journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Organisational Risk Management Policy

Ref: CORP-0066-v3

Status: Ratified
Document Type: Policy

The formally approved version of this document is that held on Tees, Esk and Wear Valleys NHS Foundation Trust website and intranet.

Printed copies or those saved electronically must be checked to ensure they match the current online version.

Contents

1 Introduction

Tees Esk and Wear Valleys NHS Foundation Trust's (the Trust) Board of Directors is committed to ensure that the needs of patients, staff, volunteers, carers, contractors and visitors are taken seriously at every level of the organisation to provide open and transparent risk management systems to ensure that the Trust meets its principal objectives for safe, sustainable, high-quality care.

The Trust Journey to Change sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to within our business plan.

The three goals are:

1 To co-create a great experience for our patients, carers and families.
2 To co-create a great experience for our colleagues.
3 To be a great partner.

The most important way we will achieve our goals is by living our values of respect, compassion, and responsibility, all the time.

Risk management involves the identification, assessment and control of risk.

Having a robust risk management system is essential in identifying where we need to focus our attention and keep on track to achieving our goals. The Trust supports a dynamic and proactive approach to risk management, identifying and managing potential threats and hazards before adverse events occur. Every risk identified and associated assessment carried out is seen as an opportunity to improve quality.

This Policy will support the delivery of our risk management strategy objectives by outlining how we will continue to embed risk management processes to support the organisation to achieve its strategic goals and will help drive risk management, integrating it within the culture and values of the organisation.

Our overall mission is to improve the quality of risk management processes to support the organisation to achieve its overall goals.

Risks arising are inherent in all Trust activities, for example, treating patients, determining service priority, project management, record keeping, communications, staffing, service design, and setting strategies. Risk is also associated with not taking any action at all. In pursuance of our three big goals, we have a low appetite for quality and safety and regulatory risk exposure that could result in harm to patients, the public, or staff. We are willing to accept risks that may result in some financial loss or exposure to address quality, safety or cyber security concerns.

2 Why we need this policy

2.1 Purpose

This Policy supports the Trusts Risk Management Strategy to outline the Trusts internal arrangements for our integrated approach to the assessment, reporting and management of risk. It sets out responsibilities, strategic systems and processes for management, to promote the delivery of high quality, safe, accountable healthcare, to minimise risk to patients, staff and the organisation and to maximise available resources.

2.2 Objectives

This Policy will support the strategy to achieve our overall mission 'to improve the quality of risk management processes to support the organisation to achieve its overall goals'. This will be achieved by delivering the following outcome-based objectives;

- Greater devolution of decision making and accountability for management of risk from Trust board to point of delivery (Board to Ward).
- Decision making well informed and risk-based, maximising the likelihood of achieving key strategic objectives and effective prioritisation of resources.
- Increased risk culture of monitoring and improvement, which ensure risks to the delivery of Trust strategic goals are identified and addressed.
- Improved open reporting culture to enable early learning from safety incidents and improvements in safety.
- Improved processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.
- Reduction of risks to service delivery and improved service provision to support service users, carers and stakeholders.
- To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.
- Increase in organisational resilience.

3 Scope

This policy is a Trust-wide document, it aligns to the Trust's values of Respect, Compassion and Responsibility, it aims to support the delivery of the Trust's Vision and Strategy articulated in Our Journey to Change and it applies equally to all members of staff, either permanent or temporary and to those working within, or for, the Trust under contracted services.

3.1 Culture

The Trust aims to embed an effective risk culture through the deployment of the Risk Management Policy to ensure individual staff and groups are able to take the right informed decision in line with Trust values and goals, embedding a risk culture in thinking, behaviours and actions around risk and risk management.

3.2 Accountability, Duties and Responsibilities

3.2.1 Organisational

The Board, with the support of its committees, have a key role in ensuring a robust risk management system is effectively maintained and to lead on a culture whereby risk management is embedded across the Trust through its strategy and plans, setting out its appetite and priorities in respect of the mitigation of risk when delivering a safe high-quality service.

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
Board of Directors	Responsible for ensuring the Trust has effective systems for managing risk.	Chief Executive	Corporate Risk Register summary At least 3 times per annum	Board Assurance Framework (BAF) At least 3 times per annum
Committees of the Board	Each Committee of the Board tests evidence and assurance relating to its duties and scope; and:	Director of Nursing and Governance (Quality Assurance Committee)	Quality and Safety Corporate risks at viewed at least 3 times per annum	BAF quality and patient safety risks reviewed at least 3 times per annum
	• Reviews the management of the Board Assurance Framework/ Corporate Risk Register and the groups top risks to ensure that the board of directors receive	Director of Finance (Strategy and Resources Committee) Director of People and Culture	Finance, investment, estates, IT/Digital Corporate risks at least 3 times per annum People and culture corporate risks at	BAF finance, investment, estates, IT/Digital risks at least 3 times per annum BAF people and culture risks at least 3 times per annum

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
	assurance that effective controls are in place to manage corporate risks. • Reports to the board of directors on any significant risk management and assurance issues	(People, Culture and Diversity Committee) Medical Director (Mental Health Legislation Committee)	least 3 times per annum Mental health legislation corporate risks at least 3 times per annum	BAF Mental Health legislation risks at least 3 times per annum
Audit and Risk Committee	Oversees the risk management system, obtaining assurances that there is an effective system operating across the Trust. Reviews and tests the establishment and maintenance of an effective system of internal control and risk management. This process is underpinned by the internal audit function, which provides an opinion on compliance with standards.			
Executive Directors Meeting	Receive updates from Managing Directors on the Care Group's operational issues, including any risks and mitigations in place. Review the Board Assurance Framework.	CEO (Chair)		BAF at least 3 times per annum
Executive Risk Group	• Ensures the consistent application of risk management policies and processes within the Trust. • Provides assurance to the Board on the delivery of mitigations to reduce exposure to the strategic	CEO (Chair)	All ≥ 15 risks and full Corporate Risk Register bi-monthly	BAF reviewed bi-monthly with deep dives as programmed

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
	risks contained in the Board Assurance Framework. • Oversees operational risks contained in the corporate risk register and provides assurance (by exception) on the management of those risks to the Board. • Monitors (by exception) the management of operational risks within the Care Group Risk Registers receiving assurance from the Care Group Board. • Agrees and oversees training in relation to risk management			
Executive Subcommittee Groups (e.g. Quality, Resource)	The committee subgroups are responsible for: • Considering wider implications of risks and themes arising, and opportunities to improve management of risk	Executive Group Chairs	Corporate risk Register aligned risks at least 3 times per annum	

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
	• Examining and challenge action plans developed to control risks, and assess their wider impact • Identifying new risks that are emerging related to the Sub-Group scope and duties			
Care Group Boards And Care Group subgroups	The Care Group Board is accountable and responsible for ensuring that there is an effective process for identifying and managing risk of all types within the Care Group. The Care Group Board receives and consider reports from its Sub-Groups as necessary. The Care Group Board will: • Examine and challenge the risks identified • Consider wider implications of risks and themes arising, and opportunities to improve management of risk • Examine and challenge action plans developed	Care Group (Operational performance) Managing Directors) Care Group Sub-Groups (Care Group Senior Leadership Team including clinical and service directors)	15+ risks monthly Will consider key aligned risks at each meeting	

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
	to control risks, and assess their wider impact • Scrutinise completed action plans and associated metrics, and reports provided as evidence of assurance of the control of risks.			
Care Group Risk Groups / Directorate Governance meetings	The Care Group's have specific risk groups in place while Directorates have different governance approaches. Both Risk Group's and Directorate governance arranges are accountable and responsible for ensuring that there is an effective process for identifying and managing risk of all types within the Care Group/ Directorates. Care Group Risk Groups reports into Care Group Boards. The Care Group Risk/ Directorate goverance group will: • Examine and challenge the risks identified • Consider wider implications of risks and themes arising, and opportunities to		8+ risks at least bi-monthly.	

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency
	improve management of risk • Examine and challenge action plans developed to control risks, and assess their wider impact • Scrutinise completed action plans and associated metrics, and reports provided as evidence of assurance of the control of risks. • Identify risks to be escalated to Care Group Board/ Executive Risk Group			
Specialty /Department governance groups	Specialty/ Department level governance groups will review and approve risks, performing quality checks and confirming appropriate controls, assurances and further actions are identified to mitigate these.		All risks	

3.2.2 Individual

Role	Responsibility
Chief Executive Officer	• The CEO as the 'Accountable Officer' has overall accountability and responsibility for the management of risk to the safe and effective, sustainable delivery of the business of the Trust and internal controls.
Executive Directors	• Executive Directors have delegated responsibility for managing risks in accordance with their portfolios and as reflected in their job descriptions. For example, the Director of Finance has executive responsibility for financial governance and associated financial risks. • Executive Directors are responsible for ensuring effective systems for risk management, compatible with this Policy, are in place within their directorate and Care Groups. Specifically, they must ensure: (i) suitably competent staff are identified to lead on risk management in the directorate and that their role and responsibilities are clearly understood, (ii) staff are familiar with the Policy and aware of their responsibility for risk, (iii) staff attend appropriate risk training (including induction and mandatory training), (iv) risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to mitigate risks are developed, documented and regularly reviewed, (v) service developments, business cases and capital plans are formally risk assessed.
Deputy Chief Executive	• Responsible to ensure the integrated performance approach and associated systems and processes are robust in order to provide assurance on the Trust's performance and commissioning functions.
Chief Nurse	• Responsible for the development and oversight of compliance to the Risk Management Policy.
Company Secretary	• Responsible for the maintenance of the Board Assurance Framework.
Head of Risk Management	• Responsible for the day-to-day management of the Trust's Risk Register. • Responsible for the review, development and embedding of the Risk Management Policy across the Trust to ensure that there is an effective Risk Management System in place.
Care Group Directors,	• Accountable for ensuring that risk is managed in line with this Policy within their Care Delivery Service and wider areas of responsibility. They are required to:

Role	Responsibility
General Management Tier, Service Management Tier	• Maintain a suitable local forum for the discussion of risks arising, at which, the local risk register is reviewed at least monthly, • Ensure that risks raised by staff are fully considered, captured on local risk registers, kept up to date, re-assessed, and re-graded as necessary, • Develop and implement action plans to ensure risks identified are appropriately treated, • Ensure that appropriate and effective risk management processes are in place within their designated area and scope of responsibility and that all staff are made aware of the risks within their work environment and of their personal responsibility to minimise risk, • Monitor any risk management control measures implemented within their designated area and scope of responsibility, ensuring that they are appropriate and adequate, and • Seek assurance on impact of mitigating actions.
All staff	• Staff (including contractors and agency staff) must ensure they are familiar and comply with the Trust's risk-related policies and relevant professional guidelines and standards
Partnership Organisations	• Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.

4 Risk Management System

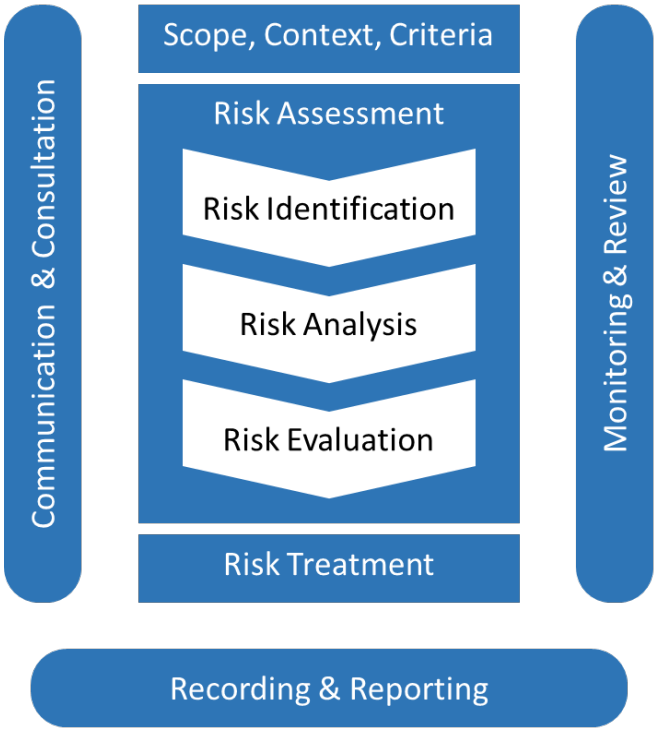
4.1 Definition of Risk Management

- Risk is defined as the 'effect of uncertainty on objectives', whether positive opportunity or negative threat, or a deviation from what is expected.
- Risk Management is defined as 'co-ordinated activities to direct and control and organisation with regard to risk'

(BS ISO 31000 Risk Management Guidelines)

Figure 1 shows, risk management involves the identification, analysis, evaluation, and treatment of risks or more specifically recognises which events may lead to harm and therefore minimising the likelihood (how often) and consequences (how bad) of these risks occurring.

Figure 1 – Risk Management Process (ISO 31000)



The Trust's process for risk management is detailed in:
(i) Appendix A: Guidelines to Identify, Assess, Action and Monitor Risks
(ii) Appendix B: Guidelines for the Use of the Risk Register.

4.2 Risk Escalation Framework

4.2.1 Risk Review and Escalation

The following diagram illustrates the role that each forum is required to undertake in relation to the Board Assurance Framework (BAF) and the Risk Register. It takes into consideration what each group should be in receipt of and the role it is accountable for discharging:

• BAF (3x annum) • Corporate Risk Register	**Board of Directors**	• Seeking assurance over strategic risks and those within the Corporate Risk Register
• Risk strategy and policy • BAF	**Audit & Risk Committee**	• Seeking assurance over the risk management systems and processes operating across the Trust.
• Relevant section of the BAF allocated to each Committee for ongoing review • Corporate Risk Register	**Board Committee**	• Seeking assurance on behalf of the Board that strategic risks identified through the BAF are being appropriately managed by Executive leads, assurance/mitigations are correctly identified, actioned, and strategic risks updated accordingly.
• Review the BAF	**Executive Directors Meeting**	• Seeking assurance that strategic risks are being appropriately managed, assurance/mitigations are correctly identified and actioned, and assurance is received.
• All risks of ≥15 • Risk Dashboard & Risk movement log • BAF	**Executive Risk Group**	• Scrutiny and challenge on organisational risks scoring ≥15 • Review, accept/challenge new ≥15 risks • Holding care Groups/Corporate Divisions to account for timely and appropriate management of risk
• ≥15 Risk Register • Care Group Risk Dashboard & Risk movement log	**Care Group Board**	• Scrutiny and challenge of ≥15 risks • Identify common risks/trends
• ≥8 Risk Register • Care Group Risk Dashboard	**Care Group Risk Group**	• Scrutiny and challenge of ≥8 Care Group risks • Holding services/ departments to account for effective and timely management of risks
• Specialty/ Department Risk Register	**Specialty/ Department**	• Ensuring effective and timely management of risks held by the Specialty/ Department with risk registers updated and maintained in a timely manner

4.2.2 Risk Appetite

The Trust has defined its risk appetite as follows:

Area	Risk Appetite
Quality and Safety (including innovation) Quality and Safety drive all major decisions in the organisation. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls and mitigations are in place.	**Score 2 (Cautious)**
Financial and Business We are prepared to accept the possibility of limited financial risk where needed to mitigate risks to quality, or staff and patient safety, progress invest-to-save opportunities, or mitigate significant risks including cyber security. We will ensure all actions represent value for money and will assess the implications of managed risk taking on our underlying cost base and in our regulatory context.	**Score 2 (Cautious)**
Regulation We will only tolerate minimal exposure to regulatory risks including to our CQC ratings. We will tolerate some exposure to wider contractual and national targets including the consequential implications of prioritising quality and safety over operational performance	**Score 1 (Minimal)**
Reputation In recognition of its three strategic objectives, we have a moderate appetite for exposure to reputational risk. The level of impact which we are willing to accept with any of its key stakeholders (patients, staff, partners and regulators) will be assessed on a case-by-case basis.	**Score 2 (Cautious)**
People We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce (but not for our clinical delivery) but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	**Score 4 (Seek)**

- Risk 'tolerance' is the minimum and maximum risk the Trust is willing to accept as reflected in the risk appetite themes above.
- The Board agreed that all risks at level ≥15 will require executive oversight by the Executive Risk Group.
- The Executive Risk Group will oversee the Board Assurance Framework and Corporate Risk Register on a bi-monthly basis.

- The Board has approved a range of Sub-Committees/Groups all charged with the responsibility of reviewing risks related to their Terms of Reference and subject matter to ensure those risks are controlled and where necessary escalated (as outlined in the Risk Escalation Framework).
- The risk appetite and tolerances will be reviewed annually.

4.2.3 Board Assurance Framework

The Board Assurance Framework (BAF) provides a range of sources of assurance that the risks to the Trust achieving its principal strategic objectives are being managed. All NHS organisations are required to sign a full Annual Governance Statement (HM Treasury requirements) and must have the evidence to support this; the BAF brings together a significant part of this evidence. Risks to the Trust achieving its principal objectives are managed in line with the process set out below.

4.2.4 Board Assurance Framework Process Flow

Trust's principal objectives agreed by Board of Directors and reviewed annually

The Trust's objectives will reflect strategic ambitions, national and local commissioning intentions, and locally defined priorities. They should also take account of patient feedback, identified risks, themes relating to reported adverse events, near-misses, incidents, complaints, claims or concerns, audit findings, external recommendations, national initiatives and directives etc.

Risks to the achievement of the objectives identified by the Board

Risks graded using Impact/Likelihood Descriptors and Risk Grading Matrix

Every risk identified is a quality improvement opportunity

Executive Directors identified as leads manage risks to principal objectives

Leads must:

Identify current and planned control mechanisms

Identify actual and potential sources of assurance on the effectiveness of the controls (e.g. key performance indicators, internal and external audits, third party reviews)

Develop mitigating action plans

Report progress on delivery of action plans via the BAF

Trust Board monitors action plans until risks resolved

Action plans devised, risks managed and monitored

Risks and action plans monitored by relevant Board Sub-Committee

As per the Risk Escalation process

Action plans implemented and monitored until required action is taken and acceptable risk grade reached

Required Action Taken

Risk managed

Links between strategic and corporate risks

Risks added to the corporate risk register are also aligned (if applicable) to the strategic risks on the Board Assurance Framework.

This provides additional risk data to inform the strategic risks and successful mitigation, as well as provide assurance that sub-risks are appropriately mitigated and do not impact strategic risks.

5 Other Proactive Risk Management Processes

5.1 Policies and supporting documentation

In addition to the Risk Management Policy there is a range of other policies that support the management of risk within the Trust, some of which are listed at section 7, and all are available on the Trust's internal website.

5.2 Resilience Management

The Trust has in place comprehensive Business Continuity Plans, as well as a range of associated documents, designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the Trust. These plans are tested and learning from these tests is communicated to relevant staff groups and Committees/Groups to ensure that processes are refined.

The Trust has an established Emergency Planning and Resilience Group. The Group meets to discuss the Trust's progress against the EPRR core standards and its progress against the work plan.

5.3 Implementation of clinical guidance

The Trust has mechanisms in place to implement the latest guidance and recommendations from National Service Frameworks, the National Institute for Health and Care Excellence (NICE) etc.

5.4 Standards and accreditation

The Trust ensures that it meets (and aims to exceed) a range of standards and accreditations. Many of these are covered by the Trust's Policy for NICE guidance implementation and Audit.

5.5 Audit activity (clinical, internal and external)

There is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back as appropriate to staff, and reports made to the Quality Assurance Committee, Audit and Risk Committee (Internal and External audit) and the Board of Directors on a range of local forums.

5.6 Organisational learning

The Trust seeks to learn from both its own experiences and those of other organisations. For example, while our reactive risk processes may be after the fact, learning identified from these and also published reports from key regulators, or as a result of research, can identify learning enabling a preventable and proactive approach. Our clinical networks and Organisational Learning Group use many data sources to help identify and embed learning to proactively as well as reactively mitigate risk.

5.7 Fraud, Bribery and Corruption

The Trust recognises the risks that fraud, bribery and corruption pose to its resources and have included this risk in InPhase, the Trust's operational risk management system. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the Trust's counter fraud provider, AuditOne, as agreed in the counter fraud work plan and using their fraud risk planning tool. Regular meetings will be held between key staff and the AuditOne counter fraud specialist to review existing and emerging risks and to ensure effective executive level monitoring.

5.8 Reactive risk processes

The Trust also identifies potential risks from events that have already occurred in the Trust and beyond and uses risk management techniques to address. Such reactive risk identification sources include:

5.8.1 Complaints

The Trust has a well-established process for the handing of complaints, ensuring that all concerns are responded to within the approved timescales, as described in detail within the Trust's Complaints Management and PALS policy.

5.8.2 Incidents

The Trust has a system for reporting adverse incidents, described within the Trust's Incidents and Serious Incidents Policy. All notified incidents are graded using a matrix consistent with that used for risk assessment.

5.8.3 Claims, Litigation and Inquests

The Trust's Legal Department works closely with the Nursing and Quality Directorate, Complaints, and Health and Safety Departments to enable the early identification of potential legal claims against the Trust. The Trust liaises with HM Coroner and clinicians in respect of the inquest process. Any concerns or recommendations raised by the coroner are communicated appropriately to ensure that remedial action is taken. The processes associated with claims, litigation and inquests are set out in the Trust's Claims Management Policy.

5.9 Specific Clinical Risks

Clinical risks are identified through a vast range of assessments carried out at the patient/clinician interface, for example, for the prevention and management of:

- Self-harm
- Suicide
- Vulnerability
- Neglect
- Violence and Aggression

Collaborative working with patients, carers and families, and staff is important in the management of clinical risk and is addressed within the Care Programme Approach Policy Safety and Risk Management Policy (previously Harm Minimisation Policy).

5.10 Central Alert System

The Trust has robust processes in place to respond to alerts issued through national frameworks, and supplements this with its own internal alert system. These are set out in the Trust's Safety Alerts Procedure.

5.11 Health and Safety Risk Assessments

The assessment of certain specific health and safety risks is required to be undertaken by the manager responsible for the service. Guidance, training and support are available from the Health and Safety Team.

5.12 Portfolio, Programme and Project Risks

The assessment of risks related to the delivery of projects, programmes and the wider portfolio is to be undertaken in accordance with the Portfolio, Programme and Project Framework.

6 Definitions

Risk management at its best will radically improve the quality of services provided and provides strategic direction to the organisation by guiding staff on the appropriate level of risk they are permitted to take to enable staff to seize important opportunities.

Term	Definition
Risk	Risk is the 'effect of uncertainty on objectives', whether positive opportunity or negative threat, or a deviation from what is expected. A risk is something uncertain – it might happen or it might not. A risk matters because, if it happens, it will have an effect on objectives.

Term	Definition
Risk management	Risk Management is defined as 'co-ordinated activities to direct and control and organisation with regard to risk' Is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing, and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Assessment	Is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk happens (impact or magnitude).
Strategic risks	Are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
Operational risks	Are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the department or directorate which is responsible for delivering services.
Risk Appetite	Is the amount and type of risk that an organisation is willing to accept in order to meet its objectives. The Trust appreciates that: • It is impossible to deliver services and achieve positive outcomes for patients and other stakeholders without risk, and these risks must be managed in a controlled way, • methods of controlling risk must be balanced to support innovation, learning and the imaginative use of resources when it is to achieve substantial benefit; some high risks may be accepted.
Risk Register	Registers are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.

Term	Definition
Board Assurance Framework	A framework for the Board of Directors to review principle risks to meeting Trust objectives, providing opportunities to analyse assurance that those risks are being managed.
Annual Governance Statement	An annual statement signed by the Accountable Officer (Chief Executive) on behalf of the Board that forms part of the Annual Report. The Annual Governance Statement aims to provide assurance on the effectiveness of the organisation's approach to governance, risk and control.
Control	A process, policy or procedure, which is being used to manage the risk, i.e. to prevent, detect and correct an undesired event.
Consequence (impact)	The effect of a risk if it happened.
Gap in assurance	An area where there is insufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Inherent risk	The assessed level of raw or untreated risk, ie the amount of risk before the application of controls.
Likelihood	The probability that risk will happen.
Mitigation/mitigating action	An action to manage or contain a risk to an acceptable level or to reduce the threat of the risk occurring, e.g. new or strengthened controls, improved assurance arrangements etc.
Positive assurance	Actual evidence that a risk is being reasonably managed and objectives are being achieved, e.g. an auditor's report.
Risk tolerance	The boundaries within which the Executive Directors group is willing to allow the true day-to- day risk profile of the organisation to fluctuate, while they are executing strategic objectives in accordance with the Board's strategy and risk appetite.
Risk grade	An expression of the seriousness of the risk based on the risk score.
Risk score	A numerical value on the quantum of a risk based on tis consequence and likelihood.

7 Related documents

Trust Policies are also in place to help reduce risks and can be accessed through the Trust internet site

- CPA Policy (The Care Programme Approach and Standard Care)
- Safety and Risk Management Policy (previously called Harm Minimisation (Clinical Risk Assessment and Management) Policy
- Duty of Candour Policy
- Claims Management Policy
- Fire Safety Policy
- Complaints Policy
- Medical Devices Policy
- Health and Safety Policy
- Incident Reporting and Response Policy
- Infection, Prevention and Control Policy
- Freedom to Speak Up (Whistleblowing) Policy
- Display Screen Equipment Procedure
- Supporting Behaviours that Challenge (BtC) Policy
- Lone Working Procedure
- Human Rights and Equality and Diversity Policy
- Equality Impact Assessment Policy and guidance

8 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- This policy will also be communicated within the Trust's bulletins, at Induction and through supporting mandatory training.
- Line managers are required to disseminate this policy to all staff through their line management briefings.

8.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Published on Trust intranet and public website	Staff able to access the policy	January 2025	Policy Coordinator	Published
Communications in weekly briefing	Staff made aware of policy update	January 2025	Policy Coordinator	Central communications re publication

8.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff	National patient safety modules (includes introduction into risk management) mandatory on starting with the Trust	2*20-30 minutes	One off
All Agenda for Change Staff 7 and above & some B6 where specialist roles.	Mandatory* risk management e-learning (*agreement to be sought via Statutory and Mandatory Training Governance)	30 -60 mins	3 yearly
Identified risk register users	Workshop and targeted support, coaching and training. InPhase system training.	1-3 hours	Initially when Risk Application access requested and as needed.
Board members/ CG Boards/Leadership Teams	High level risk management awareness training covering wider risk management techniques and risk appetite for the Board of Directors, and CG Boards and Leadership Teams.	1 hour each	Annually

9 How the implementation of this policy will be monitored

	Auditable Standard/Key Performance Indicators	Frequency/ Method/ Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored;
1	Risk Management training will be monitored in line with current Trustwide mandatory training standards.	Annually/ Report/ Head of Risk Management	Executive Risk Group Audit and Risk Committee
2	a) Risks are being appropriately assessed and graded b) Lead Risk Owners are recorded against Risks c) Initial, current and target risks are recorded d) Controls are recorded e) Mitigating actions in place f) Review of risks within appropriate timescales g) Review of actions within appropriate timescales h) Groups Receiving relevant Risk Registers in accordance with their remit	Annual Internal Audit (per audit programme) KPIs will be built into standard reports building a framework by which targets can be set and monitored.	Report on the annual review of the Trust's risk management arrangements by Internal Audit to Executive Risk Group and the Audit and Risk Committee. The outcomes of the reviews will inform the Annual Governance Statement for consideration by the Audit and Risk Committee and Board.

10 References

- Care Quality Commission Fundamental Standards
- NHS England and Improvement guidance
- ISO 31000:2018 Risk Management Guidance
- The Healthy NHS Board: Principles for Good Governance – NHS Leadership Academy
- Taking it on Trust: Questions for Boards, Health and Safety Executive, National clinical Programmes Model of Care Development, Checklist, Governance for Quality and Safety
- Health and Safety at Work Act

- Management of Health and Safety at Work Regulations
- Health and Safety Executive
- Covid Inquiry Module 1 report

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	12 December 2024
Next review date	12 December 2027
This document replaces	Organisational Risk Management Policy CORP-0066-v2
This document was approved by	Executive Risk Group 02 December 2024
This document was approved by	Audit and Risk Committee 28 November 2024
This document was ratified by	Board of Directors
This document was ratified	12 December 2024
An equality analysis was completed on this policy on	04 December 2024
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	30 January 2018	New Policy	Withdrawn
1	October 2020	Review Date Extended	Withdrawn
1	6 July 2021	Review Date Extended to 30 September 2021	Withdrawn
2	August 2022	Policy reviewed with updates, including: • updates to wording throughout, • inclusion of the Trust Risk Appetite	Withdrawn

		• reflecting the 5 by 5 multiplication matrix • updated governance framework for risk escalation • updated to new template and Our Journey to Change	
3	12 Dec 2024	Policy reviewed with update to: • abbreviations removed • Job titles/ changes and group names updated • Trust Risk Appetite updated • Care Group Board receipt of risk register changed to 15+ from 12+ • Executive Directors Group receipt of Corporate Risk Register removed, receive BAF only as full Corporate Risk Register and all 15+ risk review by the Executives in the Executive Risk Group. • Counter Fraud section included • Update to reflect use of InPhase as the Risk Management System. • Related documents section added - Equality Impact Assessment Policy and guidance • Appendix A – Guidelines to identify, assess, action and monitor risks – subsection 1. Identifying a Risk added to list: Equality Impact Assessment process	Ratified

Appendix A – Guidelines to identify, assess, action and monitor risks

In order for the Trust to manage and control the risks it faces; it needs to identify and assess them. This document provides a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

1. Identifying a Risk

There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, for example:

- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment
- Clinical risk assessments
- Environmental / workplace risk assessments
- Risk assessment as part of Trust business – at all levels of the organisation
- Annual planning cycle
- Performance management of key performance indicators
- Internal risk assessment processes e.g. requirements to assess risks as part of development and approval of policies, procedures, strategies and plans
- Claims, incidents (including Serious Untoward Incidents) complaints and PALS enquiries
- Organisational learning e.g., assurance reviews
- External reviews, visits, inspections and accreditation e.g. Health and Safety Inspections, Fire Inspections, external consultant reports
- Information Governance Toolkit
- Staff and patient surveys
- National recommendations including Confidential Inquiries, safety alerts, NICE guidance etc
- Internal and External Audit
- Clinical audits
- Information from partner organisations
- Environment scanning of future risks (both opportunities and threats)
- Equality Impact Assessment process

This list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified.

There are two distinct phases to risk identification:

a) Initial Risk identification - relevant to new services, new techniques, projects

b) Continuous Risk Identification – relevant to existing services and should include new risks or changes in existing risks e.g., external changes such as new guidance, legislation etc.

2. Describing the risk

Failure to properly describe risk is a recognised problem in risk management. Common pitfalls include describing the impact of the risk and not the risk itself, defining the risk as a statement which is simply the converse of the objective, defining the risk as an absence of controls etc.

A simple tip is to consider describing the risk in terms of cause and effect.

The example below provides a useful guide to help staff define the risk accurately and precisely:

Objective: To travel from the Lanchester Road Hospital (LRH) to West Park Hospital (WPH) for a meeting at a certain time

Risk description		**Comment**
Failure to get from the LRH to WPH for a meeting at a certain time	**x**	This is simply the converse of the objective
Being late and missing the meeting	**x**	This is a statement of the **impact** of the risk and not the risk itself
Eating on the shuttle bus is not allowed so I was hungry	**x**	This does not impact on the achievement of the objective
There is risk that I may miss the shuttle bus due to sleeping in resulting in me being late and missing the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
There is a risk that the shuttle bus is not running due to severe weather resulting in me not getting to the meeting.	√	This is a risk that I cannot control but against which I can make a contingency plan

3. Assessing the risk

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

Ideally, risk assessment is an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, such evidence and data may not be available, and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff familiar with the activity being assessed. Depending on the severity of the risk, the directorate Risk/Governance lead should be notified. Trade union representatives, external assessors or experts should be involved or consulted, as appropriate.

Risks are assigned a score based on a combination of the likelihood of a risk being realised and the consequences if the risk is realised.

The Trust uses three risk scores:

- Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.
- Target Risk Score: This is the score that is expected after the action plan has been fully implemented.

Use *Table 1. Measures of Consequence*, to score the consequence, with existing controls in place:

- Choose the most appropriate domain(s) from the left-hand column of the table. Then work along the columns in the same row and, using the descriptors as a guide, assess the severity of the consequence on the scale 1 = Insignificant, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Catastrophic.

Consequence Type and Consequence score (severity levels) and examples of descriptors

Consequence Type	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry Service delivery is not materially affected.	Overall treatment or service suboptimal Formal complaint (stage 1) / Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved / Reduced performance rating if unresolved Some inconvenience/ difficulty in operational performance of a particular service area	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) 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 Operational performance of a particular service area is affected to the extent that revised planning is required to overcome difficulties.	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report Operational performance of a particular service area is severely affected.	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards Operational performance is compromised to the extent that the organisation is unable to meet its obligations in core activity areas.

Consequence Type	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
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 duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant effect upon the achievement of the objective. Insignificant cost increase/ schedule slippage	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/cost. <5 per cent over project budget Schedule slippage	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost. 5–10 per cent over project budget Schedule slippage late delivery of key target.	Significant effect upon the objective, thus making it extremely difficult/costly to achieve. Non-compliance with national 10–25 per cent over project budget Schedule slippage	An effect upon the objective that renders it unachievable. Incident leading >25 per cent over project budget Schedule slippage Key objectives not met Non-delivery of key targets.

Consequence Type	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
				Key objectives not met Partial delivery of key targets	
Finance including claims	Small loss (less that 0.1% of budget) Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour No impact on ability to meet internal and external reporting requirements even though a particular service area is affected. Minimal or no impact on the environment	Loss/interruption of >8 hours Inability to meet a specific reporting requirement. Minor impact on environment	Loss/interruption of >1 day Difficulty in complying with key reporting requirements. Moderate impact on environment	Loss/interruption of >1 week Unable to comply with the majority of reporting requirements. Major impact on environment	Permanent loss of service or facility Unable to access any service user or corporate information. Catastrophic impact on environment

Use *Table 2 Likelihood*, to score the likelihood of the consequence(s) occurring with existing controls in place, using the frequency scale of Rare = 1, Unlikely = 2, Possible = 3, Likely = 4 and Certain = 5.

Table 2 Likelihood

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Chance of the risk happening	<5%	5% - 20%	20-50%	50-80%	>80%

Likelihood can be scored by considering;

- Frequency - i.e. how many times the consequence(s) being assessed will actually be realised

or

- Probability - i.e., what is the chance the consequence(s) being assessed will occur in a given period

4. Scoring the risk

Calculate the risk score by multiplying the consequence score by the likelihood score. *See Table 3 Risk Score*.

IMPORTANT: It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the overall score, however as a rule-of-thumb take the highest domain score.

Table 3: Risk Score

			Severity of Impact/ Consequence				
			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
Likelihood	5	Almost certain	5 Low	10 Moderate	15 High	20 High	25 High
	4	Likely	4 Low	8 Moderate	12 Moderate	16 High	20 High
	3	Possible	3 Very low	6 Low	9 Moderate	12 Moderate	15 High
	2	Unlikely	2 Very low	4 Low	6 Low	8 Moderate	10 Moderate
	1	Rare	1 Very low	2 Very low	3 Very low	4 Low	5 Low

5. Rating the Risk

Risk rating makes it easier to understand the directorate and/or Trust-wide risk profile. It provides a systematic framework to identify the level at which risks will be managed and overseen in the organisation; prioritise remedial action and availability of resources to address risks; and direct which risks should be included on the Trust's risk register.

6. Documenting the risk

It is important that identified risks are appropriately documented within the Inphase system risk register. (See Appendix B)

7. Addressing risks

Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved.

In general, there are four potential responses to address a risk once it has been identified and assessed – commonly known as the 4 T's:

- Tolerate
- Treat
- Transfer
- Terminate

a) Tolerate the risk

The risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated Very Low or is within appetite and tolerance. It can also be applicable where the Trust's ability to mitigate the risk is constrained or if taking action is disproportionately costly. If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised.

b) Treating the Risk

This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e., as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level. Action plans must be documented on the risk assessment form, have a nominated owner and progress monitored by the appropriate risk forum.

c) Transfer the risk

Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets. It is important to note that many risks cannot be fully transferred.

d) Terminate the risk

The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently. However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.

8. Mitigation/ Action Plans

Mitigation plans should be developed:

- To close off any gaps in control or assurance
- To reduce the threat (likelihood and consequence) of the risk.

All mitigations must:

- Include a description of the planned action, a due date and identify an individual responsible for delivering the action.
- Be outcome focussed and directly related to cause of the risk.
- Be approved (together with any resource implications) by the appropriate governance group for the risk (as specified in the risk escalation framework).

Monitoring of the delivery of mitigating actions will be undertaken through usual reporting arrangements.

Appendix B – Guidelines for the use of the risk register

1. Introduction

This applies to all Trust Risk Registers.

A risk register is a log of risks of all kinds that threaten the delivery of ambitions and the delivery of services. It should be a live document which is populated through the risk assessment and evaluation process.

Risk Registers operate at all levels in the Trust – at local ward, department and service level, major projects and programmes, directorate, Care Group and Corporate level.

The InPhase Risk Management System is the system used to record risks.

2. Registering a risk on InPhase

As outlined in Appendix A - Guidelines to Identify, Assess, Action and Monitor Risks, risks can be identified in a number of ways and from a range of sources.

It is often better to fully evaluate the risk before trying to enter it in the electronic system.

Guidance documents and forms to help with this are on the Trust intranet.

- Risk assessments can and should be made at any level in the organisation.
- Use the risk assessment matrix to assess the likelihood and consequence of the risk.
- Log your risk on the risk register including the following for each risk you have identified:
  - Describe the risk.
  - Document the source of the risk
  - Identify any existing control measures in place (policies/procedures, training/physical controls) to prevent the risk occurring or reduce the potential impact if it occurred. Consider whether the controls already in place are adequate.
  - Score the risk (consider what evidence you have to support how often it happens and the usual consequence).
  - Describe additional action that must be taken to manage the risk and the level of resources required (if any) to manage it effectively.
  - Identify the person responsible for managing the action plan (risk owner)
    If financial input is required to manage the risk, include what action is required (e.g. business case), timescales & lead personnel.

3. A Guide to developing an action plan

When identifying mitigating actions to manage identified risks there is a need to identify the most appropriate way of managing each risk.

Document an action plan for each risk you have identified. Actions will need to be followed up on a regular basis. For each action ensure that you:

1 Identify which option you have chosen to manage the risk.
2 List any actions that are needed to manage the risk indicating the agreed time scale for each action.
3 Ensure a designated person is chosen to take responsibility for managing the risk and signs up to the action plan.
4 Re-score the risk once the appropriate actions have been implemented.

4. Risk Escalation

Risks are managed according to the level of risk identified as set out in the risk escalation framework.

5. Review of risks

Risks registered on InPhase must specify when the current risk score, action plan and target risk score will be reviewed.

Risk Level	Review Frequency
15 or above	Monthly
12	Bi-Monthly
8 to 10	Quarterly
6 or less	At least annually.

It is expected that as action plans are progressed the current risk score will move towards the target risk score and may be closed (if the risk has been eliminated) or tolerated (if the risk remains but all planned mitigating action has been taken). This may be achieved within one review period but it may take longer, in which case a new review date must be set

6. Quality Assurance

Quality Assurance of the Risk Registers will be secured via a number of mechanisms:

- Designated risk forums have primary responsibility for their risk registers,

- Executive Risk Group provides ongoing oversight of all risk registers, supplemented by detailed reviews to assess risk scoring and treatment plans, appropriate escalation and aggregation and that all risks remain in date,
- Annual Audit as detailed in section 9 of the policy, and
- Internal Audit will review risk registers as part of their annual review of Risk Management

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing & Governance
Title	Organisational Risk Management Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	To support delivery of the Trust's goals, including: Improving patient experience and the delivery of safe care through effective identification escalation and management of risks, and Co-creating a great experience for colleagues by having robust systems to ensure the management of risks. To support compliance with legal and regulatory requirements and expectations. To embed a standardised approach to the management of risk throughout the Trust. To provide understanding on the Trust's risk appetite to support effective decision making.
Start date of Equality Analysis Screening	18 November 2024
End date of Equality Analysis Screening	04 December 2024

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Everyone, it provides a framework for assessing and responding to organisational risk
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO**

	• **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	At times specific risk management and mitigation may be needed which may have an impact on a people from protected characteristic groups. TEWV would however always try and mitigate as much as possible any negative impact whilst trying to ensure risks are managed safely.
Describe any positive impacts	Risk management aims to improve how we manage and mitigate all risks, including risks of discrimination, data used to monitor and improve how we manage these may have a positive impact.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	ISO 31000:2018 CQC feedback
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	Consultation undertaken via the; Executive Risk Group
If you answered No above, describe future plans that you may have to engage and involve people from different groups	Feedback received as part of any surveys, data from audits, incidents and complaints etc, will be considered and changes incorporated into policy revision at annual review or sooner if required.

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	Training for staff is outlined in the policy and will differ depending on role and use of the risk register.
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	Executives surveyed and feedback from meetings throughout the year.
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	E&D EIA completed 04 Dec 2024
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	