North Bristol NHS Trust

Risk Management Strategy and Policy

Policy number CO2

This policy can only be considered valid when viewed via the NBT intranet Sharepoint. If this policy is printed onto paper or saved to another location, you must check that the version number on your copy matches the one online on Sharepoint.

Specific staff groups to whom this policy directly applies	**Likely frequency of use**	**Other staff who may need to be familiar with policy**
Staff that input and manage risks on the trust wide risk register.	Monthly	All staff in contact with volunteers

Owner:	Director of Corporate Affairs and Trust Secretary
Consultation Route:	Quality and Risk Management Committee Patient Safety Committee Health & Safety Committee
Effective from:	01 June 2019
Approved at: • **Quality and Risk Management Committee** • **Trust Board**	 09 May 2019 30 May 2019
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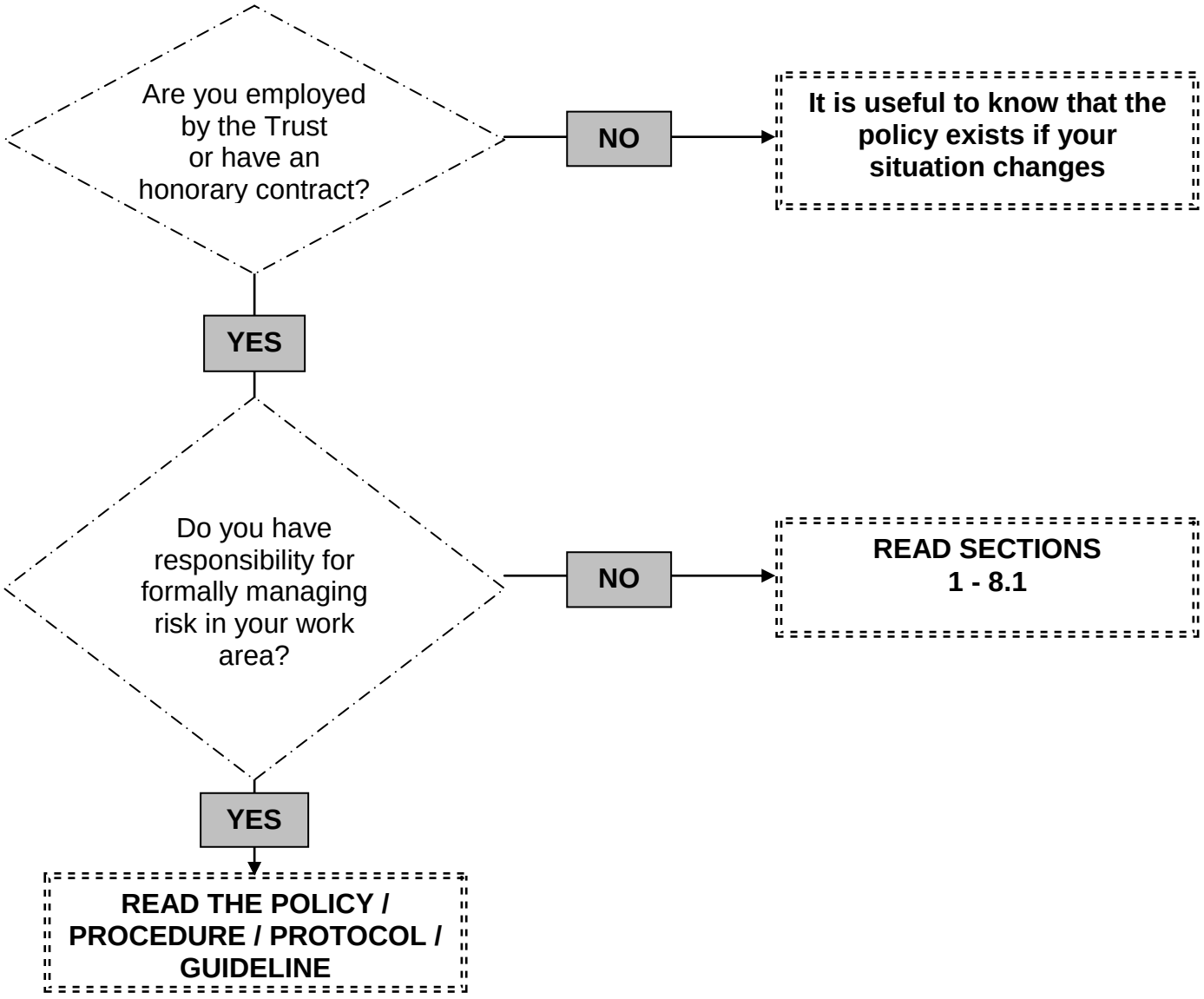
Version:	v2.0
KEY WORDS:	**risk management, risk register, Datix, risk matrix, trust level risk**

Policy

Flowchart for use of this Policy

Risk Management Policy

DO I NEED TO READ THIS POLICY?



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1 POLICY STATEMENT

1.1 The Trust recognises that the complex nature of health care provision is an inherently risky activity. Whilst acknowledging the skills and dedication of all of the team, accidents, incidents and mistakes can potentially happen.

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

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

2 POLICY AIM

2.1 To achieve optimum quality care and treatment of patients, and the provision of services which are safe and free of unnecessary risks by making maximum use of available resources and reducing wasteful expenditure.

3 POLICY OBJECTIVES

3.1

a) Embed a systematic approach to the management of risk, integrating risk into the overall arrangements for quality governance.

b) Support achievement of the Trust's organisational objectives.

c) Have clearly defined roles and responsibilities for the management of risk.

d) Ensure that risks are continuously identified, assessed and minimised.

e) Provide a high quality service and continuously strive to improve patient and staff safety.

f) Comply with national standards and key regulators.

g) Establish clear and effective communication that enables information sharing.

h) Foster an open culture that allows organisation wide learning.

4 PURPOSE AND SCOPE OF THE POLICY

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

4.2 The purpose of the risk management policy is to explain North Bristol NHS 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.

4.3 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 all of the Trust services and activities.

4.4 The policy applies to all Trust staff and staff who have an honorary contract.

4.5 Board Statement of Risk Appetite

The Trust Board of Directors defines its Risk Appetite as:

(a) The Trust Board of Directors has zero tolerance for harm to patients and staff through the actions or omissions of the Trust;

(b) 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,

(c) 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.

5 PRINCIPLES OF THE POLICY

5.1

- Proactively identify risks.
- Applies to staff at all levels.
- Promote an open, learning and fair culture.
- Empower staff to manage risk locally wherever it is reasonable and where this is not possible, risks are reported to a more senior level of management.
- Focus on shared understanding of the trust's approach to risk management.

6 DEFINITIONS

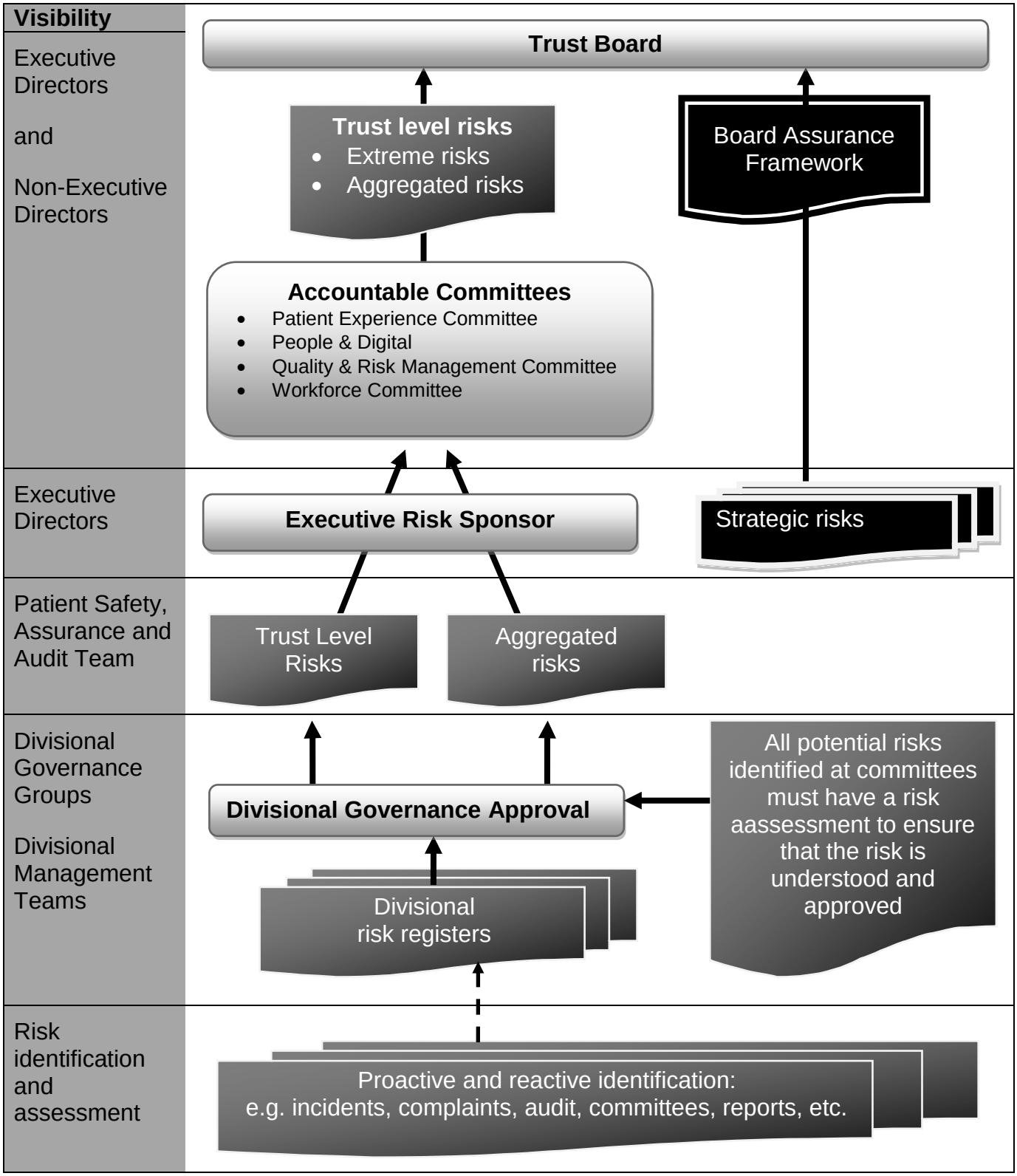
Risk	(a) Risk is defined as "the effect of uncertainty on objectives". An 'effect' may be positive, negative or a deviation from the expected position. (b) Risk is measured as a combination of the likelihood and the impact of an event occurring.
Risk appetite	The amount of risk exposure an organisation is willing to accept in connection with delivering a set of objectives.
Trust risk register	The formal record of risks across the trust, in a prescribed format, that details what the risk is, its related controls, gaps and actions. This is maintained on the Datix Risk Module.
Trust level risk	These are risks that have an impact at trust level. For the purposes of clarity and reporting these are: • All approved extreme risks

	• All approved risks that meet/exceed to the risk appetite / tolerance score for each risk type (refer to 8.8) • All risks that have been determined to be Trust Level Risk as part of the process of aggregation as noted in sections 6 & 7 & 8.7 of this policy.
Risk aggregation	The process used to review and consider Trust Level Risks. Possible Trust Level Risks are identified and assessed by the Patient Safety, Assurance and Audit Team by ≤ quarterly Trust risk profiling. The process includes identification of risks that are very similar in nature and appear on more than one divisional risk register with at least one risk graded as "high risk".
Board Assurance Framework (BAF)	The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.
Strategic risk	The principal risks to the trust's 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, Trust Level Risks at every meeting 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 to Board • Consider as being part of a wider, trust level risk • Note / identify potential risks and request assessment The role of Accountable Committee is supported by the committees and groups that report into it (Executive Assurance Committees). For example, the Patient Safety and Clinical Risk Committee shall review, scrutinise and challenge *patient safety* risks.
Executive Assurance Committees	Report to an Accountable Committees and may receive Trust Level Risks for relevant risk types. For example, the Patient Safety and Clinical Risk Committee shall review, scrutinise and challenge *patient safety* risks.
Division / Divisional	This refers to all Clinical and Corporate Divisions.
Risk scoring matrix	A document used to assess risk scores. It lists descriptions of the impact of a risk by the type of risk (e.g. financial) and descriptions to assess the probability or likelihood of the risk

	occurring.
Risk score	This is the total number when multiplying impact by likelihood.
Risk grade	This is the descriptor that the risk score relates to; low, moderate, high, extreme.
Risk type	A risk may impact on several areas of business, for example finance, health and safety. The risk type reflects the main impact of the risk and the area that planned actions will be based on. The main risk type must be identified in order to accurately score the risk.
Open risk	Actions are planned or underway to improve control or to mitigate the identified risk. The risk is reviewed at regular intervals in line with the timeframes set out in this policy.
Closed risk	The risk has been eliminated or controlled, or in some cases sufficiently reduced to an acceptable level of risk; 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. A trust level risk or a risk graded as ≥ high cannot be a "closed risk".
Accepted risk	The risk cannot be eliminated completely, or does not justify further investment of resource.
Risk owner	The member of staff responsible for managing the risk and keeping the risk entry up-to-date. The risk owner co-ordinates completion of actions.
Action owner	Responsible for completing risk actions and liaising with the risk owner to provide progress updates on risk actions.
Executive Risk Sponsor (ERS)	Each approved Trust Level Risk will have an executive director sponsor who will provide support and challenge to effectively progress control of the risk. The ERS is not responsible for managing the risk.

7 ROLES AND RESPONSIBILITIES

7.1 Summary of our Risk Management Structure



7.2 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.
Chief Executive	Overall responsibility 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.
Executive Directors	Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in this document. Sponsor for risks allocated to them on the Trust Risk Register as described in this document.
Director of Corporate Governance and Trust Secretary	Responsible for ensuring that the Trust Board of Directors is cognisant of its duties as set out in this document and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. As such, leads on the identification and management of strategic risks facing the Trust and their inclusion and update within the Board Assurance Framework.

7.3 Other key roles / responsibilities

Associate Director of Quality Governance	To provide general management support to the Director of Nursing and Quality and the Medical Director across a range of functions. The key objective of this role is to steer the Trust to successfully implement and maintain requirements of quality governance and compliance with standards as per local and national requirements. The development and maintenance of a robust integrated risk management strategy and governance framework that meets internal and external requirements.
Patient Safety, Assurance and Audit Manager	Responsible for operational management of the systems, processes and policies that support risk management across the trust. Act as expert in risk management and risk registers.

Head of Health & Safety Services	To assist in the management of health and safety in an advisory capacity by participating in development of risk control strategies and risk assessment. Supporting Directors, Designated Managers, Line Managers, Competent Persons and Risk Assessors to undertake their role including the provision of information and training. Planning and developing health and safety related policies / procedures to support the Trust's safety and risk programmes in liaison with the Trust's Health & Safety Committee.
Senior Lead for Risk Management and Datix	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.
Executive Assurance 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 Assurance 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 Assurance Committees include: • Patient Safety and Clinical Risk Committee • Health & Safety Committee • Safeguarding Committee • Workforce Steering Group • Clinical Audit and Effectiveness Committee • Drugs and Therapeutics Committee • Equality and Diversity Committee

7.4 Divisional Management Team (DMT) responsibilities

The DMT is accountable for risk management in all their areas of responsibility. They are responsible for:

- Ensuring that the systems and processes of governance within their Division are sufficient and effective.
- Ensuring that a systematic approach to identifying, approving and managing risks is in place.
- A member of the DMT is identified as the "risk owner" for all approved Trust Level risks within their Division.
- Managing and controlling specific risks within their Division.
- Ensuring that appropriate resources are allocated to adequately control risk,

which will include the provision of suitable information, instruction, training and supervision.

7.5 Divisional Governance Team responsibilities

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)	Responsible for risk assessment and prioritisation of risk assessment findings in their area. Taking any risks or problems that cannot be resolved at a local level to Senior Managers. Ensuring sufficient training and supervision (including coverage of Trust and Divisional policies, hazards, risks) and information is given to all staff to enable them to work safely and that this has been recorded. Ensuring that staff, within their area, are aware of the Trust's processes for managing risk.
Expectations of ALL staff	In carrying out their normal duties, report to their managers any potential risks identified and work in accordance with policy and documented protocols to reduce and mitigate risk.

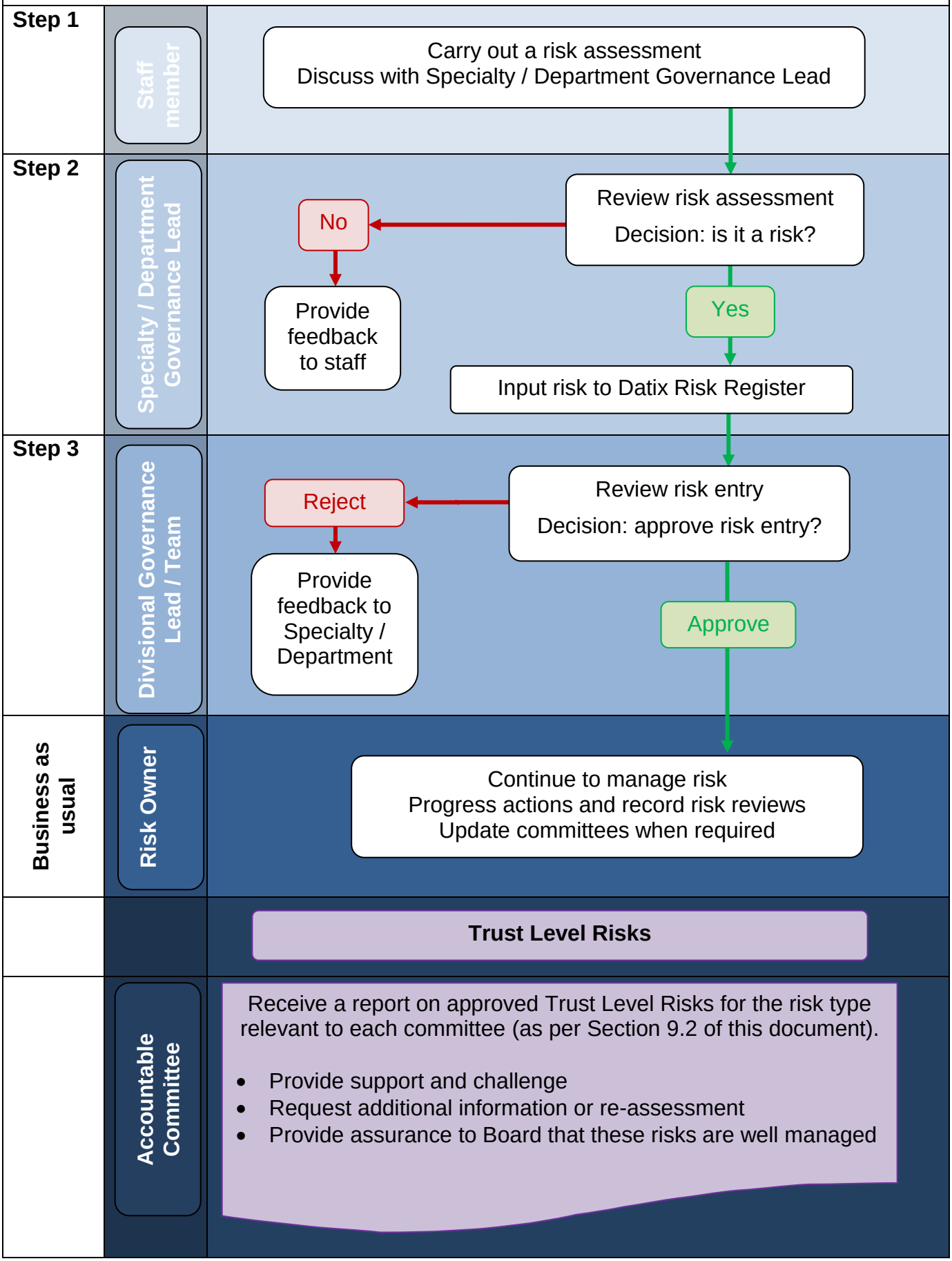
7.6 Risk Management Training

The Trust has a mandatory and statutory training policy and training prospectus that details what risk training is available and what the training requirements are for each staff group / type.

At annual staff appraisal and development reviews Line Managers review staff compliance with mandatory and statutory training requirements and identify any other risk management training needs.

Trust Board members and senior managers will receive appropriate training on risk awareness every two years, as detailed in the Trust's training needs analysis (TNA), attendance will be documented in MLE via signed attendance sheets and any non-attendance followed up by the Trust Secretary, until training has been attended.

8. PROCESS FOR ASSESSING AND APPROVING RISKS



8.1 Detailed procedural guidance

This policy states the key steps for managing risk at NBT.

Detailed guidance for staff with specific risk management responsibilities within their specialty or division is available from the Patient Safety, Assurance and Audit team and is published on their intranet pages.

8.2 Risk identification

Risks are generally identified either proactively or reactively.

Proactively — For example, but not limited to:

- As part of business planning, objective setting or preparedness for new regulations, systems, processes or environments.
- Implementation of new systems, interventions or processes.

Reactively — For example, but not limited to:

- Outcomes from inspections
- Incident trends
- Patient feedback
- Staff feedback
- Loss of service
- By existing committees
- By individual staff, for example executive directors

When potential risks are identified, it is important that they are assessed to understand their nature, impact, existing controls and gaps. Depending on the outcome of this process, they may or may not be approved for entry onto the trust's risk register.

This decision is made by the specialty / department governance lead or the divisional governance lead, according to the grade and scope of the risk.

8.3 Risk assessment

A risk assessment can be 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.

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 harm".

b. List all controls currently in place; things that reduce the likelihood of the risk happening.

c. List all the gaps in controls; things that should be in place that are not (these will indicate what your actions should be).

d. Score the risk using the risk matrix; what is likely to happen and how likely is this to occur?

   It is important that the risk score is based on the actual risk. Using the example above, the scoring is based on how likely it is that a patient will fall resulting in ≥ moderate harm, it is NOT assessing how often patients fall over as that is a different risk.

   A simple way to do this is always try to agree the impact first and then consider the likelihood. Doing it this way focuses on the risk being the likelihood of the impact that you have identified as opposed to the likelihood of any event with varying impacts.

e. State what actions are required to fill the gaps to reduce the likelihood of the risk happening.

Possible risk identified
Can be through (but not limited to):

- Incident Reporting themes and trends
- Committees *see examples 1 & 2 below*
- Complaints
- Audit, Reports
- Individuals
- Inspections (including internal)
- Investigations

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To fully understand the risk, with clarity of description, controls, gaps and grade, **the possible risk must be assessed in line with policy before it can be an "approved risk"**.
The Datix Risk Module can be used to do this. It will be entered as a "draft" risk and will be reviewed and validated by the responsible Division.

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Risk Validated
through Divisional approval process

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Risk approved
on Risk Register (Datix Risk module)

↓

Managed in line with policy

Example 1
The Workforce Steering Group receives a report that highlights a potential risk. The Group requests that the **People and Transformation Division** assess the risk to determine its type, grade and required actions.
The assessment determines that it is high risk (type: workforce) and that should be on the risk register.
It is reviewed and validated by the People and Transformation Division and approved.
This approved risk is subject to quarterly review as it is graded "high".

Example 2
Using the same process in Example 1, the Workforce Steering Group receives a report that highlights a potential risk. On this occasion **the risk type appears to be Health and Safety** as it relates to violence and aggression towards staff. Health and Safety is part of the Facilities Division, therefore the Group requests that the **Facilities Division assess the risk to determine its type, grade and required actions**.
The assessment determines that it is high risk (type: health and Safety) that should be on the risk register.
It is reviewed and validated by the Facilities Division and approved.
This approved risk is subject to quarterly review as it is graded "high".

8.4 Risk score

The risk score is calculated by multiplying the impact by likelihood scores. We use a risk scoring matrix to determine the impact and likelihood score.

	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 potential risk impact are grouped into types of risk, for example, patient safety, patient experience, performance, health and safety. The risk scoring matrix with risk impact descriptions is available in Appendix 2 of this policy.

8.5 Risk approval

Risks are approved within each division. Entry to the risk register and approval of risks is managed as part of each division's governance procedures. Divisions are responsible for ensuring that all approved risks:

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

For Trust Level Risks

Divisional Management Teams 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 risks is based on risk grade as follows

Risk Grade	Approval authority (must be approved by)
Low	Divisional Risk Lead
Moderate	
Non-Trust Level High	
Trust Level / Extreme	Divisional Management Team

8.6 Risk Ownership

Risk entries will be owned by the Division approving and inputting the risk to the trust's risk register. It is therefore imperative that risks identified are discussed with managers that are best placed to manage and control the risk to ensure they are initiated and approved by the most appropriate divisional governance team.

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

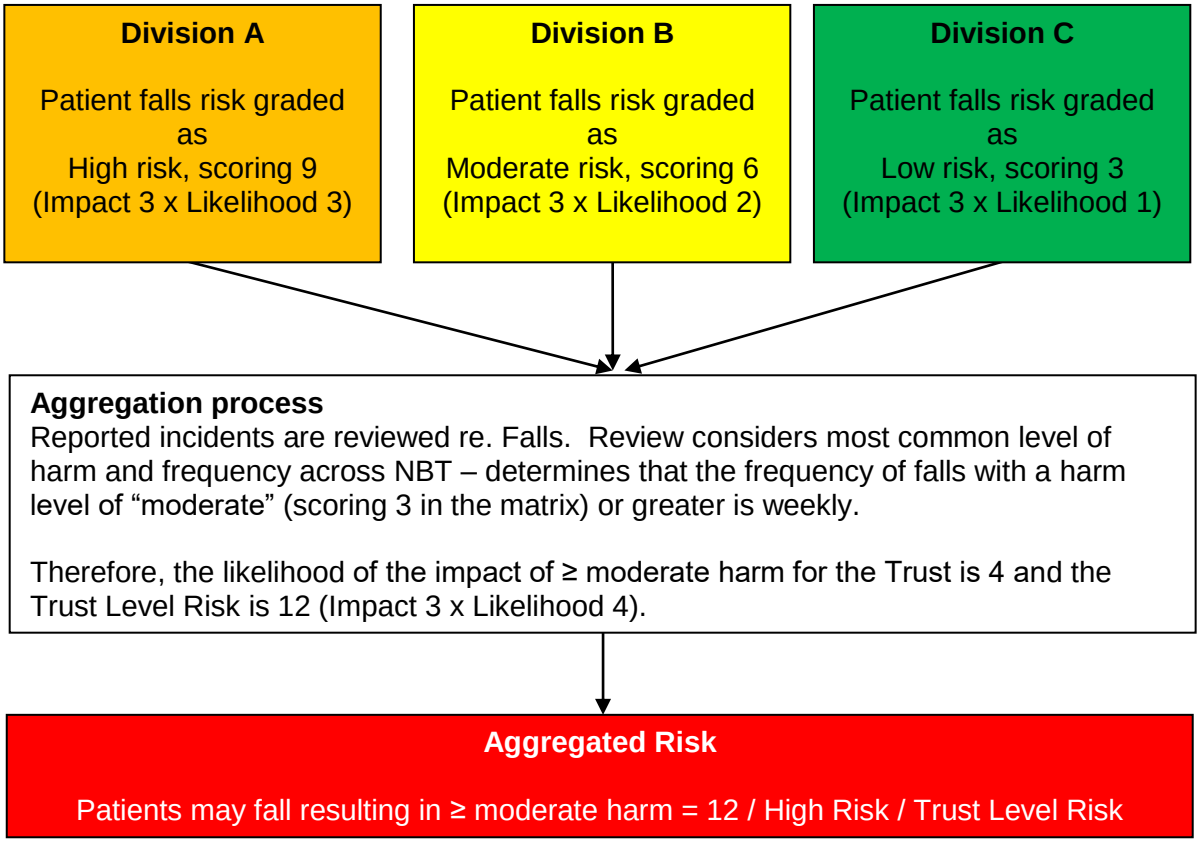
8.7 Trust Level Risks

Trust Level Risks refers to:

- All approved extreme risks
- All approved risks that meet/exceed to the risk appetite / tolerance score for each risk type (refer to 8.8)
- All risks that have been determined to be Trust Level Risk as part of the process of aggregation as noted in sections 6 & 7 of this policy (example below)

Aggregation Process example

There may be risks that affect more than one division or risks that are considered to have a 'trust wide' impact. The Patient Safety, Assurance and Audit Team will perform thematic reviews of the trust's risk register on a quarterly basis to identify these risks (this is the aggregation process).



Divisional Governance Teams may highlight to the Patient Safety, Assurance and Audit Team (PSAAS) any new risks they identify within their division that should be considered as a Trust Level Risk, i.e. where the risk also affects activity and / or patients for another division. These will be considered for inclusion in the aggregation process.

Risks recorded on the trust's risk register can only be assigned to one risk owner and one division.

For Trust Level risks, the PSAAS will identify an Executive Risk Sponsor as per the table in 8.9. A quality assurance review against the risk matrix will be conducted by PSAAS prior to assigning the risk to the ERS.

Ownership of trust level risks can change if, during the life of the risk, a more suitable risk owner or division is identified to manage the risk.

8.8 Risk Appetite / Tolerance

The annual Trust Board Risk Seminar agreed the following risk appetite and tolerance scores for each risk type:

- Health & Safety: ≥12
- Reputation: ≥15
- Regulation/compliance: ≥15
- Patient Experience: ≥12
- Patient Safety: ≥12
- Workforce: ≥15
- Finance: ≥12
- Performance: ≥15
- IM&T: ≥12

8.9 Executive Risk Sponsors

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

Risk Type	Executive Risk Sponsor (ERS)
Patient Safety	Director of Nursing and Quality or Medical Director
Patient Experience	Director of Nursing and Quality
Health and Safety	Director of Estates, Facilities and Capital Planning
Reputational	Will be determined by nature of the subject; as a guide: • Patient Safety - Director of Nursing and Quality or Medical Director • Performance - Chief Operating Officer • Health and Safety - Director of Estates, Facilities and Capital Planning
Workforce	Director of People and Transformation
IM&T	Director of Informatics
Performance	Chief Operating Officer
Service Delivery	Chief Operating Officer
Finance	Director of Finance
Statutory Duty	Will be determined by nature of statute; as a guide: • CQC - Director of Nursing and Quality • MHRA - Medical Director • HSE - Director of Estates, Facilities and Capital Planning

8.10 Process for Risk review

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

<table>
<tr><th colspan="2">Risk Score / grade</th><th>Review frequency</th><th>Reporting Level
Reporting frequency</th></tr>
<tr><td>1-3</td><td>Low</td><td rowspan="2">at least annually</td><td rowspan="2">Within the Department / Specialty</td></tr>
<tr><td>4-6</td><td>Moderate</td></tr>
<tr><td>8-12</td><td>High</td><td>at least quarterly</td><td>Within the Division</td></tr>
<tr><td colspan="2">Trust Level
(as per risk appetite / tolerance)</td><td rowspan="4">at least monthly</td><td>Divisional Governance
(management of the risk is owned at this level)</td></tr>
<tr><td rowspan="3">15-25</td><td rowspan="3">Extreme</td><td>Accountable Committee
to be received at each meeting</td></tr>
<tr><td>Quality & Risk Management Committee
to be received at each meeting</td></tr>
<tr><td>Trust Board
to be received quarterly</td></tr>
</table>

8.11 Process for reporting through the organisation

As a minimum, risks shall be reported to the following levels within NBT (in line with frequencies in section 8.10).

For example, all approved *Trust Level* risks shall report to:

- Divisional Governance meeting monthly
- Accountable Committee (every meeting)
- Quality and Risk Management Committee (every meeting)
- Trust Board (quarterly)

For example, all approved *moderate* risks shall report to Specialty Governance annually.

9 ACCOUNTABILITY

9.1 Ownership of each risk will reside with the responsible Division.

9.2 Accountable Committees

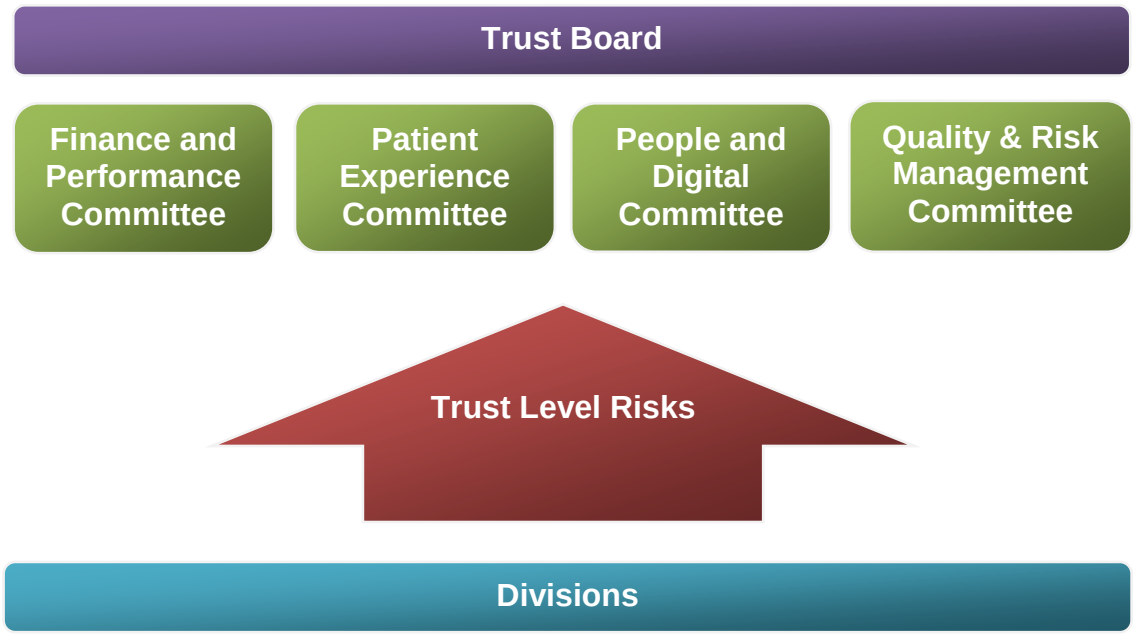
Accountable committees are sub-committees of the Board. They shall receive approved trust level risks determined by type as set out in the table below. All approved, Trust Level Risks shall be received at each Accountable Committee.

As a minimum, the Trust Board shall receive approved Trust Level Risks on a quarterly basis.

Accountable committee	Risk Type
Finance and Performance Committee	Finance Performance Service delivery Reputational (Finance and Performance related)
Patient Experience Committee	Patient experience Reputational (Patient experience related)
People and Digital Committee	Workforce IM&T Health and Safety Statutory duty (HSE) Reputational (People and Digital related)
Quality and Risk Management Committee	Patient safety Statutory duty (CQC, MHRA) Reputational (Quality related)

Accountable Committees may request that certain types of Trust Level Risks are also reported to an appropriate sub-committee. For example, the Patient Safety and Clinical Risk Committee shall receive a report of all patient safety Trust Level Risks and report on these risks to their parent committee, the Quality and Risk Management Committee.

Appendix 3 sets out which Executive Assurance committees shall receive trust level risks by risk type.



9.3 Board Assurance Framework

The Board Assurance Framework (BAF) defines and assesses the principle strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these. Each of the strategic risks in the BAF have been aligned to the objectives within the Trust Strategy, have their original, current and target risk scores reported, and information showing the anticipated changes in scoring over time. Gaps or areas where controls can be improved are identified which 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.

10 MONITORING EFFECTIVENESS

The Patient Safety, Assurance and Audit team will conduct an annual assessment to monitor compliance with the policy. The results of this exercise will be reported annually to the Quality and Risk Management Committee. The monitoring tool is available in Appendix 1.

11 ASSOCIATED DOCUMENTS

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

12 APPENDICES

Appendix 1 Policy Monitoring Tool

Appendix 2 Risk Scoring Matrix

Appendix 3 Risk types mapped to the Trust's Governance Structure

Appendix 4 Trust Board Risk Appetite

Appendix 1

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 presented to)*	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.	Patient Safety, Assurance and Audit Team	Annually	Quality and Risk Management Committee	To be determined through discussion with - the Director of Corporate Governance and Trust Secretary - the Associate Director of Quality Governance - the Patient Safety, Assurance and Audit Manager And approval at QRMC. Report and learning and actions planned to be shared with: - Accountable Committees - Divisional Governance Teams
Quarterly reporting of the Trust-level risks to Trust Board.	Review Board papers to ensure risk report is present.				
Ensure that all risks from the Accountable Committees are reported to Trust Board.	Compare the risk reports provided to the Accountable Committees with the Trust-level risk report provided to Trust Board.				
That risk approval permissions have been granted to staff with the appropriate authority.	Review DMT and Divisional Governance Team user accounts in Datix.				
Divisions will promptly approve risks.	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.				

Risk Scoring Matrix — Appendix *2*

Table 1 Impact Score (severity 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
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, Business Objectives	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 & Business Continuity	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
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.
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 (consider which measure works best for the risk that is being assessed)

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 [1]	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 [2] Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

[1] **Very useful for recurring events such as incidents. Commonly used measure for patient safety and patient experience risks.**

[2] **Very useful for a one-off or infrequent events such as delivery of a project.**

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

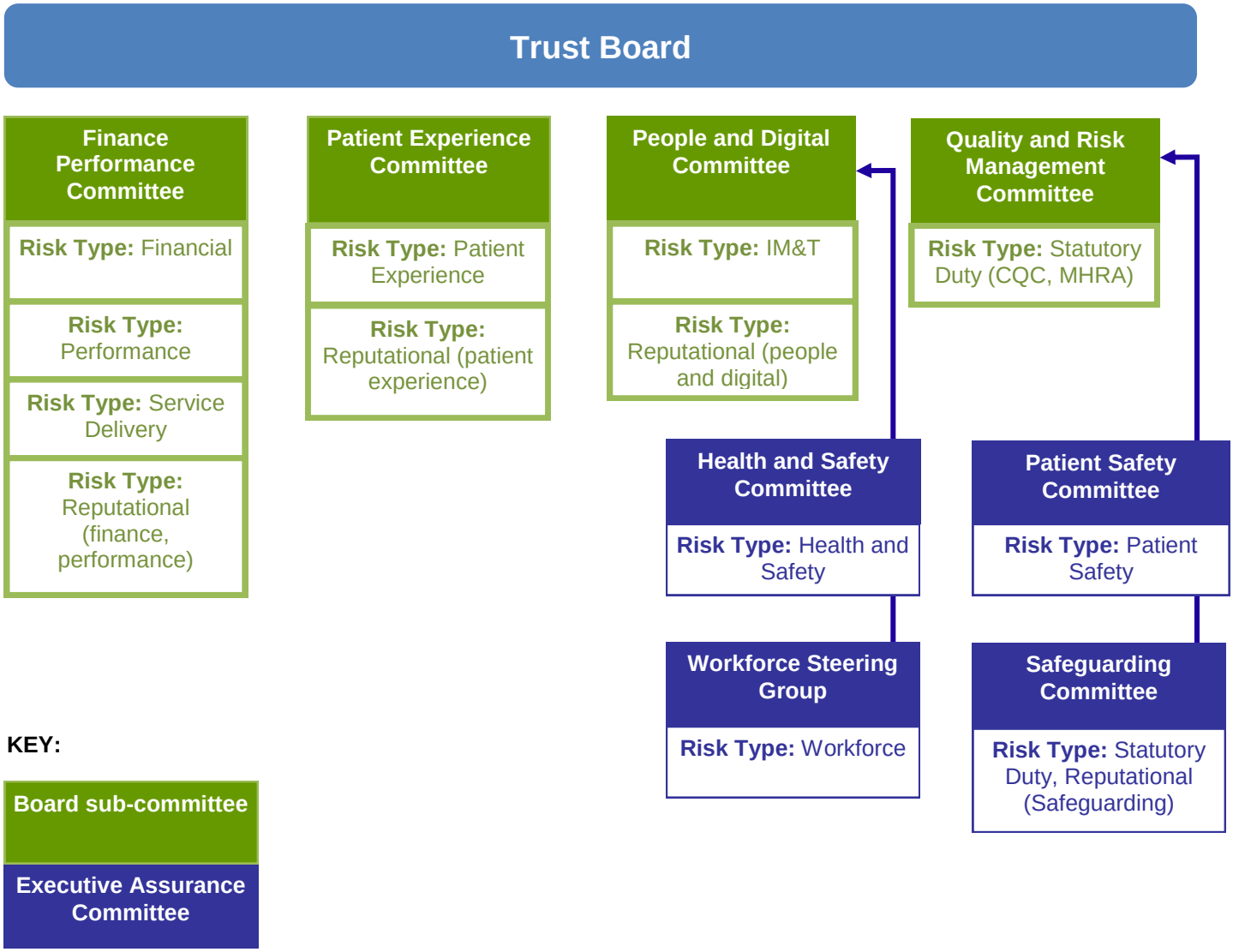
Table 4 Risk Grade

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

Risk types mapped to the Trust's Governance Structure **Appendix *3***

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

Risk Type	Executive Assurance Committee	Accountable Committee
Finance	-	Finance and Performance Committee
Health and Safety	Health & Safety Committee	People and Digital Committee
IM&T	-	People and Digital Committee
Patient experience	-	Patient Experience Committee
Patient safety	Patient Safety and Clinical Risk Committee	Quality and Risk Management 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 and Digital Committee
Service delivery	-	Finance and Performance Committee
Statutory duty *HSE*	Health & Safety Committee	People and Digital Committee
Statutory duty *safeguarding*	Safeguarding Committee	Quality and Risk Management Committee
Workforce	Workforce Steering Group	People and Digital Committee


Trust Board
Finance Performance Committee
Risk Type: Financial
Risk Type: Performance
Risk Type: Service Delivery
Risk Type: Reputational (finance, performance)
Patient Experience Committee
Risk Type: Patient Experience
Risk Type: Reputational (patient experience)
People and Digital Committee
Risk Type: IM&T
Risk Type: Reputational (people and digital)
Quality and Risk Management Committee
Risk Type: Statutory Duty (CQC, MHRA)
Health and Safety Committee
Risk Type: Health and Safety
Patient Safety Committee
Risk Type: Patient Safety
Workforce Steering Group
Risk Type: Workforce
Safeguarding Committee
Risk Type: Statutory Duty, Reputational (Safeguarding)
KEY:
Board sub-committee
Executive Assurance Committee

31 May 2019

Trust Board Risk Appetite

North Bristol NHS Trust

Risk Appetite Statement

The Trust recognises the complex nature of health care provision is an inherently risky activity. Whilst acknowledging the skills and dedication of all of the team, accidents, incidents and mistakes can potentially happen.

North Bristol NHS Trust makes every effort to ensure that there is a systematic approach to the identification, evaluation and control of risk and, wherever possible, risks are designed out of procedures and practice, to reduce it to the lowest possible level through the introduction of control and mitigation measures.

The Board received and approved the updated Risk Management Strategy and Policy on 30 May 2019.

The Risk Management Strategy and Policy describes North Bristol NHS Trust's approach to risk management.

This Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. It supports delivery of the Trust's Risk Management Strategy and Policy.

The Board is assured that for risks that do not meet these thresholds, there is a robust approach to risk management across North Bristol Trust. The Board also recognises and supports the ongoing work to improve our approach to risk management to ensure that North Bristol Trust is at the forefront of good governance.

Trust Board Risk Seminar

At its Annual Risk Seminar on 30 May 2019, the Board agreed the tolerances highlighted opposite for each of the main risk types 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.

Trust Level Risk

Tolerance Thresholds

- Health & Safety: ≥12
- IM&T: ≥12
- Finance: ≥12
- Patient Experience: ≥12
- Patient Safety: ≥12
- Performance: ≥15
- Service Delivery ≥15
- Reputation: ≥15
- Regulation: ≥15
- Workforce: ≥15