Risk Management Strategy and Policy
Document No: CO2

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy
All NBT staff, including temporary staff and those with Honorary Contracts	Monthly	All staff in contact with volunteers External Contractors

This policy can only be considered valid when viewed via the NBT intranet.

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Consultation:	Risk Management Group (10 October 2022) Health & Safety Committee Members
Ratifying Committee:	Audit & Risk Committee
Executive Lead:	Steve Hams, Chief Nursing Officer
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KEYWORDS:	Risk management, risk register, Datix, risk scoring matrix, Trust level risk
Summary of changes since the previous version	• Transfer of accountability for risk management from the Patient Safety Team to the Corporate Governance Team • Introduction of a new Risk Management Group • Changes to risk appetite scores since previous version • Addition of new Head of Risk Management role • Inclusion of requirement to add any risk scored with an impact score of 5 (irrespective of likelihood) to the Trust Level Risk Register • V3.1 – minor changes made to reflect changes to Trust governance structures and responsibilies. • V3.2 – changes to risk appetite statements since previous version.

COMMITTEE DECISION FORM

To be completed as appropriate and returned to author after the Committee meeting

Committee:	**Audit & Risk**
Committee Chair and title:	**Richard Gaunt, NED**
Document name:	**Risk Management Strategy and Policy**
Lead Author/ Clinician:	**Nina Goodwin, Interim Head of Risk Management**
Specialty/ Division/ Trust-wide:	**Corporate Governance**
Committee meeting date at which the document was discussed:	**10 November 2022**

DECISION (please tick appropriate box)

Approved	√
Approved subject to following minor amendments being made:	
Not approved, Amendments required by the author – Chair to be sent amended document – approval will be given when changes are made	
Not approved, Amendments or rewrite required by the author before resubmission to the next Committee meeting	
The Committee made the following comments and required these amendments:	
For further discussion please contact:	Head of Risk Management

Contents

1. Executive Summary:

The Risk Management Strategy and policy will assist the organisation in ensuring risks are either eliminated or reduced to an acceptable level to protect the people using the Trust's services and its assets and finances. North Bristol NHS Trust (hereinafter referred to as the Trust) is aware that some risks will always exist and will not be eliminated and recognises the importance of managing these risks effectively.

The policy objectives are as follows:

- Embed a systematic approach to the management of risk, integrating risk into the overall arrangements for quality governance
- Support achievement of the Trust's organisational objectives
- Have clearly defined roles and responsibilities for the management of risk
- Ensure that risks are continuously identified, assessed, and minimised
- Provide a high-quality service and continuously strive to improve patient and staff safety
- Enhance health and safety performance, as well as environmental protection
- Comply with national standards and relevant legal and regulatory requirements
- Establish clear and effective communication that enables information sharing
- Foster an open culture that allows organisation-wide learning and resilience
- Improve patient, public and stakeholder confidence and protect the reputation of the Trust

2. Policy Statement

2.1. The Trust recognises that risk is inherent in the provision of healthcare and its services.

2.2. The Trust makes every effort to ensure that wherever possible risks are designed out of procedures and practice. Where it is not possible to eliminate all the risk, The Trust seeks to reduce it to the lowest possible level through the introduction of control measures.

2.3. Risk management is central to the effective running of any organisation and must be part of the organisational culture. At its simplest, it is good management practice and should not be seen as an end in itself, but as part of an overall management approach. The Trust Board will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risk.

2.4. The Trust will consider strategic and operational decisions in the context of risk-assessed strategies, business cases, and projects to allow for these decisions to be taken with due regard to the quality, safety and sustainability of services to patients and other service users.

2.5. The Trust Board of Directors has zero tolerance for harm to patients and staff through the actions or omissions of the Trust

2.6. Trust Level Risk scores are based on the Trust's annual Risk Appetite Seminar (Appendix 4). The Trust Board requires the reporting of Trust Level Risks (as described in this policy) to the Board by quarterly presentation of the Trust Level Risk Report and the Board Assurance Framework.

2.7. The Trust Board will ensure there are effective governance and risk management arrangements in place to meet its statutory duties and comply with all appropriate regulations, accreditation requirements and external reporting requirements.

3. Purpose and Scope of the Policy

3.1. Risk Management involves the planned and systematic approach to the identification, evaluation, and control of risk. It is concerned with evaluating the measures the organisation has in place to manage identified risks and then suggesting actions the organisation should take to control these risks more effectively.

3.2. The purpose of the risk management policy is to explain the Trust's underlying approach to risk management and to document the roles and responsibilities of Trust Board, its sub-committees, the senior management team and other key parties.

3.3. To outline key aspects of the risk management process, identifying the main reporting procedures for how the Trust will identify, manage, and monitor its risks across the Trust's services and activities.

3.4. The policy applies to all Trust staff, including temporary staff and those who have an honorary contract.

3.5. Risks cannot be considered in isolation. They will be collated within Trust's Risk Register and will contribute and be aligned to the Board Assurance Framework, determining where strategic risk faces the organisation.

4. Definition of Terms

Risk

Risk is defined as "the effect of uncertainty on objectives". An 'effect' may be positive, negative or be a deviation from the expected position. Risk is measured as a combination of the impact and likelihood of an event occurring.

Harm

For the purposes of this document harm refers to "something with an unwanted or negative impact;" examples are highlighted below:

- harm to a person (e.g., a patient, member of staff) such as a physical injury or a poor outcome of treatment
- harm to the organisation, such as financial or reputational harm, harm to physical assets, such as damage to property or inability to deliver services or corporate objectives

Risk Management Process

The risk management process is "*the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk*" (AS/NZS ISO 31000:2009).

Risk Assessment

Risk assessment is a statutory requirement for all significant hazards. Risk assessment involves the following stages:

- Identify the hazards, including tasks activities and situations
- Determine who may be exposed to the hazard
- Evaluate the risk
- Introduce control measures
- Record the findings

The risk assessment is completed on Datix.

Risk Profiling

The tool which enables risks to be analysed and rated. The process is based on three factors;

- Likelihood of exposure to risk and of harm being caused
- Impact of the harm
- Controls in place to manage the risk

Risk Appetite

The amount of risk exposure an organisation is willing to seek, accept in connection with delivering a set of objectives. The Trust's Risk Appetite will be discussed and reviewed by the Trust Board at least annually to ensure that it remains current and continues to reflect the Trust's tolerance to areas of strategic and operational risk.

Risk Register

The formal record of risks within an organisation, in a prescribed format, that details the nature and grade of the risk, its related controls, gaps and mitigating actions. The risk register is maintained on the Datix Risk Module within the Trust.

Trust Level Risks (TLR's)

These are risks that have an impact at Trust level and that are deemed significant enough to require monitoring by the Board (i.e. principle/strategic risks that threaten the achievement of Trust objectives).

For the purposes of clarity and reporting TLR's are:

- All risks approved by the Risk Management Group that meet/exceed the risk appetite threshold for each risk type (refer to section 6.9)

- All risks approved by the Risk Management Group with an impact score of 5, irrespective of the likelihood score

- All risks that have been determined to be Trust Level Risks as part of the process of aggregation (refer to section 6.7).

Executive Risk Sponsor (ERS)

An Executive Director who will provide support and challenge to effectively progress control of the risk.

Risk Aggregation

The process of risk aggregation includes identification of risks that are very similar in nature and appear on more than one divisional risk register with at least one risk meeting the TLR threshold. Where appropriate, the Head of Risk Management will create an overarching risk entry which will provide oversight of how the risk impacts the Trust as a whole. The individual divisional risks will be linked to the overarching TLR.

Board Assurance Framework (BAF)

The Board Assurance Framework defines and assesses the principle/strategic risks to the Trust's organisational objectives and sets out the controls and assurances in place to mitigate these.

Strategic Risks

These are principal risks which threaten the Trust meeting its key strategic objectives.

Accountable Committees

For the purposes of this policy, these are Board sub-committees that receive risk reports by risk types as defined within this policy. They receive approved, TLRs for the risk type appropriate to that committee. Each committee can (but is not limited to):

- Offer advice /guidance/challenge
- Request further information
- Request reassessment of the risk score
- Escalate risks to the Trust Board
- Recommend that a risk be part of a wider, aggregated Trust level risk
- Identify potential risks and request assessment

The role of an accountable committee is supported by the committees and groups that report into it (Executive Committees). For example, the Patient Safety Committee shall review, scrutinise, and challenge patient safety risks, and reports to the Board's Quality Committee.

Executive Committees

Executive Committees report to an Accountable Committee and may receive a Risk Report highlighting relevant risk types (including TLRs).

Executive Assurance Forum

This is a monthly meeting of the Executive Team where the TLRs are reviewed, scrutinised and challenged.

Division / Divisional

This refers to all Clinical Divisions and Corporate Directorates across the Trust.

Risk Scoring Matrix

A document used to assess risk scores and provide an overall "risk grade". It lists descriptions of the impact of a risk by the type of risk (e.g., patient safety, financial, health and safety, etc.) and descriptions of the likelihood of the risk occurring.

Risk Score

This is calculated by multiplying a risk's impact by its likelihood.

Risk Grade

This is the descriptor that the risk score relates to; Low, Moderate, High or Extreme.

Control Measures

Control measures are the precautions that are put into place to reduce the risk.

Risk Type

A risk may impact on several areas of business, for example finance, health and safety, and patient safety. Only one risk type can be chosen on Datix when logging a risk type. The risk type chosen will reflect the main impact of the risk and this will be the area that planned mitigating actions will be based on. The main risk type must be identified in order to accurately score the risk. There are 10 Trust descriptions listed on the Risk Scoring Matrix (refer to Appendix 2).

Open Risk

An open risk is one where actions are planned or are underway to improve control or mitigate the risk. The risk is reviewed at regular intervals in line with timeframes set out in this policy (refer to section 6.11).

Closed Risk

The risk has been eliminated or controlled, or in some cases sufficiently reduced to an accepted level of risk (i.e., the grade has reached the risk appetite); judged in the context of the demands on the Trust's resources, the potential for harm against individuals, the Trust's reputation and any statutory obligations. The risk will no longer be reviewed and there must be no outstanding actions. When a risk is closed, it will have been mitigated to its 'target' risk score. A TLR or a risk graded as ≥ high cannot be a "closed risk".

Accepted Risk

This is where the risk cannot be eliminated completely or does not justify further investment of resource and has reached the risk appetite score'. The risk entry will continue to be "open" and will be monitored at infrequent intervals.

Risk Owner

The member of staff responsible for managing the risk and keeping the risk entry up to date on Datix. The risk owner co-ordinates completion of actions and amends the risk score, where appropriate.

Action Owner

Responsible for completing risk actions and liaising with the risk owner to provide progress on the status of actions.

Executive Risk Sponsor (ERS)

Each approved TLR will be assigned an Executive Director who will provide support and challenge to effectively progress control of the risk. The ERS is not responsible for managing the risk The risk owner is responsible for identifying an ERS and ensuring their engagement.

Summary of Definitions (alphabetically)

Accepted Risk	The risk cannot be eliminated completely or does not justify further investment of resource and has reached the risk appetite score.
Accountable Committee	Board sub-committees that receive risk reports by risk types as defined within this policy.
Action Owner	Responsible for completing risk actions and liaising with the Risk Owner to provide progress on the status of actions.
Board Assurance Framework	The BAF provides a framework for reporting key strategic risk information to the Trust Board.
Closed risk	The risk has been eliminated or controlled, or in some cases sufficiently reduced to an acceptable/tolerable level of risk (i.e the grade has reached the risk appetite.
Control Measures (Controls)	Control measures are the precautions that are put into place to reduce the risk.
Division/Divisional	Includes Clinical Divisions and Corporate Directorates.
Executive Assurance Forum	A monthly meeting of the Executive Team where the TLR's are reviewed, scrutinised and challenged.
Executive Committee	Reports to an Accountable Committee and may receive TLR's for relevant risk types.
Executive Risk Sponsor (ERS)	An Executive Director who will provide support and challenge to effectively progress control of the risk.
Harm	Something with an unwanted or negative impact.
Open Risk	An open or "active" risk is one where actions are planned or are underway to improve control or mitigate the risk.
Risk	A risk is the chance or likelihood that harm or adverse outcome will arise from a hazard (or threat) and includes the severity (or consequence) of the injury or the impact on the Trust.
Risk Appetite	Risk appetite is the level of risk an organisation is prepared to accept.
Risk Aggregation	The process of having an overarching risk entry which will provide oversight of how the risk impacts the Trust as a whole across the various Divisions.
Risk Assessment	Risk assessment is a statutory requirement for all significant risks and is a 5-step process. This is completed on Datix.
Risk Score	The total number when multiplying impact by likelihood.
Risk Grade	The descriptor that the risk score relates to; low, moderate, high or extreme.
Risk Scoring Matrix	The document used to assess risk scores and provide an overall "risk grade". It lists descriptions of the impact of a risk by the type of risk and likelihood of the risk occurring.
Risk Management Process	The risk management process is "the systematic application of management policies, procedures and practices to the tasks of

	establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk".
Risk Owner	The Risk Owner is operationally responsible for the management, oversight and monitoring of the risk and for the recording of all risk details on the risk management database (Datix).
Risk Register	The formal record of risks within an organisation, in a prescribed format, that details the nature and grade of the risk, its related controls, gaps and mitigating actions. The risk register is maintained on the Datix Risk Module within the Trust.
Risk Treatment	Risk treatment is the name given to a wide range of strategies which are used to reduce, remove, avoid, transfer or otherwise alter the risk.
Risk Type	One of ten Trust descriptions as defined in the Risk Scoring Matrix.
Trust Level Risks (TLR's)	Trust level risks are principal risks that could impact on the Trust achieving its strategic objectives and are recorded on the Trust's Board Assurance Framework.
Strategic Risk	These are principal risks which threaten the Trust meeting its objectives.

5. Roles and responsibilities

5.1. Summary of the Trusts' Risk Management Structure from the top down

Board Responsibilities:

Trust Board	Corporate responsibility for ensuring appropriate standards and policies are available to provide guidance and for receiving reports of risk as per the process set out in this policy. Each strategic risk recorded within the Board Assurance Framework is owned and reviewed by the Board with an identified Executive Director Owner.
Audit and Risk Committee	The Audit and Risk Committee will ensure that the Trust has robust risk management systems and processes in place and shall receive a regular report setting out all Trust Level Risks and the Board Assurance Framework.
Chief Executive	The Chief Executive is the Accountable Officer of the Trust and assumed overall accountability for ensuring the Trust has an effective risk management system in place, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.
Chief Nursing Officer	Executive lead for risk management
Executive Directors	Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in this document Sponsor risks allocated to them on the Trust's Risk Register as described in this document.

Other key roles/ responsibilities:

Head of Risk Management	The development and maintenance of a robust integrated risk management strategy and framework that meets internal and external requirements. Responsible for operational management of the systems, processes and policies that support risk management across the trust. Provides advice on risk management processes and supports the development of the Board Assurance Framework.
Corporate Governance Team	Management of system that supports risk management (Datix). To support the development of risk registers and work with teams across the Trust to ensure the processes for risk identification, assessment and reporting are being implemented. To edit and update information on the Board Assurance Framework.
Executive Committees	These are committees that report to Board sub-committees. For the purposes of this policy, the Board sub-committees are "Accountable Committees" as described above. Executive Committees form an integral role in risk management by reviewing, scrutinising and challenging risks on the trust risk register. They may also identify areas of emerging risk and request assessment. Executive Committees include: ➢ Patient Safety Committee ➢ Health & Safety Committee ➢ Operational Management Board ➢ Risk Management Group This list is an example of the committees who regularly review Trust Level Risks; the Corporate Governance structure chart can be found here: Corporate Governance Committee Structure - LINK (nbt.nhs.uk) The Executive Assurance Forum also plays a role in risk management by reviewing, scrutinising, and challenging Trust Level Risks on the risk register.
Divisional Management Teams (DMT)	Accountable for risk management in all their areas of responsibility. They are responsible for: ➢ Ensuring that systems and processes of governance within their Division are sufficient and effective. ➢ Ensuring a systematic approach to identifying, approving, and managing risks is in place. ➢ Managing and controlling specific risks within their Division. ➢ Ensuring appropriate resources are allocated to adequately control risk, which will include the provision of suitable information, instruction, training, and supervision.

	➢ Escalating difficulties with mitigating risks ➢ Identifying and engaging an Executive Risk Sponsor for risks which meet the TLR threshold score for the risk type ➢ Escalating risks which meet the TLR threshold score for the risk type, to the Head of Risk management ➢ Presenting progress reports for Divisional TLR's to the RMG on a monthly basis and seeking approval of significant changes A member of the DMT will be identified as the "risk owner" for all approved Trust Level Risks within their Division.
Specialty/ Divisional Governance Team (Heads/Deputy Heads of Corporate Services)	Day-to-day management of the systems and processes that support risk management. For example, facilitating the process of reviewing new risk entries and ensuring accuracy in the risk approval process.
Managers **(Departmental / Ward Managers and equivalents)**	Departmental/Ward Managers are responsible for the identification and management of risk in their team or service area. Risk management is integral to their day-to-day management responsibilities. This includes the identification, assessment, management and mitigation of all risks at a local level wherever possible. If risks cannot be mitigated locally, these should be escalated, and action undertaken by the management level above Ensuring sufficient training and supervision (including coverage of Trust and Divisional policies, risk identification) and information is given to staff to enable them to work safely. Managers must ensure staff within their area are aware of the Trust's processes for managing risk.
Expectations of all staff	In carrying out their normal duties, staff are expected to report to their managers any hazards and potential risks. All staff must work in accordance with Trust policy, guidelines, standard operating procedures and protocols to reduce and mitigate risk.

5.2 Risk Management Training

The Trust has a mandatory and statutory training matrix that details risk training available and training requirements for each staff group.

At annual staff appraisal and development reviews Line Managers review staff compliance with mandatory and statutory training requirements and identify additional risk management training needs which may be required.

Trust Board members and senior managers will receive appropriate training on risk awareness at least every two years.

6. Process for Assessing, Approving and Escalating Risks

6.1. Table: Summary of Process for Assessing, Approving and Escalating Risks

Step	Owner	Action	
Step 1	Manager	**Carry out a risk assessment** Discuss with Specialty/ Department Governance Lead	
Step 2	Specialty/ Department Governance Lead	**Review Risk Assessment** Decision: Is there a risk which needs escalation?	No: Provide feedback to staff Yes: Input risk into Datix Risk Register
Step 3	Divisional Governance Lead/ Team	**Review Risk Entry** Decision: Is the risk entry approved?	No: Provide feedback to Specialty / Department Governance Lead Yes: Escalate to DMT
Step 4	Divisional Management Team (DMT)	**Risk Profiling** Decision: Does this meet the threshold of a TLR?	No: Continue to manage locally Yes: Escalate to Head of Risk Management (and continue to manage locally) Identify Risk Owner Identify & engage an ERS for TLR's
Step 5	Head of Risk Management	**Validate TLR** Decision: Is a TLR validated?	No: Feedback to Risk Owner Yes: Quality Assure risk entry with Risk Owner Provide report to RMG Consider aggregated risk if apparent in more than one Division
Step 6	Risk management Group (RMG)	**Approve TLR** Decision: Does the Group accept the TLR?	No: Provide feedback to DMT Yes: Monitor on a monthly basis and include in TLR Reports for Executive Committees

Detailed guidance for staff with specific risk management responsibilities within their specialty/Division is available from the Corporate Governance Team and is published on their intranet pages.

6.2. Risk Identification

Risks are identified either proactively or reactively.

Proactively: For example, but not limited to:

- As part of a part of business planning, objective setting or preparedness for new regulations, systems, processes or environments.
- As a result of new legislation or national guidance
- As a result of 'intelligence' from external sources
- As a result of Freedom to Speak Up: Raising Concerns (Whistleblowing)

Reactively: For example, but not limited to:

- Outcomes from external inspections
- Results of internal and/or external audits
- CAS (Central Alerting System) Alerts Incident, complaint, or Patient Advice & Liaison Service (PALS) trends
- Patient feedback, survey's, etc
- Staff feedback
- Loss of service/Business Continuity exercises or live events
- Via committee meetings
- From staff

When potential risks are identified, it is important they are logged onto the Divisional risk register; this is usually by a senior manager, Patient Safety Manager or Specialty/Divisional Governance Lead. A risk assessment will be completed on Datix (this is known as a draft risk entry); each risk must be assessed in order to understand the nature, impact, existing controls and gaps in control. Once in draft, the Divisional Governance Lead will decline or accept the risk entry.

Once approved on the Divisional risk register, the risk will be managed locally and assigned a Risk Owner. If the risk grade meets the threshold of the TLR register it will be escalated by the Risk Owner to the Divisional Management Team (DMT) who are responsible for identifying and engaging an Executive Risk Sponsor (ERS) and for escalating the risk to the Head of Risk Management for review and validation. New TLR's will be presented to the Risk Management Group (RMG) at the next monthly meeting. The Divisional Triumvirate representative (or in their absence the Divisional Governance Lead) will be responsible for presenting each new risk. Depending on the outcome of discussion at the meeting, the risk may or may not be approved for entry onto the Trust's Risk Register by the RMG.

6.3. Risk Assessment

A risk assessment is performed by completing the mandatory fields within the electronic risk register entry form on the Datix Risk Register. This record can be held as a 'draft' risk entry on the electronic system prior to approval. Approval should take place within one month.

Risk assessments must:

a) Clearly and succinctly describe the risk. The description should be written in a "cause and effect" style, e.g. "*There is a risk that* ……patients will fall resulting in moderate/severe harm". *This is due to…….* or *this is as a result of…….*

b) List all controls currently in place; things that are already in place to reduce (or mitigate) the likelihood and impact of the risk occurring.

c) List all the gaps in controls; these are things that should be in place that are not. These will be additional actions, which if implemented, would further reduce the risk

d) Score the risk using the Trust's Risk Scoring Matrix; what is the harm (impact) and how likely is this to occur (likelihood)

e) It is important that the risk score is based on the actual risk of harm. Using the example shown below in section 6.7, the scoring is based on how likely it is that a patient will fall resulting in moderate/severe harm; it is not assessing how often patients fall over as that is a different risk.

f) A simple way to do this is to agree the impact first and then consider the likelihood. Doing it this way focuses on the actual risk of harm. NB "harm" does not solely mean physical injury, please refer to Definitions in section 5. Some risks may have a number of potential impacts; these should be listed within the risk description.

g) State what actions are required to fill the gaps to mitigate the risk. Risk actions should be Specific, Measurable, Attainable Relevant and Time-bound (SMART). State the target dates of each additional action as well as when the overall action plan will be completed.

6.4. Risk Scoring Matrix

The risk grade is calculated by multiplying the impact by likelihood scores together.

	Likelihood				
	1	**2**	**3**	**4**	**5**
Impact	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Severe	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

Descriptions of the risk impact are grouped into risk types, for example, patient safety, patient experience, performance, health & safety, etc (there are 10 separate risk types). The risk scoring matrix can be found in Appendix 2 of this policy.

6.5. Risk Approval

Risks are approved within each Division as part of each Division's governance procedures. Divisions are responsible for ensuring that all approved risks:

- simply and clearly describe the risk, controls, gaps and mitigating actions
- are correctly scored
- are assigned and appropriate risk owners
- have appropriate action owners, who may be separate from the risk owner
- have planned actions, with timescales, that are adequately progressed
- are approved promptly, within a month

DMT's must demonstrate through the risk register entry that the risk has been scored in line with the Risk Scoring Matrix (Appendix 2).

Authority to approve risk is based on risk grade as follows:

Risk Grade	Approval authority
Low	Divisional/Specialty Quality Governance Lead
Moderate	Divisional/Specialty Quality Governance Lead
Non-Trust Level, High	DMT
Trust Level, High	DMT (to be approved by RMG)
Trust Level Extreme	DMT (to be approved by RMG)
Trust Level Impact of 5	DMT (to be approved by RMG)

6.6. Risk Ownership

Risk entries will be owned by the Division inputting and approving the risk.

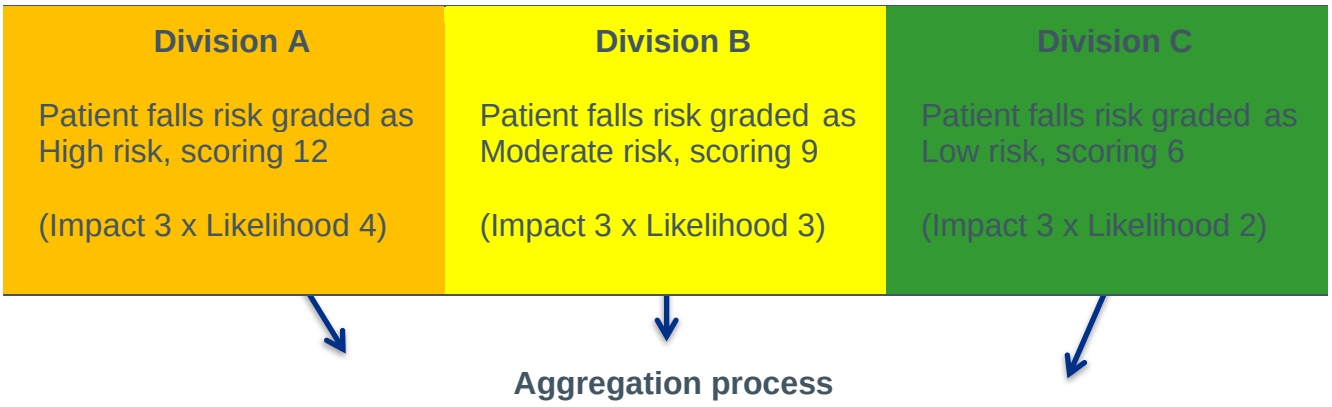
Risk ownership can change if, during the life of the risk, a more suitable risk owner is identified to manage and mitigate the risk.

An Action Owner, who may be separate from the Risk Owner, will be assigned to each planned action. The Risk Owner will be responsible for monitoring progress of the actions overall.

6.7. Aggregation Process

The process of risk aggregation includes identification of risks that are very similar in nature and appear on more than one divisional risk register with at least one risk meeting the "threshold" as a TLR. Where appropriate, the Head of Risk Management will create an overarching risk entry which will provide oversight of how the risk impacts the Trust as a whole. The individual divisional risks will be linked to the overarching TLR and will continue to be managed by the divisions. Usually, only the aggregated risk will appear on the TLR Report.

The Head of Risk Management will perform thematic reviews of the Trust's risk register on a regular (at least quarterly) basis to identify risks that may need to be aggregated.



Reported incidents are reviewed re. Falls. Review considers most common level of harm and frequency across NBT – determines that the frequency of falls with a harm level of "moderate" (scoring >3 in the matrix) is weekly.

Therefore, the likelihood of ≥ moderate harm for the Trust is 4 and the Trust Level Risk is 12 (Impact-3 x Likelihood 4).

Aggregated Risk

Patients may fall resulting in ≥ moderate harm = 12 / High Risk / Trust Level Risk

Divisional Governance Teams may highlight to the Head of Risk Management any new risks they identify within their Division that should be considered as an aggregated Trust Level Risk, i.e. where the risk also affects activity and/or patients within another Division. These will be considered for inclusion in the aggregation process.

Risks recorded on the TLR can only be assigned to one ERS, one risk owner and one Division. The owner of any aggregate risk will be agreed via the Risk Management Group.

6.6 Risk Appetite

At the Trust Board Risk Seminar in April 2022, the Trust Board agreed the following risk appetite scores for each risk type:

- Finance: ≥16
- Health & Safety: ≥12
- IM&T: ≥20
- Patient Experience: ≥15
- Patient Safety: ≥12
- Performance: ≥15
- Reputation: ≥16
- Service Delivery: ≥15
- Statutory Duty: ≥15
- Workforce: ≥16

6.7 Executive Risk Sponsors (ERS)

The table below provides a guide for identifying Executive Risk Sponsorship. There may be occasions where a risk is more appropriately sponsored by an ERS from a different Division; this must be agreed by the receiving ERS.

For approved TLR's, the Divisional Management Team will identify an Executive Risk Sponsor as per the table in below. A quality assurance review against the risk matrix will be conducted by the DMT prior to assigning the risk to the ERS. Approved TLR's must be discussed with the appropriate executive risk sponsor.

Risk Type	Executive Risk Sponsor (ERS)
Patient Safety	Chief Nursing Officer or Chief Medical Officer
Patient Experience	Chief Nursing Officer
Health &Safety	Chief Finance Officer
Reputational	Will be determined by nature of the subject; as a guide: • Patient Safety – Chief Nursing Officer or Chief Medical Officer • Performance - Chief Operating Officer • Health & Safety - Chief Finance Officer
Workforce	Chief People Officer
IM&T	Chief Digital Information Officer
Performance	Chief Operating Officer
Service Delivery	Chief Operating Officer
Finance	Chief Finance Officer
Statutory Duty	Will be determined by nature of statute; as a guide: • CQC – Chief Nursing Officer • MHRA – Chief Medical Officer • HSE – Chief Finance Officer

6.8 Process for Risk Review

Approved risks shall be reviewed in accordance with the minimum frequencies set out below according to their current risk grade. Risk reviews and any changes made to the risk entry should be recorded within the electronic risk register record (Datix).

Risk Score/ grade	Review Frequency	Reporting Level
1-3 Low	At least annually	Within the Department / Specialty
4-6 Moderate	At least annually	Within the Department / Specialty
8-12 High, non-Trust-Level	At least quarterly	Within the Division
12 High, Trust-Level	At least monthly	Divisional Governance (management of risk is owned at this level) RMG at each meeting Accountable Committee risk report to be received at the frequency set by the Chair of the Committee Audit & Risk Committee risk report to be received at each quarterly meeting Trust Board risk report to be received quarterly
15-25 Extreme	At least monthly	Divisional Governance (management of risk is owned at this level) RMG at each meeting Accountable Committee risk report to be received at the frequency set by the Chair of the Committee Audit & Risk Committee risk report to be received at each meeting Trust Board risk report to be received quarterly

7 Accountability

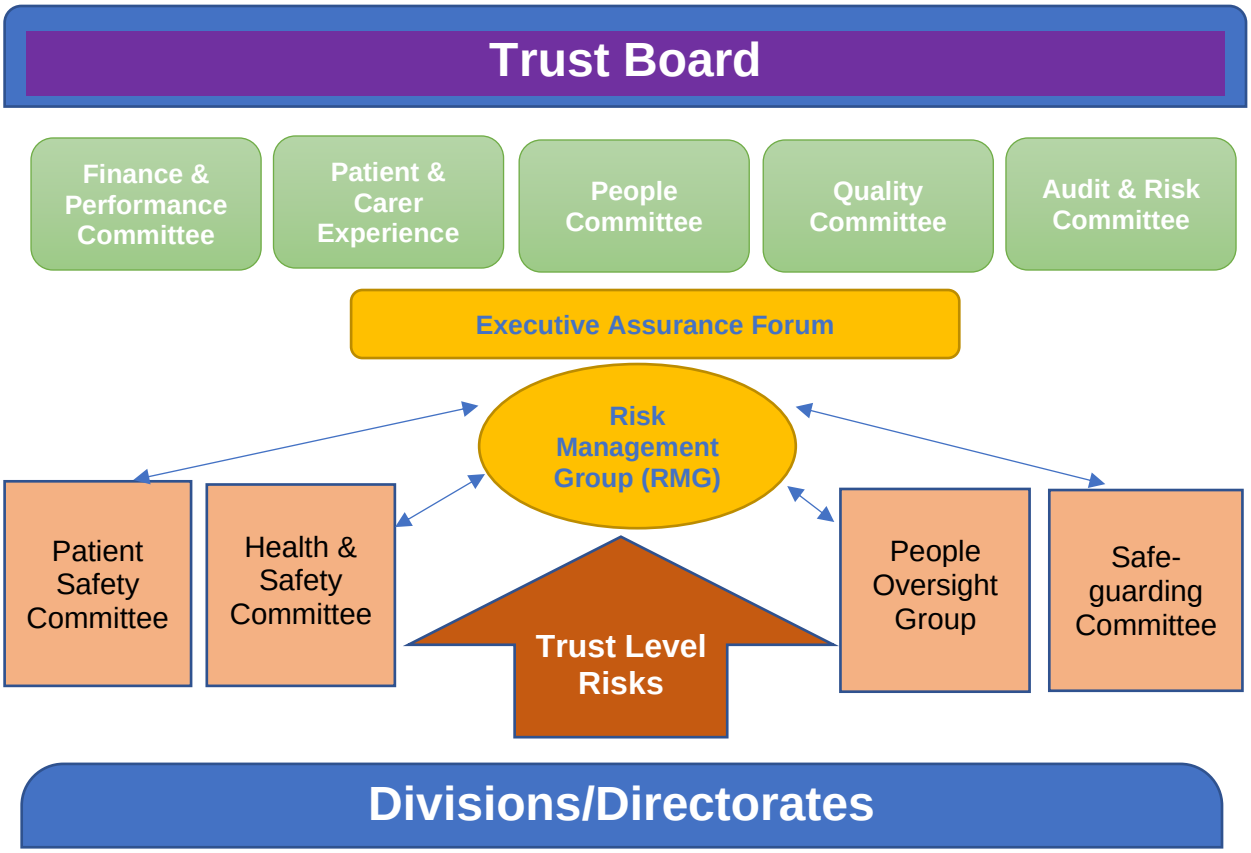
Ownership of each risk will reside with the responsible Division (including TLR's).

7.1 Accountable Committees

Accountable committees are sub-committees of the Board. They shall receive risk reports regarding approved TLR's determined by type, as set out in the table below. As a minimum, the Trust Board shall receive a risk report regarding approved Trust Level Risks, on a quarterly basis.

Accountable Committee	Risk Type
Finance & Performance Committee	Finance IM&T Performance Service delivery Reputational (related to above types)
Patient & Carer Experience Committee	Patient experience Reputational (patient experience related)
People Committee	Workforce Health & Safety Statutory duty (Health & Safety Executive (HSE)) Reputational (people and digital related)
Quality Committee	Patient safety Statutory duty (Care Quality Commission (CQC), Medicines & Healthcare products Regulatory Authority (MHRA), Human Tissue Authority (HTA)) Reputational (Quality related)

Accountable Committees may request that certain types of TLR's are also reported to an appropriate sub-committee. For example, the Patient Safety Committee shall receive a risk report of all patient safety TLR's and report on these risks to their parent committee, the Quality Committee. Appendix 3 sets out which Executive Committees shall receive risk reports on TLR's, by risk type.



7.2 Board Assurance Framework

The Board Assurance Framework (BAF) defines and assesses the principle strategic risks to the Trust's organisational objectives and sets out the controls and assurances in place to mitigate these. Each risk in the BAF has been aligned to one of 4 Trust Strategic Themes outlined within the Trust Strategy and states inherent, current and target risk scores. They each highlight anticipated changes in grading over the next 12 months (Forecast Trajectory).

Gaps or areas where controls can be improved, are identified and are translated into actions.

The BAF is reviewed by the Board in an ongoing quarterly cycle with key risk changes highlighted, and updates provided on any ongoing actions to improve risk control and mitigation. The BAF is also used to inform the Internal Audit work programme, and audit outcomes are used to inform further actions, or are used by the Board as part of its assurance process that the risk is adequately controlled. The risks are also used to inform the Board's committees' work programmes to ensure they are focusing on the key risks to the delivery of the Trust's Strategy.

8 Associated policies/documents

- Health and Safety Policy, HS01
- Health and Safety Risk Assessments Policy, HS19
- Incident Reporting Policy, CG01a
- Serious Incident Reporting Policy and Procedures, CG01b

Appendix 1 - Monitoring Effectiveness

The Corporate Governance Team will conduct an annual assessment to monitor compliance with the policy. The results of this exercise will be reported annually to the Audit & Risk Committee.

Policy monitoring tool:

What will be monitored	Monitoring / Audit method	Monitoring responsibility *(individual / group / committee)*	Frequency of monitoring	Reporting arrangements *(committee / group the monitoring results are*	How will actions be taken to ensure improvements and learning where the monitoring has identified deficiencies
Quarterly reporting of the BAF to Trust Board	Review Board papers to ensure BAF is present.	Corporate Governance Team	Annually	Audit & Risk Committee	To be determined through discussion with: - the Director of Corporate Governance and Trust Secretary - the Chief Nursing Officer And approval at Audit & Risk Committee. Reports, learning and action plans to be shared with: - Accountable Committees - Specialty/Divisional Governance Teams
Quarterly reporting of the Trust-Level Risks to Trust Board.	Review Board papers to ensure risk report is present.				
Risks from the Accountable Committees are reported to Trust Board.	Compare risk reports provided to Accountable Committees with the Trust-level risk report provided to Trust Board.				
Risk approval permissions have been granted to staff with the appropriate authority.	Review DMT and Divisional Governance Team user accounts in Datix.				
The prompt approval of risks by Divisions.	Review sample of risk records using the audit trail function in Datix.				
Divisions review risks in line with frequency stated in this policy.	Review sample of risk records in Datix.				

Appendix 2 - Risk Scoring Matrix

Table 1: Impact Score (impact of potential harm)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Patient Experience	Unsatisfactory patient experience not directly related to patient care Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Unsatisfactory patient experience – readily resolvable Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Minor implications for patient safety if unresolved	Mismanagement of patient care Repeated failure to meet internal standards Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Major patient safety implications if findings are not acted on	Serious mismanagement of patient care Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
Patient Safety	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity / disability 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
Health & Safety	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Financial	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold" Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time Uncertain delivery of key objective Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow Failure to meet specification/ slippage Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
IM&T	Information system issue affecting one service user	Information system issue affecting one department Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division. Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
Workforce	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Performance	Interim and recoverable position Negligible reduction in scope or quality Insignificant cost increase	Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives Definite reduction in scope or quality Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met Irrecoverable schedule slippage Low performance rating	Trust Objectives not met Irrecoverable schedule slippage that will have a critical impact on project success Zero performance rating

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Service Delivery	Loss / interruption of >1 hour	Loss / interruption of >8 hours	Loss / interruption of >1 day	Loss / interruption of >1 week	Permanent loss of service or facility
Reputational	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days. MP Concern (Questions in House)
Statutory Duty & Inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards reduced rating. Recommendations given.	Single breach in statutory duty Challenging external recommendation Improvement notice	Enforcement Action Multiple challenging recommendations Improvement notices Critical report	Prosecution Multiple breaches in statutory duty Complete systems change required Severely critical report

Table 2: Likelihood Score (how often the harm could occur)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad descriptor	This will probably never happen/recur	Do not expect it to happen / recur	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possibly frequently
Frequency Very useful for recurring events such as incidents. Commonly used measure for patient safety and patient experience risks.	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not? Very useful for a one-off or infrequent events such as delivery of a project.	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

Table 3 Risk Score = Impact x Likelihood

Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5

Table 4 Risk Grade

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk

Appendix 3 - Risk Types Mapped to the Trust's Governance Structure

An Accountable Committee may nominate one of their sub-committees to also receive reports on Trust level risks where the risk type is appropriate to that lower level committee. Relevant examples are set out below.

Risk Type	Executive Committee	Accountable Committee
Finance	-	Finance and Performance Committee
Health and Safety	Health & Safety Committee	People Committee
IM&T	IM&T Board	Finance and Performance Committee
Patient experience	-	Patient Experience Committee
Patient safety	Patient Safety Committee	Quality Committee
Performance	-	Finance and Performance Committee
Reputational *finance and performance related*	-	Finance and Performance Committee
Reputational *patient experience related*	-	Patient Experience Committee
Reputational *people and digital related*		People Committee
Service delivery	-	Finance and Performance Committee
Statutory duty *HSE*	Health & Safety Committee	People Committee
Statutory duty *safeguarding*	Safeguarding Committee	Quality Committee
Workforce	People Oversight Group	People Committee

Appendix 4 - Risk Appetite Statement

Risk Appetite Statement

This risk appetite statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. It provides guidance on the level of risk that the organisation is willing to take in order to achieve its objectives.

Risk Appetite Definitions:

Appetite	Definition
None	Avoidance of risk is a key organisational objective
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

No risk exists in isolation from others, and risk management is about finding the right balance between risks and opportunities to act in the best interests of patients and the public. When balancing risks, we will tolerate some risks more than others. For example, we will seek to minimise avoidable risks to patient safety in the delivery of care (**minimal** risk appetite) but in the case of innovative approaches to service delivery, we are **open** to taking risks so long as appropriate controls are in place.
Where we have identified a risk appetite of **open** or higher, this still means that appropriate action must be taken to understand and manage the risk, including:

- A clear and comprehensive risk assessment, ensuring that the risk is understood, and that trade-offs and unintended impacts have been considered.
- Clear controls and mitigations are in place, and that the risk has been reported and escalated in line with the Trust's policy.
- We can evidence that there are worthwhile and measurable potential benefits to taking the risk.
- Appropriate rapid cycle monitoring is in place to enable swift corrective action if necessary.

Trust Level Risk

Tolerance Thresholds

- Health & Safety: ≥12
- Digital: ≥20
- Finance: ≥16
- Patient Experience: ≥15
- Patient Safety: ≥12
- Performance: ≥15
- Service Delivery ≥15
- Reputation: ≥16
- Workforce: ≥16
- Statutory Duty ≥15

North Bristol NHS Trust Risk Appetite			
Risk Type	**Overall Risk Appetite Level**	**Risk Tolerance Thresholds***	**Risk Appetite Statement**
Patient Safety	Minimal	≥12	We have a **MINIMAL** appetite for risk taking in relation to patient safety. We will take measured and considered risks to improve and deliver safety outcomes where there is potential for significant benefit, and where it is supported by robust controls and mitigations; however, we will not compromise the safety of our patients.
Patient Experience	Cautious	≥15	We have a **CAUTIOUS** appetite for risk taking in relation to patient experience. We recognise that in limited circumstances, such as extreme operational pressures, we may have to risk poorer patient experience to reduce risk in other areas such as patient safety.
Workforce	Seek	≥16	We have a **CAUTIOUS** appetite for risk taking that may impact staff wellbeing, but we recognise that workforce shortages are amongst the most significant issues facing the Trust and we are willing to **SEEK** innovative practices and opportunities that fit with our values and behaviours, despite higher inherent risk.
Performance	Cautious	≥15	We have a **CAUTIOUS** appetite for risk taking in relation to performance. We recognise the constraints of national and constitutional performance targets and the significant safety, quality, and

			financial impacts of not attaining these targets.
Service Delivery	Open	≥15	We are **OPEN** to taking measured risks in how we deliver services, recognising the benefits and advantages of innovation.
Finance	Open	≥16	We are **OPEN** to taking measured financial risks to support operational delivery and high-quality care, while recognising the limited resources at a system level and the organisation's statutory responsibility to deliver its financial plan. We will not take any material financial risks which will have a negative impact on the overall sustainability of the Trust.
Health and Safety	Minimal	≥12	We have a **MINIMAL** appetite for risk taking in relation to health and safety. We will take measured and considered risks where there is potential for significant benefit, and where it is supported by robust controls and mitigations; however, we will not compromise the safety of our staff or the public.
Digital	Seek	≥20	Digital Innovation: We recognise the significant benefits that digital innovation can bring to our patients and staff, and we are willing to **SEEK** these opportunities despite higher inherent risk. Cyber Security & Compliance: We have **NO** appetite for taking risk that increases our exposure to cyber-

			attack, or which impacts our compliance with data protection regulations.
Statutory Duty	Minimal	≥15	We have a **MINIMAL** risk appetite in this area, and we will not knowingly take any risks which will impact on our ability to meet our statutory or regulatory obligations.
Reputation	Open	≥16	We are **OPEN** to taking risks that will enhance our reputation as an organisation, and we recognise that protecting the reputation of the organisation may not always be the priority when balanced against other risks.

*The score at which a risk becomes a Trust Level Risk and is reported to Trust Board/Committee

Trust Board Risk Seminar

At its annual risk seminar the Board agreed the tolerances highlighted above for each of the risk type described in the Risk Management Strategy and Policy. These risk types and scores are referred to as “Trust Level Risks.”

The Board, as a minimum, will receive a report on risks that meet these thresholds on a quarterly basis. This reporting is in conjunction with the Board Assurance Framework and is supported by Board sub-Committees described in the policy receiving a report at each committee.

Additionally, the Board is assured that all Trust Level Risks will have an associated Executive Risk Sponsor.