance historically and re-emphasises the importance that risks remain 'live';
- **Risk Oversight Group** (page 24 and Appendix 5). This key additional control has been added as part of the governance of managing risks within the organisation. It is anticipated that the group will oversee the application of the Risk Management Strategy and will respond to many of the issues that have been identified through the year (such as inconsistent scoring, missing entries or lack of movement in scores despite ample controls being listed). It should be noted that this group is new and therefore still developing. While a Terms of Reference has been prepared (and will be appended to the Risk Management Strategy upon completion), it is anticipated that this may be refined or re-focused as they year develops;
- **Regularity of reporting to Board/committees** (throughout). All references to quarterly reporting of both the Board Assurance Framework and Corporate Risk Register have been removed. It is the intention that these will be reported at all public scheduled meetings moving forward to increase ownership at Board level;
- **General changes/updates** (throughout). There have been minor tweaks to update items such as job titles and the deletion of defunct bodies (such as Executive Director Group).

2.2 Reviews undertaken not resulting in changes

One area which it was determined at the Board Development session in February to explore was the thresholds qualifying risks to be scored at various levels, to ensure they reflected the organisation's Risk Appetite Statement. Particular regard was paid to the scoring of finance-related risks, after it was highlighted that some risks in the Corporate Risk Register were scored higher than some Board members would have anticipated, yet in full compliance with the thresholds set out within the Risk Management Strategy.

This has been reviewed, but the exercise has demonstrated that the existing thresholds are consistent with good practice applied by NHS providers. There would be some risk in SHSC taking a different approach to the thresholds it applies, particularly in the context of collaborative working with partners. A more appropriate means to ensure this is considered in the context of the Risk Appetite Strategy by the latter being included and referred to in future reporting.

2.3 Internal Audit

There has been a separate internal audit into Strategic Risk Management which has resulted in a number of recommendations. Actions have been drafted and will roll out throughout 2021/22. However, some immediate changes have been made to this draft following the Audit and Risk Committee and in response to the internal audit. They are:

- **Risk Actions** – additional guidance now included to ensure risk actions are appropriate, including reference to 'SMART' principles. There is a specific focus around the timeliness of the actions to ensure they can be measured effectively.
- **Training** – although most agreed actions relating to training refer to activity which will take place later in 2021/22, the strategy now makes reference to this more systematic approach;
- **Monitoring compliance** – the existing narrative describing the roles of Board and the Audit and Risk Committee has been supplemented by a description of the role of the Risk Oversight Group and cross-referencing to the monitoring of risks at team, directorate and corporate level which is now undertaken in line with the Performance Framework at service performance reviews.

3 Next Steps

Following approval, the Risk Management Strategy will be published and a programme of training developed in line with the recommendations within the internal audit that has been undertaken

Actions and timescales thereafter include:

- Development of a training programme including identification of training needs and systematic arrangements to ensure regular updates thereafter **by end of August 2021**
- Modifications to Ulysses system to ensure simplified escalation/de-escalation of risks as soon as possible and no later than the commencement of training from **the end of August 2021**
- Re-audit of random sample of risks to test application following roll-out of training programme **by the end of March 2022**
- Review of appropriate application of target risk score in line with the Risk Appetite Statement by **end of October 2021** and full re-audit by **end of March 2022.**

4 Required Actions

Board is asked to:

1. Approve the draft Risk Management Strategy;
2. Receive assurance on plans to ensure its successful training and application during 2021/22 .

5 Monitoring Arrangements

As detailed within the main document, the organisation is enhancing its monitoring arrangements of risk management through the development of the Risk Oversight Group.

6 Contact Details

David Walsh, Director of Corporate Governance (Board Secretary)
Email: david.walsh@shsc.nhs.uk

Risk Management Strategy~~,~~ ~~Policy & Procedure~~

Category:	Strategy, Policy & Procedure
Summary:	The overarching purpose of the risk management strategy is to describe the framework and processes within Sheffield Health & Social Care NHS Foundation Trust to: • Identify, manage, eliminate or reduce to an acceptable level, risks that threaten the delivery of high quality care and services. • Maintain a safe environment for individuals who are legitimately accessing Trust services. • Minimise financial loss to the organisation, and to • Demonstrate to the public, regulators, staff and commissioners that the Trust is a safe and efficient organisation
Valid From:	26 May 2021
Date of Next Review:	~~2023/4~~March-April 2022
Approval Date/ Via:	Audit and~~&~~ Risk Committee Trust Board
Distribution:	Trust-wide
Related Documents:	IMT 006 Data & Information Quality Management Health & Safety Policy
Executive Lead:	Chief Executive
Strategy Lead:	Director of Corporate Governance (Board Secretary)
Author(s):	~~Sam Stoddart, Deputy Board Secretary~~David Walsh, Director of Corporate Governance
Document Ref:	SHSC Risk Management Strategy 202~~0~~1 version 2~~1.0~~
This document replaces:	Risk Management Strategy 2020~~19~~ version 1~~.0~~

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Introduction

1. Sheffield Health and Social Care NHS Foundation Trust (~~the Trust~~SHSC) is committed to putting the safety of service users, carers, staff and the public at the heart of its business and as such is committed to ensuring effective risk management is a fundamental part of its management approach and underpins all activities. ~~The Trust's~~Our approach to risk management is one of proactively identifying, mitigating, monitoring and reviewing risk.

2. Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.

3. This Board~~'s~~ approved strategy for managing risk identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation based upon the Board's identified risk appetite (see paragraphs 18-24).

4. Effective risk management should protect and add value to the organisation and its stakeholders, and in turn robustly support the organisation's objectives by:

   - Providing a framework that enables future activity to take place in a consistent and controlled manner;
   - Improving decision making, planning and prioritisation by comprehensive and structured understanding of business activity, volatility and project opportunity/threat;
   - Contributing to the efficient use/allocation of capital and resources within the organisation;
   - Protecting individuals who come into contact with the organisation;
   - Protecting and enhancing assets and organisational reputation;
   - Developing and support people and the organisation's knowledge base;
   - Optimising operational efficiency.

5. ~~The Trust~~We recognise~~s~~ that health and social care is, by its ~~very~~ nature, a high risk activity. A positive risk management culture supports staff to make sound judgements and informed decisions concerning the management of risk and risk taking. In these circumstances, where staff have undertaken and document~~ed~~ a risk assessment, identified appropriate action, monitored the implementation of such action and complied with ~~Trust~~ policies and procedures, they can be assured of ~~the Trust's~~ commitment and support for their actions.

6. Successful risk management involves:

   - Identifying and assessing risks;
   - Taking action to anticipate or manage risks;
   - Monitoring risks and reviewing progress in order to establish whether further action is necessary or not; and
   - Ensuring effective contingency plans are in place.

Policy Statement

7. The ~~Trust~~ Board is committed to delivering services to a high standard, ~~and that~~with any risks ~~are~~ minimised through organisation-wide robust risk management processes. ~~The Trust's~~Our strategic objectives ~~and associated strategies, policies and plans~~ demonstrate a commitment to raise standards and continuously improve the quality of services through making risk management part of normal daily work practice.

8. In setting out processes which seek to effectively identify, analyse and control risk, this strategy is consistent with requirements of the International Organisation for Standardisation (ISO) 31000:2018 Risk Management – Guidelines. In addition, this strategy will support ~~the Trust~~SHSC to demonstrate compliance with regulatory requirements.

9. ~~The Trust is~~We are committed to having a risk management culture that underpins and supports ~~the~~ our business ~~of the Trust.~~ and ~~The Trust intends to demonstrate an ongoing commitment to~~ improving the management of risk throughout the organisation.

10. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

11. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be ~~embraced and~~ explored in order to grow business and services, and take opportunities in relation to the risk.

12. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

13. **Senior management** will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

14. **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.

Purpose and Aim

15. The aim of this strategy is to set out ~~the Trust's~~our vision for managing risk. Through the management of risk, ~~the Trust~~we seek~~s~~ to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:

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

Scope

16. The objective of the Risk Management Strategy is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

17. ~~At the Trust w~~We use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

    - All salaried employees;
    - Contractors, sub-contractors and External Consultants;
    - Agency staff, those seconded to the Trust from other organisations, those covered by a letter of authority / honorary contract, apprentices, trainees, volunteers and those on work experience; and
    - Board, Committee, sub-committee, Council of Governors and advisory group members (who may not be directly employed or engaged by the Trust).

    The strategy applies to all ~~Trust~~ staff, as referred to above. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

Risk Appetite

18. The risk appetite is the amount of the risk ~~that the Trust is~~ we are willing to seek or ~~accept~~ tolerate in the pursuit of ~~its~~ our long~~-~~term objectives. In practice, an organisation's risk appetite should address several dimensions:

    a. The nature of the risks to be assumed;
    b. The amount of risk to be taken on; and
    c. The desired balance of risk versus reward.

19. On an annual basis the ~~Trust~~ Board ~~will~~ determines its risk appetite statement covering the overarching areas of:

    d. Safety;
    e. Quality;
    f. Workforce
    g. Statutory
    h. Reputational;
    i. Business;
    j. Financial; and
    k. Environmental risk.

These categories of risk are more fully explained in Appendix 1.

~~Trust's~~ Risk Appetite 202~~0~~1/22~~0~~/~~21~~

	The amount of risk the organisation is prepared to ***tolerate*** in relation to general, identified risks that arise and are not invited
	The ***appetite*** for risks to be taken or invited in relation to accepted or invited risks that arise as a result of the pursuit of strategic objectives

Category	Relative Willingness to Accept Risk				
	Zero	Low	Moderate	High	Very High
	1	2	3	4	5
Safety					
Quality					
Workforce					
Statutory					
Reputation					
Business					
Finance					
Environmental					

Assessment	Description of Potential Effect
~~LOWEST THRESHOLD~~	
Zero Risk Appetite Score – 1	The ~~Trust~~ Board seeks to **avoid risks under any circumstances** ~~that may result in compromised quality and safety of staff and service users, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.~~
Low Risk Appetite Score – 2	The ~~Trust~~ Board seeks to **avoid risks (expect in very exceptional circumstances)** ~~that may result in compromised quality and safety of staff and service users, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.~~
Moderate Risk Appetite Score – 3	The Trust Board is willing to **accept some risks in certain circumstances** ~~that may result in compromised quality and safety of staff and service users, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.~~
High Risk Appetite Score – 4	The Trust Board is **willing to accept risks** ~~that may result in compromised quality and safety of staff and service users, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative~~

	compliance.
UPPER THRESHOLD	
Very High Risk Appetite Score - 5	The Trust Board **accepts risks that are likely** to result in compromised quality and safety of staff and service users, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

20. The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

21. Risks throughout the organisation should be managed within the Trust's risk appetite., or Wwhere this is exceeded, action should be taken to reduce the risk.

22. For corporate and BAF risks, target risk scores are required and these are determined by the Trust's rRisk Aappetite Statement. The table below shows the target score range.

Risk Appetite	Target Score Range
ZERO	1-4
LOW	5-8
MODERATE	9-12
HIGH	15
VERY HIGH	25

23. The Trust Board will review its appetite for, and attitude to, risk on an annual basis, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The review will consider:

- Risk leadership;
- People;
- Risk policy and strategy;
- Partnerships;
- Risk management process;
- Risk handling; and
- Outcomes.

24. In reviewing its Rrisk appetite, Board will be mindful of how much risk the organisation is able to absorb (risk capacity) and the amount of risk variation tolerance can be measured as an acceptable/unacceptable range of variation relative to the achievement of a specific objective (risk tolerance). or to the aggregated risk appetite. Risk tolerance provides constraints around the level of risk, which may have upper boundaries (e.g., tolerate no more than) and lower boundaries (e.g., tolerate at a minimum or not tolerate a return less than x based on the risk assumed). It may be measured using the same units as the related objective. These risk tolerances may be accompanied by a risk target.

Risk appetite and tolerance both need to be considered in the context of risk capacity. This is the amount of risk the Trust can actually bear. The Trust's Board may have a high risk appetite but not have enough capacity to handle a risk's potential volatility or impact. Conversely, the risk capacity may be high but the Trust may decide based on strategy and objectives to adopt a lower risk appetite. An example of how this can be illustrated is shown below.

Risk Capacity	The maximum amount of risk the Trust is **able to support** within its available resources
Risk Appetite	How much and what type of risk the Trust is generally prepared to accept to achieve its strategic objectives.
Risk Tolerance	The maximum amount or type of risk the Trust is prepared to tolerate above risk appetite.

~~Appetite and tolerances for each management level of the risk management framework are defined for staff in the Risk Management Handbook.~~

25. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

Definitions of Risk and Risk Management

26. **A risk** is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.

27. **Risk Management** is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 2 for further definitions that relate to this strategy.

Principles of successful Risk Management

28. It is the role of the **Trust Board** to lead and support risk management across the organisation. The principles of successful risk management are:

    a. to embrace an open, objective and supportive culture;
    b. to acknowledge that there are risks in all areas of work;
    c. for all staff to be actively involved in recognising and reducing risk;
    d. to communicate risks across the Trust through escalation and de-escalation processes; and
    e. to learn from mistakes.

Responsibilities and accountabilities for risk management

29. Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

30. Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks. To support the governance and escalation process. Appendix 3 sets out the specific risk management responsibilities of ~~the following~~specific staff ~~/ staff groups:~~.

    ~~a. Chief Executive;~~
    ~~b. Executive Director of Finance;~~

~~c. Executive Medical Director;~~
~~d. Executive Director of Nursing &, Professions and Care Standards;~~
~~e. Executive Directors and Associate Directors;~~
~~f. Director of Corporate Governance (Board Secretary);~~
~~g. Head of Clinical Governance;~~
~~h. Director/Clinical Director of Operations & Transformation, Associate Directors, Associate Clinical Directors and Deputy Directors~~
~~i. Senior Managers and Senior Staff;~~
~~j. All staff; and~~
~~k. Staff side representatives.~~

31. **All managers** are expected to make risk management a fundamental part of their approach to clinical and corporate governance and have the authority and responsibility for health and safety and the effective management of risks including the reporting and management of incidents and serious occurrences within their teams, services or departments. They have the authority to assess and manage risks and directly manage risks graded very low to moderate reporting to their directors on completion. Their specific duties include:

- maintaining an up-to-date and live service level risk register so that they can demonstrate they have considered risks both reactively and proactively and that they have effective plans in place to control these risks
- making sure all incidents occurring in their area or affecting service users in their care are reported and investigated appropriately, following the Trust's Incident Management Policy;
- making sure that lessons learnt from when things go wrong (whether through incidents, complaints or national reports) are disseminated and implemented within their teams, services or departments as appropriate
- making sure health and safety assessments are carried out and any problems found are put right quickly
- making sure all staff in their teams, services or departments are aware of and work to all Trust policies and procedures
- making sure all staff are aware of any risks with their work and what plans they need to follow to control these risks as much as possible (e.g. personal safety plans, managing violence and aggression guidance)
- making sure all staff in their teams, services or departments have annual personal development reviews which include consideration of risk and safety aspects of their roles
- making sure all new staff receive Trust and local induction – local induction to include risk and safety issues as described in the Trust Induction policy
- identifying any staff training and development needs with regard to risk and safety, including all statutory or mandatory training needs (e.g. First Aid, clinical risk assessment and management) and make sure staff are enabled to undertake the necessary training and development
- making sure all staff are fit and well and able to carry out their duties safely (in line with the Trust's Promoting Attendance and Managing Sickness Absence Policy)
- making sure all equipment and devices provided for the team or department's work is safe and fit for purpose (Medical Devices Policy)
- making sure the environment is safe for staff, service users, carers and members of the public (Health and Safety checklist, PLACE assessment and reporting of RIDDOR incidents)

Risk Assessment and Management Tools

32. The Trust has developed a number of tools to support staff in the identification, assessment, actions and monitoring arrangements. These tools are to be used for clinical and non-clinical risk management.

33. NHS England's Risk Management Policy and Process Guide, 2015 sets out an overarching strategic direction to manage risk. More specifically, the Department of Health published Best Practice in Managing Risk, guidance on risk assessment and management in mental health in 2007. This document sets a framework of principles to underpin best practice in mental health settings, and provides a list of tools for risk assessment and management. The philosophy underpinning this framework is one that balances care needs against risk needs and emphasises:

- positive risk management
- collaboration with the service user and others involved in their care
- the importance of recognising and building on service users' strengths
- the organisation's role in risk management alongside the individual practitioner

34. It stresses the importance of linking risk management with the Care Programme Approach and the Mental Health Act. Positive risk assessment, as part of a carefully constructed plan, is a required competency for all mental health practitioners.

35. The clinical/service user risk assessment and management document that is approved for use within the Trust is the Detailed Risk Assessment and Management plan (DRAM). Other risk screening/assessment tools may be used as required to meet specific needs, e.g. falls risk, suicide risk, MUST (Malnutrition Universal Screening Tool, MRSA screening,etc.

36. The DRAM is available through Insight, the Trust's service user administration system.

Risk Management Process

37. The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

38. Risks are events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. Risk management also includes issues that 'have' happened and were not planned, but require management action.

39. Risks are clarified and managed in the following key stages:

a. Clarifying objectives;
b. Identifying risks that relate to objectives;
c. Defining and recording risks;
d. Completion of the risk register;
e. Identifying mitigating actions;
f. Recording the Likelihood and Consequence of risks; and
g. Escalation, de-escalation and archiving of risks as appropriate.

Stage 1: Clarifying objectives

40. Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.

41. In order to clarify:

    a. Strategic (Corporate) Objectives - determine which Trust Strategic Objective(s) is relevant to the Directorate, Division or Service area.

    b. Local Objectives – determine objectives that are only relevant to the Directorate, Division or Service area.

Stage 2: Identifying risks to objectives

42. Once the objectives are clarified, risks are more easily identified.

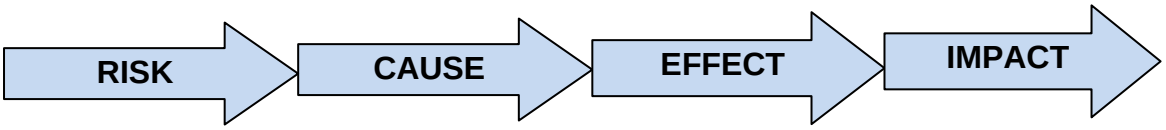
43. Where appropriate, working collaboratively with colleagues, with consideration of the following suggested questions. This enables stakeholders to more accurately identify risk:
    a. What are the risks which may prevent the delivery of your objectives?
    b. What risks have an impact on the delivery of high quality, safe care?
    c. What could happen or what could go wrong?
    d. How and why could this happen?
    e. What must we do to enable continued success in achieving objectives?
    f. Who else might provide a different perspective on your risks?
    g. Is it an operational risk or a risk to a strategic objective?

Stage 3: Describing Risk and Assigning Controls

44. Risks are described in a clear, concise and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

45. When wording the risk, it is helpful to think about it in four parts. For example:
    "There is a risk that….. This is caused by ….. and would result in…. leading to an impact upon ……."

46. The Trust's standard for recording risks is to define risks in relation to:



    a. A **Risk** is described as something uncertain that may happen and could prevent us from meeting our objectives.
    b. The **Cause** is the problem or issue that 'could' cause the risk to happen.
    c. The **Effect** is the result of something that will happen if we do nothing about the risk
    d. The **Impact** is the wider impact of the risk on the objectives if we do nothing.

47. An example of describing risk in the Trust standard is detailed in table 1 below:

Objective:	To ensure safe staffing levels
Risk:	Risk of failure to maintain safe staffing levels
Cause:	• High staff sickness rate • Difficulties in recruiting clinical staff
Effect:	Staff not receiving mandatory training in resuscitation or blood safety
Impact:	Increased safety risk to patient

48. **Key Controls** are identified and put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does. Where a gap in control has been identified you must ensure that actions to address this are identified. Each action must have an owner (i.e., a named individual, responsible for the action) and target completion date.

49. Key controls must describe the practical steps that are being taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

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

    a. **Tolerate** – the likelihood and consequence of a particular risk happening is accepted;
    b. **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
    c. **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
    d. **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity; or
    e. **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit.

51. 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:

    a. Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.

    b. When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

52. Contingency Plans – if a risk has already occurred and cannot be prevented *or* if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the register. Good risk management is about being risk aware and able to handle the risk, not risk averse.

53. All risks and controls are to be described in accordance to the Trust standard and recorded in the risk register following assessment.

Stage 4: Completing the Risk Register

54. Trust Risk Registers are web based and stored electronically. It is a transparent system to enable users to share learning. ~~All staff with permissions to access risk registers are able to see risks for the whole organisation but can update only those risks associated with their areas.~~ Confidential risks are restricted to those staff with appropriate authority.
55. The process for completing risk registers

- Number (automatically assigned)
- Assign risk level
- Date identified
- Directorate/Care Network
- Board Assurance Framework (BAF) Risk link (only for corporate level risks)
- Risk type
- Risk source
- Risk description
- Nominated executive lead
- Assessor
- Manager/owner of the risk
- Initial risk assessment (rate the **likelihood** of the risk materialising against the **consequence** of the risk happening without controls in place)
- Identify and list controls
- Controls effectiveness
- Residual risk rating (following the implementation of controls)
- Actions (with responsible person and following SMART principles (see paragraph 58)~~target date~~)
- Review of risk frequency
- Reviews (when a review is undertaken and why – for audit purposes)

56. Headings in the register that need to be completed are:

a. **Risk Manager/Owner** is 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 or the Assessor. High severity corporate risks, for example, will be owned by one Executive Director (nominated executive lead), but there may be many Action Owners. However, the system only allows for one action owner to be identified. This must therefore be the primary individual. The Risk Owner must know, or be informed, that they are the owner, and accept this.

b. **Source** of how or where the risk was identified. This could include:

i. Business planning
ii. Audit (can be internal, external, clinical)
iii. Complaints
iv. External Review

v. Incident
vi. Legislation
vii. Litigation
viii. NICE guidance
ix. Regulatory standard
x. Risk Assessment

c. **Initial Risk Rating** and **Residual Risk Rating** **(also known as current risk score)** – when identifying a risk the initial risk rating should be stated (the severity and likelihood of the risk occurring without any controls in place) followed by the residual risk rating (the severity and likelihood of the risk occurring with controls in place). Each time the register is reviewed or the risk score is updated, this must be recorded in the review section. This is so the history and progress of a risk can be reviewed. The Trust's guidance on the matrix and advice on scoring in contained in Appendix 4.

d. **Review Date** should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

57. It is crucial that attention is paid to the quality of information inputted onto the risk register. Staff must be mindful of the Trust's Data & Information Quality Management Policy and must ensure that information is complete, accurate, relevant, accessible and timely. In addition, it is equally important that information is up-to-date and reflects the current risk situation. In the event that information is found to be inaccurate, remedial action must be taken by the risk owner immediately.

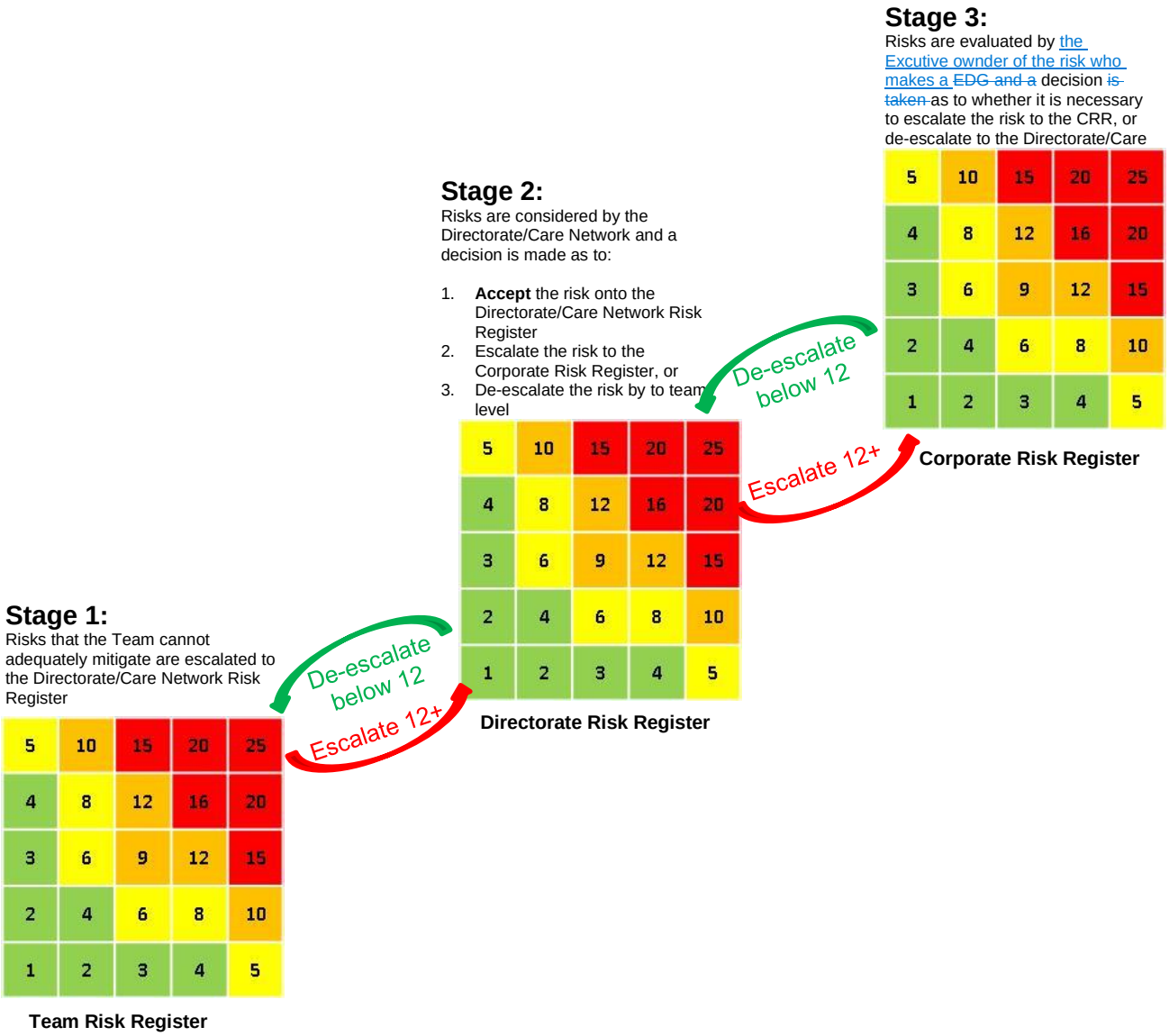
~~57.~~58. When including actions, it is essential that these are assigned to an individual who is able to take responsibility for them, and that they follow SMART principles. This means actions should be **specific** rather than general, should be **measurable** to enable assurance to be provided upon their completion, should be **achievable** from the outset so any exception reporting is meaningful, should be **relevant** to managing the risk to which they have been applied, and should be **time-based** – meaning they should set a clear deadline by which they will be completed.

Stage 5: Escalation and De-escalation of Risks

~~58.~~59. The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Team Risk Register to a Directorate/Care Network Risk Register, or from the Directorate/Care Network Risk Register to the Corporate Risk Register. Corporate risks are ~~The latter is~~ reviewed by ~~the Executive Director's Group, Audit & Risk Committee, Finance & Investment Performance Committee, Quality Assurance Committee, People~~~~Workforce & OD Committee~~Board Committees~~,~~ and finally the Board.

~~59.~~60. Risks will be escalated or de-escalated within the defined tolerances. Further guidance is contained in the Risk Management Handbook.

Escalating and De-escalating Risks



60. ~~Wherever possible, t~~The risk owner should discuss and seek approval from their manager before risk escalation to the next level. All risks that are rated 12 or above ***must*** be escalated for consideration onto the next level risk register. ~~However, this does not preclude risks below 12 being escalated.~~

61. An escalated risk will then be reviewed in the appropriate governance meeting and either accepted at the next level or rejected and returned to the management team to review and rescore, or for further action (for clinical team risks, this will be in the Patient Safety meeting. For corporate risks, the director will determine whether a team risk should be escalated to directorate level and the executive director will determine whether a risk should be included on the corporate risk register; however, it should be noted that some corporate services only have directorate level risks). ~~—~~Within clinical operations there must be a clear a transparent process for identifying who will be responsible for ensuring an escalated team risk is added to the care network risk register. Once on the risk register, the Senior Operational Manager under whom the risk sits is responsible for updating the risk on a monthly basis or according to the review frequency. When considering clinical care network directorate level risks for escalation onto the corporate risk register, this should be discussed and the decision recorded in

the appropriate clinical network governance meeting and approval sought from the executive director owner of the risk.

62. 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 high) at Directorate level will be re-evaluated and may not be rated at 25 at Corporate level.

63. Once controls are in place and actions completed and the residual risk rating is revised below 12, it should~~will~~ be de-escalated for local management and oversight. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate governance meeting to ensure that the risk continues to be contained and mitigated. In some instances it may be necessary to re-escalate the risk at a later date.

64. It is important that risks are reviewed regularly to ensure actions and controls reflect the current situation, to ensure actions are updated and timescales adhered to and to close a risk or action where necessary.

65. Risk registers at Directorate/Care Network level are reviewed by the Senior Management Team in the relevant Directorate Governance Meetings on a **monthly** basis to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. 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. It is essential that there is an adequate record of discussions and decisions taken in relation to risk in the minutes of the meeting.

Department/Team/Service Risk Registers

Individual teams, departments and services hold their own risk registers to evidence that consideration has been given to risks. In addition to a risk register, individual teams will complete generic risk assessments for risks such as lone working, manual handling, fire safety, environmental risks etc. Where risk cannot be managed by the application of local policies and standard operating procedures they should be entered on the risk register where teams are responsible for implementing any required actions to mitigate, control or remove the risk. Where risk ratings reach 12 or above, they ***must*** be escalated to the appropriate directorate/care network risk register, for consideration and identification of further actions. Local risk registers should be reviewed monthly in line with the Trust's governance framework.

Directorate/Care Network Risk Registers

Each directorate/care network will be responsible for holding their own risk register, and the continual review, monitoring and updating of that risk register through the directorate's local governance structure and Trust's agreed governance framework. Key directorate risks are ~~They are~~ also reviewed as part of the service review process undertaken with Executive Directors every six months~~ to ensure that they are live, effective and contemporaneous~~. Where a residual risk is assessed as or above 12, this will be escalated onto the Corporate Risk Register, via the escalation process detailed in paragraphs 5~~7~~6-6~~0~~4 above.

Corporate Risk Register

Risks which have a residual risk rating of 12 or above, or risks that impact on several or

all directorates/care networks are considered for inclusion onto the ~~by the Executive Director's Group for inclusion onto the~~ Corporate Risk Register ~~on a monthly basis~~. The risk should be discussed with the executive director own who will make the decision as to whether to escalate the risk to corporate level. This decision and its date should be recorded within the risk. The corporate risk register~~This process~~ is managed by the Director of Corporate Governance (Board Secretary). Individual risks within it ~~These risks~~ are managed by the individual directorate(s)/care networks with accountable individuals responsible for their review. They are monitored through the appropriate operational governance group.

~~The Executive Directors Group is responsible for reviewing all corporate risks and allocating responsibility to an executive lead and the relevant Board Committee. EDG is also responsible for identifying when a corporate risk reaches a level that compromises any of the Trust's strategic objectives and should therefore be escalated to the Board Assurance Framework.~~

The Corporate Risk Register is reviewed ~~quarterly by~~at every Board meeting. ~~and monthly by EDG.~~ Board committees review their risks on a quarterly basis to ensure they are fully aware of the high level risks within the Trust and can provide assurance on the robust processes/controls in place to manage them. If committees have any concerns about the progress made to mitigate risks this should be escalated to Board via their significant issues report. Committees should also consider whether papers brought before it provide any further mitigate to risks or indeed bring into question the mitigation being provided for risks. Committee and the Board should also consider when a corporate risk reaches a level that compromises any of the Trust's strategic objectives and should therefore be escalated to the Board Assurance Framework.

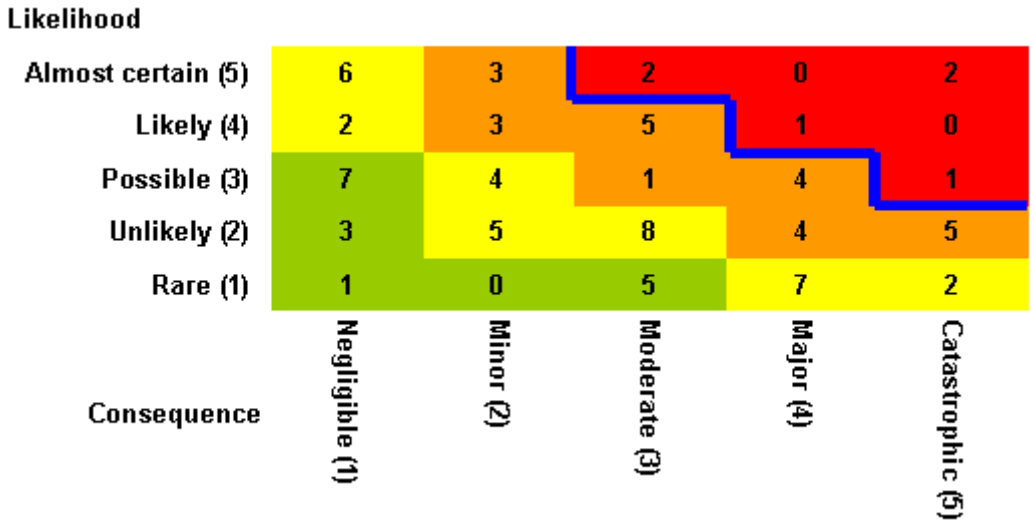
Risk Review

66. Individual risks should be reviewed in line with their residual risk rating. Those entering risks on the risk register are responsible for ensuring they attribute the correct risk review to their risk. This is not done automatically.

Response Required		**Frequency**
Score		
1-6	Remains on local risk register for monitoring to the point where it has been sufficiently managed whereupon it should be removed	~~Six monthly~~Quarterly
8-10	Remains on local risk register with local level actions identified to reduce the risk as low as is reasonably practicable.	~~Quarterly~~Monthly
12+	Actions must be identified and risks escalated for consideration onto the next level risk register.	Monthly

Risk Profile

67. A summary 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 considered. The risk profile can be shown (as below) according to residual risk rating or can be shown according to



risk type.

Example risk profile diagram

Project and Programme Risk

68. 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 registers or logs will still be maintained for risks to programmes or projects as part of project documentation.

69. Project and programme opportunities and threats are generally identified:

a. Through the escalation of risks from projects within the programme;
b. During project or programme start up;
c. By other projects or programmes with dependencies or interdependencies with this project or programme;
d. 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:

e. Identify the owners of a programme and individual projects within the programme;
f. Identify any additional benefits of adopting risk management within this project or programme;
g. Identify the nature and level of risk acceptable within the programme and associated projects;
h. 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;
i. Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects;
j. Identify how inter-project dependencies will be monitored and managed;
k. Clarify relationships with associated strategies, policies, and guidelines;
l. Have clear processes for escalating programme risks to the Corporate Risk Register or Board Assurance Framework

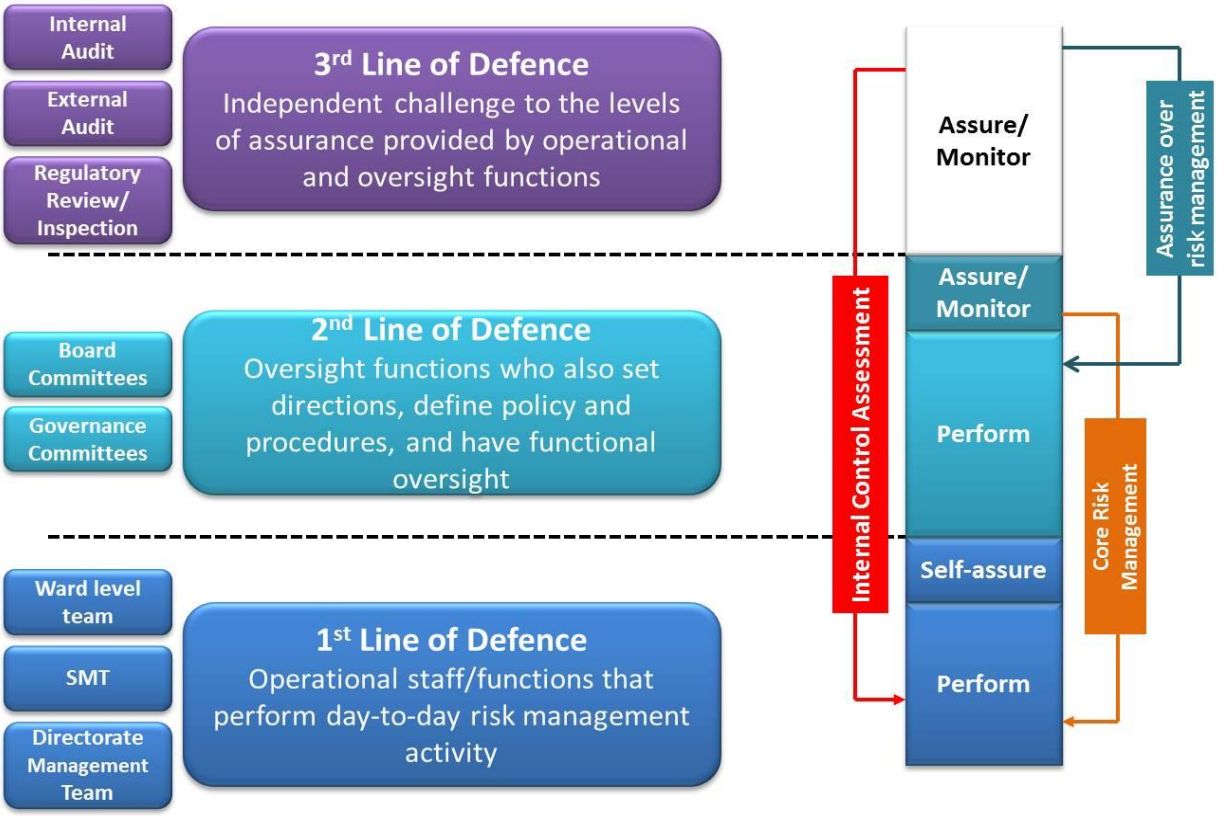
70. Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

71. 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 description column of the risk register as part of the impact description. The cost of mitigating the risk should also be recorded in the 'Key controls and Contingency Plans' column, if this can be determined. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

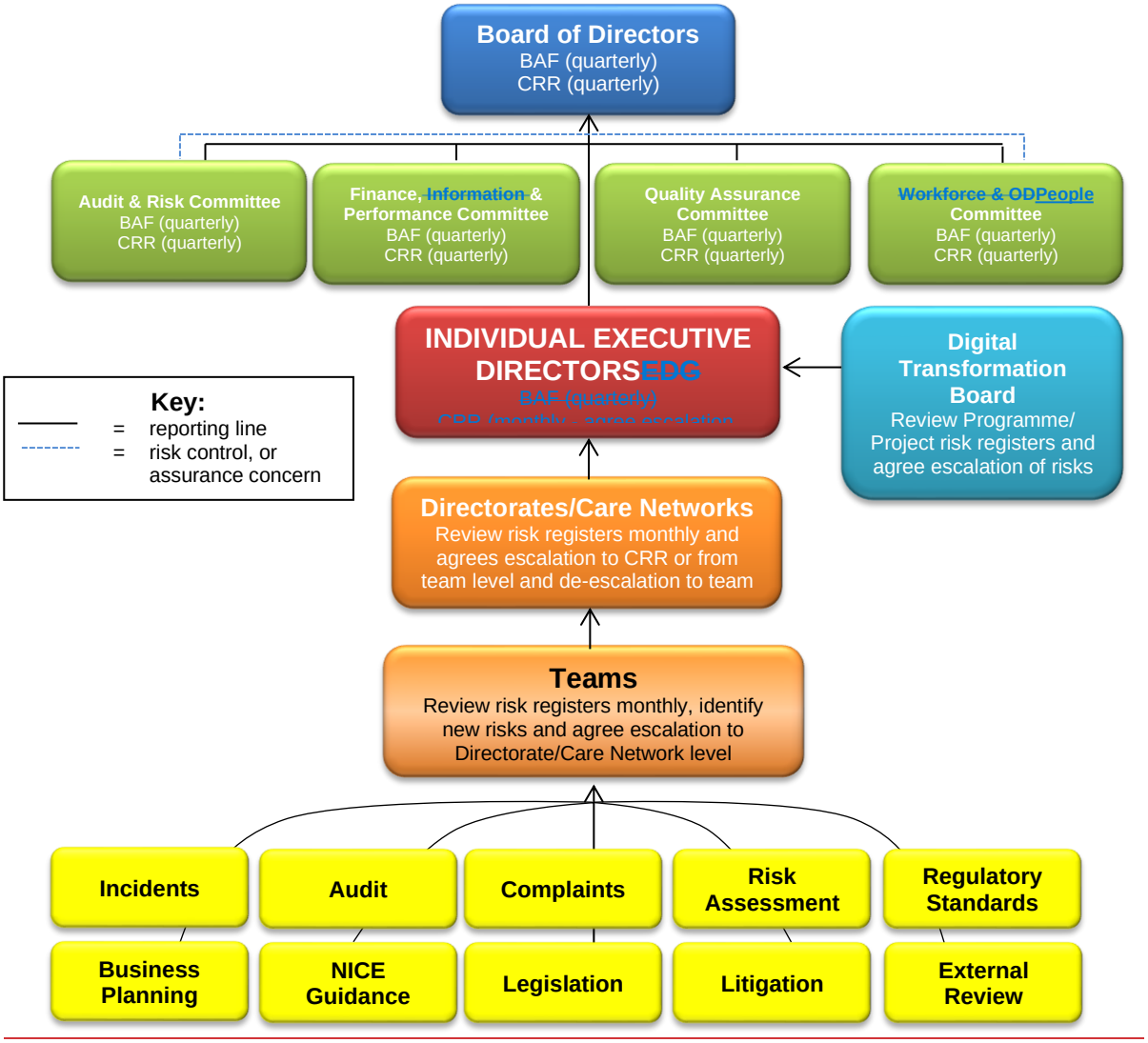
Risk Management and Assurance

72. Assurance is provided through transparent, timely and objective risk reporting. High quality and accurate risk management information helps to ensure that senior management is fully aware of material risks to which the organisation is exposed.

73. Appropriate internal control processes to manage risk can be demonstrated through the 3 lines of defence model.



~~Governance Structure~~



74. The Trust's governance structure identifies the relevant Committees and their relationship to the Board. Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by ~~the following~~ Committees and ~~management~~ their reporting groups (further detailed in Appendix 5):

~~a. Board of Directors~~
~~b. Audit & Risk Committee~~
~~c. Finance, Information & Performance Committee (FIPC)~~
~~d. Quality Assurance Committee (QAC)~~
~~e. Workforce and Organisational Development People Committee (PWODC)~~
~~f. Executive Director's Group (EDG)~~
~~g. Digital Transformation Board (DTB)~~
~~h. Directorate Governance Committees~~

75. Additionally the Audit & Risk Committee and other Board Committees ~~(FIPC, QAC and WODPC)~~ exist to provide assurance of the robustness of risk processes and to support the Board of Directors.

76. Each Directorate/Care Network and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.

77. Risks are correspondingly monitored at operational level (ward, team, service) through the appropriate governance team meetings.

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

    a. The **Board Assurance Framework** (BAF) identifies risks in relation to each of the Trust's strategic objectives along with the controls in place and assurances available on their operation. Board agendas are structured to ensure appropriate discussion and assurance that risks which may result in non-achievement of Trust objectives are appropriately mitigated. The BAF is reviewed by risk owners and quality assured by Executive Directors prior to presentation to Board and its committees on a quarterly basis. The BAF is also refreshed annually by the Board to reflect any risk to achieving operational priorities.

    b. The **Corporate Risk Register (CRR)** is a high level risk register (risks rated 12 and above at directorate/care network level) used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust. The CRR is reviewed monthly by risk owners and quality assured by Executive Director owners of each risk ~~s~~ who determine whether risks should be escalated onto the CRR or de-escalated back down to directorate/care network level or closed.~~prior to a monthly presentation to the Executive Directors Group which includes risks escalated from clinical and corporate directorates to be considered for inclusion onto the CRR. It is at this stage that Executives will identify whether a risk has escalated to such a stage as to compromise strategic objectives and is therefore required to be included on the Board Assurance Framework.~~ The CRR is presented quarterly to the Board and its committees for oversight and assurance purposes.

    c. 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.

	Board Assurance Framework	Corporate Risk Register	Directorate/Care Network Risk Registers	Team Risk Registers
Risk Type	Risks to the organisation's strategic objectives	High level risks in the context of operational objectives	Broad range of operational risks	Risks specific to teams/services
Risk Owner	**Key focus**: Board of Directors. Risks managed by the executive team.	**Key focus:** Executive Directors. Risks managed by executive/ senior management.	**Key focus**: senior management. Risks managed by heads of service/ department.	**Key focus:** Senior Operational Managers. Risks managed by team/service managers.

	Board Assurance Framework	Corporate Risk Register	Directorate/Care Network Risk Registers	Team Risk Registers
How risks are identified	Risks identified by the board and executives or escalated from the corporate risk register.	Risks identified through escalation from departmental risk registers and by senior management.	Risks identified through documented risk assessments and may be linked to incidents, audits, external assessments or other qualitative information.	Risks identified by team/service managers.
Coverage	**Includes:** Objectives, residual risk score, target risk score, controls (to mitigate the risk), gaps in control, assurances, gaps in assurances, action plan.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks deemed to impact upon the achievement of strategic objectives should be escalated to the assurance framework.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk strategy) should be escalated to the corporate risk register.	**Includes:** Details of the risk, initial risk score, residual risk score, controls and mitigation/action plan. Risks scored 12 or over (as per risk strategy) should be escalated to the directorate/care network risk register.

Risk Oversight Group

79. The Risk Oversight Group reports into the Audit and Risk Committee and has responsibility for supporting the effective implementation of the Risk Management Strategy across the organisation.

80. The group's responsibilites include, but are not limited to, reviewing risks and registers, requiring reports or information from employees demonstrating compliance with the Risk Management Strategy, developing proposals for future changes to the management of risk, and providing assurance or identifying assurance gaps in upward reporting to the Assurance and Risk Committee.

81. The group's establishment is concurrent to the development of this Risk Management Strategy. The final terms of reference will be appended to this strategy.

Horizon Scanning

~~79.~~82. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably 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.

~~80.~~83. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

~~81.~~84. 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:

i. Legislation;
ii. Government white papers;
iii. Government consultations;
iv. Socio-economic trends;
v. Trends in public attitude towards health;
vi. International developments;
vii. Department of Health and regulatory body publications;
viii. Local demographics; and
ix. Seeking stakeholder's views.

~~82.~~85. 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.

~~83.~~86. Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

Training

~~84.~~87. Staff learning and development is critical to safety at work and safe working practices. All staff are expected to have a certain level of understanding of safety and risk management as determined by their job role.

~~85.~~88. Health and social care professionals will also be expected to meet core competencies with regard to service user safety, safe practice and risk assessment and management as part of their training and in their continuing professional development requirements.

89. Clinical risk assessment and management training, including familiarisation with the DRAM, is provided to staff in line with the Trust's Training Needs Analysis, incorporated within the Trust's Mandatory Training Policy. This training is required to be updated at least every three years (Best Practice in Managing Risk, DH 2007).

90. This Risk Management Strategy has been reviewed following a period of improvement for the organisation and when the management of risk moving forward becomes even more important. Systematic training will be introduced to ensure those identifying risks, those managing risks and those owning and responsible for risks are equipped with the knowledge needed to do so effectively and in compliance with this strategy.

~~86. Want to put something in here about the new foundation course for managers and supervisors, but this isn't in place yet and I'm not sure if there's something else in the pipeline regarding risk management~~

Monitoring Compliance

91. The Risk Management Strategy is subject to Annual Review prior to presentation to Board.

Item monitored	Monitoring Method	Responsibility for monitoring	Frequency of Monitoring	Group or Committee
Risk Management Strategy	Review	Director of Corporate Governance (Board Secretary)	Annual or 3 yearly depending on circumstances	~~EDG,~~ Audit & Risk Committee & Board
Annual Governance Statement	Internal/ External Audit	Director of Corporate Governance (Board Secretary)	Annual	Audit & Risk Committee
Risk Management Process	Internal Audit	Director of Corporate Governance (Board Secretary) and Directorates	Annual	~~EDG and~~ Audit & Risk Committee

92. The Risk Oversight Group, referred to separately in this document, will provide focused ongoing review of the organisation's risk arrangements to ensure they are fit for purpose and prior to consideration at the stages detailed in the table above.

93. In addition, the Performance Framework includes review of risks at team, directorate and corporate level in a setting which is service-focused. Feedback is provided on risks in performance meetings and fed back to teams thereafter by the Executive Director of Finance, IMST and Performance or their nominee.

~~Strategy Review~~

~~87. This strategy will be reviewed every three years or sooner if circumstances dictate.~~

References

~~88.~~94. The references relating to this strategy are:

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- NHS Audit & Risk Committee Handbook, Department of Health (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- HFMA – NHS Governance 2017

Equality Impact Assessment

~~89.~~95. As part of its development; this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

Appendix 1: Categories of Risks

Risk Domain	Description
Safety	The risk has the potential to impact upon the safety of patients, staff or public. The harm may be physical or psychological. The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and carers and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in partnership with each other, patients and carers to minimise risk to the greatest extent possible and promote patient well-being.
Quality	The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks. The risk is delivering a poorer quality of service. The risk may manifest itself in increased complaints or poor audit results.
Workforce	The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, operational, financial etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses. Risks to workforce are associated with human resources, organisational development, staffing issues or competence and training issues.
Statutory	Risk of non-compliance with a statutory duty or other regulatory / compliance frameworks or inspections e.g. NHS Improvement, Care Quality Commission, Health and Safety Executive, HM Coroner, individual data and data protection.
Reputational	The Trust models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with

Risk Domain	Description
	partner organisations and statutory bodies to horizon scan and be attentive and responsive to change. Risks of damaging/adverse publicity that threatens the confidence of the general public in our services.
Business	The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Strategy and Strategic Planning Framework, whilst respecting and abiding by its statutory obligations. Risks in this domain relate to the threat to our business or delivery of projects.
Finance	Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wider range of risk areas to ensure safety and quality is maintained. Risk to our financial stability including failure to make planned savings, reductions in income or excessive legal claims.
Environmental	Environmental risks that may result in service / business disruption (e.g. extreme weather, loss of water, loss of power) or threat to the environment from our activities (e.g. chemical spills, clinical waste).

Appendix 2: Definitions

Key term	Definition
Annual Governance Statement	Provides assurance that the Trust has a generally sound system of internal control that supports achievement of policies, aims and objectives and provides details of any significant internal control issues.
Assurance	Evidence that control measures are working effectively to manage risk. This can be internal (eg. workplace review, scrutiny by a committee or the board) or external (eg. Audit by external body). Assurance can be positive (providing evidence that controls are achieve the desired outcome) or negative (provide no such assurance and perhaps indicating the need for further action).
Board Assurance Framework (BAF)	A dynamic board-level summary identifying which of the Trust's strategic objectives are at risk because of inadequacies in the operation of controls of where the Trust has insufficient assurance that controls are effective. It also provides a summary of action being taken to address inadequate controls. It also records structured, positive assurances about where principal risks are being managed effectively and objectives are being delivered.
Clinical Risk	Any clinical activity which could have a direct effect on patient may include the lack of availability of services, supervision and competency of staff or adherence to Trust policies.
Control(s)	A measure in place to manage risk and assist in security the delivery of objectives. Controls are designed to make a risk less likely to happen or reduce its effect if it does happen. The controls recorded on the BAF should focus on the key strategic controls that help the Trust to manage principal risks and secure delivery of organisational objectives. The risk register may document additional controls in more detail, along with actions to address perceived gaps, as it serves as an action planning tool to manage risk, rather than a board level summary.
Corporate Risk Register (CRR)	A log of all high level risks that may threaten the achievement of the Trust's objectives. It is a dynamic document which is populated through the organisation's risk assessment and evaluation process. It enables risks to be quantified and ranked and provides a structure for collating information about risks.
Financial Business Risk	May include financial restraints, losses, irregularities or lost opportunities to deliver financial gain which may affect the Trust's ability to resource the services it provides.
Financial Impact	Where appropriate, risk should be assessed for their financial impact which is the cost the Trust accepts in order to achieve adequate management of the risk and should be considered alongside the maximum cost the Trust is willing to tolerate by way of losses if the risk were to materialise. It is acknowledged that not all risks are easily assessed in terms of their financial impact.

Key term	Definition
Health & Safety Risk	May include fire safety, security, buildings, plant and machinery, unsafe systems of work, failure to comply with health and safety legislation.
Internal Control	A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.
Inherent Risk	The level of risk before any control activities are applied.
Impact	The potential consequence if the adverse effect occurs as a result of the hazard.
Likelihood	The change or possibility of something happening.
Operational Risk	Results from day to day running of the Trust and includes a broad range of risks including clinical, financial, health and safety, information governance. These are usually managed by the service line in which they are identified.
Organisational Risk	Any activity which could have a detrimental effect on the day to day performance of the Trust and the services it provides. This may include the recruitment of staff, training and education, finance and information system, confidentiality and communication.
Principal Risk	Any risk that prevent the achievement of one or more of the Trust's strategic objectives as recorded in the BAF. Principal risks must be approved/removed by the Board. They may also be recorded on the CRR.
Residual Risk	The current risk "left over" after controls, actions or contingency plans have been put in place.
Risk	The change of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality care.
Risk Appetite	The level of risk the Trust is prepared to accept, tolerate or be exposed to at any point in time.
Risk Capacity	Maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in: • identifying, assessing and judging risks; • assigning ownership; • taking actions to mitigate and anticipate them; and • monitoring and reviewing progress.
Risk Owner	The individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation to risk (or a given level of the organisation).

Key term	Definition
Risk Rating	The total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

Appendix 3: Roles and Responsibilities

Title	Responsibilities
Chief Executive	The Chief Executive is the responsible officer for Sheffield Health and Social Care 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.
Executive Directors ~~of Nursing & Professions & Chief Operating Officer~~ ~~Deputy Chief Executive~~ ~~Executive Director of Operations~~	The Executive Directors have responsibility for overall strategic risk management within their portfolio area of responsibility. Executive Directors are expected to be able to speak about risks included on the Corporate Risk Register or Board Assurance Framework, and will be informed of new or emerging risks on other registers as appropriate by their direct reports. ~~of Nursing & Professions/Chief Operating Offer has responsibility for nursing leadership, International health partnership, infection prevention and control, Professions lead, CQC core services, Equality and diversity, (service users and carers), Physical health including end of life~~ ~~The Executive Director of Operations has responsibility for all clinical operations, strategic planning and business development, social care and emergency planning., COVID/Emergency planning, Safeguarding adults and children~~
~~**Executive Director of Finance**~~	~~The Executive Director of Finance has responsibility for financial governance and associated financial risk, contracting, Estates and facilities, Sustainability, Information management and system technology (IMST), Senior information risk owner (SIRO), Performance and performance framework, Business planning, Strategy and transformation (including PMO~~IMST, facilities and performance management. ~~) and health and safety (including fire)~~
~~**Executive Medical Director**~~	~~The Executive Medical Director has responsibility for Quality governance and improvement (including care standards), service user and carer engagement, medicines management, research and development, Mental Health Act Legislation, medical leadership and management (including EDT), clinical strategy development, Caldicott guardian, Chief clinical~~

Title	Responsibilities
	information officerclinical governance and clinical risk, patient safety and patient experience, incident management, quality and compliance with care standards.
Executive Director of Nursing & Professions	The Executive Director of Nursing & Professions has responsibility for nursing, resuscitation, physical health, infection prevention and control, safeguarding children, safeguarding adults, Prevent and mental health legislation.
Executive Directors and Associate DirectorsThose reporting to Executive Directors	The Executive Directors and Associate Directors have responsibility for the management of strategic andThose reporting directly to Executive Directors have responsibility for 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. TheyExecutive and Associate Directors also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk. They are also responsible for ensuring Executive Directors are appropriately informed of new or emerging risks and must These senior staff are accountable for ensuring that appropriate and effective risk management processes are in place in their designated areas and that risks are identified, assessed and acted upon; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk registers; and ensuring that appropriate local and directorate governance groups review risk registers **at least monthly** as part of performance monitoring, to consider and plan actions being taken. They are accountable for ensuring that all staff are aware of the risks within their work environment, together with their personal responsibilities. They must ensure appropriate escalation of risks. from team or service to Directorate level or from directorate to corporate level within the defined tolerances. They have further responsibility for ensuring compliance with standards and the overall risk management system

Title	Responsibilities
	as outlined in this strategy and related documentation. They are responsible for ensuring that staff receive the relevant elements of risk management training and that non-attendance is followed up.
DDirector of Corporate Governance (Board Secretary)	The Director of Corporate Governance (Board Secretary) is accountable to the Chief Executive for the overall performance of corporate governance functions, including the risk management framework, monitoring and assurance of the system of internal control; including the system and supporting processes for risk registers and maintenance of the Board Assurance Framework and its supporting processes.
Director of Quality	The Director of Quality has responsibility for effective management of the electronic risk management system, clinical governance, patient safety, care standards and quality.
Director/Clinical Director of Operations & Transformation, Directors, Associate Directors, Associate Clinical Directors, Deputy Directors	These senior staff are accountable for ensuring that appropriate and effective risk management processes are in place in their designated areas and that risks are identified, assessed and acted upon; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk registers; and ensuring that appropriate local and directorate governance groups review risk registers **at least monthly** as part of performance monitoring, to consider and plan actions being taken. They are accountable for ensuring that all staff are aware of the risks within their work environment, together with their personal responsibilities. They must ensure appropriate escalation of risks from team or service to Directorate level or from directorate to corporate level within the defined tolerances. They have further responsibility for ensuring compliance

Title	Responsibilities
	~~with standards and the overall risk management system as outlined in this strategy and related documentation.~~ ~~They are responsible for ensuring that staff receive the relevant elements of risk management training and that non-attendance is followed up.~~
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 regularly and 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 the top risks. • Escalating risks from the front line. • Considering risks from a number of perspectives including financial, business continuity, environmental, strategy etc, not only from a service delivery perspective. • 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 managers are expected to be aware of and adhere to the risk management best practice to: • Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front line

Title	Responsibilities
	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 risks on a risk register • Check frequently on action progress, especially for high severity risks • Apply healthy critical challenge • Implement a process to escalate the most severe risks, and use it •
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 follow the Speaking Up: Whistleblowing Policy incorporating guidance on both whistleblowing and raising concerns.
Staff side represe~~n~~ntatives	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.

Appendix 4: Risk matrix and risk scoring guidance

Calculate the consequence and likelihood rating using the scales below.

Consequence						
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
		Rare	Unlikely	Possible	Likely	Almost Certain
		1	**2**	**3**	**4**	**5**
		Likelihood				

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

1-4	Very Low Risk
5-8	Low Risk
9-12	Moderate Risk
12+	High Risk

First, cross reference the likelihood and impact scores on the matrix above. For example, if you have a '*moderate*' consequence and '*almost certain'* likelihood then the overall risk rating would be:

Consequence x Likelihood = Overall risk rating

3 x 5 = 15

Moderate x Almost certain = High Risk

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements and any relevant publication can be used to inform a judgement.

Likelihood – consider how likely it is that the risk will occur

Likelihood Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency (general) 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
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability Will it happen or not?	<0.1%	0.1-1%	1-10%	10-50%	>50%

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. In some cases it may be more appropriate to assess the probability of a risk occurring, especially for specific areas of risk which are time limited.

Consequence – consider how severe the impact, or consequence, or the risk would be if it did materialise.

Consequence is the term given to the resulting loss, injury, disadvantage, or gain if a risk materialises. Remember – there are likely to be a range of outcomes for this event.

Note - Evaluating risk is an iterative process. Once you calculate the risk rating, it could lead to the conclusion that, for example, a particular risk seems to have too high a risk rating. In such cases the rating may need to be reviewed, checking the likelihood and/or consequence ratings.

Consequence Table

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
SAFETY Impact on the safety of patients, staff or public (physical/ psychological harm)	• Minimal injury requiring no/ minimal intervention or treatment. • No time off work • Incorrect medication dispensed but not taken • Incident resulting in a bruise/graze • Delay in routine transport for patient • Expected death • Missing patient (low risk)	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days • Wrong drug or dosage administered, with no adverse effects • Physical attack, such as pushing, shoving or pinching, causing minor injury • Self-harm resulting in minor injuries • Grade 1 pressure ulcer • Laceration, sprain, anxiety requiring occupational health counselling	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients • Wrong drug or dosage administered with potential adverse effects • Physical attack causing moderate injury	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects • Wrong drug or dosage administered with adverse effects • Physical attack resulting in serious injury • Grade 4 pressure ulcer • Long-term HCAI • Slip/fall resulting in injury such as dislocation/fracture / blow to the head • Post-traumatic	• Incident leading to death • Multiple permanent • injuries or irreversible health effects • An event which impacts on a large number of patients • Unexpected death • Suicide of a patient known to the service in the past 12 months • Homicide (or suspected homicide) committed by a mental health patient • Incident leading to paralysis • Incident leading to long-term mental health problem

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		(no time off work required) • Missing patient (medium risk)	• Self-harm requiring medical attention • Grade 2/3 pressure ulcer • Healthcare Acquired Infection (HCAI) • Incorrect or inadequate information/ communication on transfer of care • Vehicle carrying patient involved in a road traffic accident • Slip/fall resulting in injury such as a sprain • Missing patient (high risk)	stress disorder	• Rape/serious sexual assault • Loss of a limb
QUALITY Quality/Complaints/ Audit	• Peripheral element of treatment or service suboptimal • Informal complaint/ inquiry	• Overall treatment or service suboptimal • Formal complaint (stage 1) Local resolution • Single failure to	• Treatment or service has significantly reduced effectiveness • Formal complaint (stage 2)	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	complaint • Local resolution (with potential to go to independent review) • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on	complaints/ independent review • Low performance rating Critical report • Major complaint / claim	upon • Inquest/ ombudsman inquiry • Gross failure to meet national standards
WORKFORCE Human resources/ organisational development/staffing/ competence	• Short-term low staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff Very low staff morale No staff attending • mandatory/ key training	• Non-delivery of key objective/service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training /key training on an ongoing basis
STATUTORY Statutory duty /	• No or minimal impact or breach of guidance/	• Breach of statutory legislation	• Single breach in statutory duty • Challenging	• Enforcement action • Multiple breaches	• Multiple breaches in statutory duty • Prosecution

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
inspections	statutory duty	• Reduced performance rating if unresolved	external recommendations / improvement notice	in statutory duty • Improvement notices Low performance rating Critical report	• Complete systems change required • Zero performance rating Severely critical report
REPUTATIONAL Adverse publicity/ reputation	• Rumours • Potential for public concern	• Local media coverage • short-term reduction in public confidence • Elements of public expectation not being met	• Local media coverage – • long-term reduction in public confidence	• National media coverage with <3 days service well below reasonable public expectation	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Total loss of public confidence
BUSINESS Business objectives/projects	• Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage Key objectives not met
FINANCE Finance including claims	• Small loss Risk of claim remote	• Loss of 0.1–0.25 per cent of budget • Claim less than £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and	• Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	• Non-delivery of key objective/ Loss of >1 per cent of budget • Failure to meet

			CONSEQUENCE		
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		• Vandalism / theft <£10k • Cosmetic damage to premises	£100,000 • Vandalism / theft £10-50k	• Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time • Vandalism / theft £50k - £100k	specification/ slippage • Loss of contract / payment by results • Claim(s) >£1 million • Vandalism / theft over £100k
ENVIRONMENTAL Service/business interruption Environmental impact	• Loss/interruption of >1 hour • Minimal or no impact on the environment	• Loss/interruption >8 hours • Minor impact on environment • Cosmetic damage to premises	• Loss/interruption of >1 day • Moderate impact on environment • Structural damage to premises	• Loss/interruption of > 1 week • Major impact on environment • Permanent irreparable damages to premises/damage up to £100k	• Permanent loss of service or facility • Catastrophic impact on the environment • Serious fire • Permanent/ irreparable damage to premises/damage over £100k

Appendix 5: Committees and Governance Structures

Committee	Responsibilities
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 Board will receive and scrutinise the Board Assurance Framework ~~quarterly and the Corporate Risk Register bi-monthly~~at all its scheduled public meetings (bi-monthly). **Non-Executive Directors:** the role of Non-Executive Directors in the Board and as Chairs of Board Committees is that of oversight and challenge to ensure that internal systems of control and the process for management of risk is effective and fit for purpose.
Audit & Risk Committee	The Audit & Risk Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review 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 corporate risk register on a quarterly basis. • To monitor and review 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.
Finance , ~~Information~~ and Performance Committee	The Finance~~, Information~~ & Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and

Committee	Responsibilities
	operational 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 & Risk Committee or the Board as appropriate.
Quality Assurance Committee	The Quality Assurance 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, 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 & Risk Committee or the Board as appropriate.
~~Workforce and Organisation Development~~People Committee	The ~~Workforce and Organisation Development~~People Committee is responsible for providing information and making recommendations to the Trust Board on workforce and organizational development 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 & Risk Committee or the Board as appropriate.
~~Executive Directors Group~~	~~The Executive Directors Groups (EDG) is in its role as the Executive decision making group of the Trust maintains oversight of strategic and operational risks. Risk is monitored through the Corporate Risk Register and Board Assurance Framework. EDG is also responsible for agreeing resourced risk treatment plans and ensuring their delivery.~~
Risk Oversight Group	The Risk Oversight Group monitors compliance with the Risk Management Strategy, reports assurance or gaps in assurance to the Audit and Risk Committee and makes recommendations on future improvements to the risk arrangements within the organisation.

Committee	Responsibilities
Digital Transformation Board	The digital transformation board oversees three portfolios: clinical systems, business systems and infrastructure and the projects and programmes underneath them. ~~The board attendance includes the executive medical and financial directors and the deputy chief executive.~~ The group manages risks and issues that have been escalated from the strategy groups that report into them and makes strategic decisions regarding digital products
~~Directorate, Service, Clinical and Corporate Directors / Manager~~	~~Directorate, Service, Clinical and Corporate Directors / Managers, are responsible for the risks to their services and for putting in place appropriate arrangements for the identification and management of risks. They will develop, populate and review their risks, drawing on risk processes within the services, to ensure that relevant Risk Registers are kept up to date through regular review.~~ ~~They and their 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.~~