NHS
Mid and South Essex
NHS Foundation Trust

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Related Trust Policies (to be read in conjunction with)	(Refer to the main body of the text) Risk Management Policy Policy for the management of incidents Health and Safety policy and procedures Complaints Policy and Procedure Information Governance Policy Corporate Business Continuity Plan All policies and procedures associated with Healthcare Acquired Infections The Management of Violence and Aggression Safeguarding policies and procedures (Adult and Child) Whistleblowing policy

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1.0	Tracy Turner	Newly created MSE strategy replaces: Broomfield: 18030 Risk Management Strategy Basildon: CO/PO/00018 Risk Management Strategy Key changes relate to roles and responsibilities and reporting structures.	

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Mid and South Essex NHS Foundation Trust Risk Statement

The Trust Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients and service users, employment of staff, maintenance of premises and management of finances, by their nature, incur risks.

The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Trust recognises that the principles of governance must be supported by an effective risk management framework, designed to ensure safe care and treatment to patients, the safety of staff, patients and visitors and deliver continuous improvement.

The Risk Management Strategy describes a consistent and integrated approach to the management of all risk across the Trust.

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

The Trust recognises that strategic and business risks can not always be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational, relationship and reputational risks.

1 Introduction

1.1 Risk management is a statutory requirement and an indispensable element of good governance. It is a fundamental part of the integrated approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its function as a partner in the health and social care community, as a provider of health services to the public and as a major local employer.

1.2 The trust recognises that risk is inherent in the delivery of healthcare services and its key strategic objectives. The Trust is committed to ensuring that the risk management framework minimises threats as far as reasonably possible, though not necessarily eliminating treats and maximise opportunities This will support the trust to achieve its objectives and safeguarding against harm to patients, staff and visitors, minimising financial loss and reputational damage.

1.3 The Risk Management Strategy sets out the vision for managing risk, identifies the accountability arrangements and resources for managing risk and provides guidance on acceptable levels of risk within the organisation.

1.4 By managing risk effectively, the Trust aims to support the achievement of the trust objectives; protect patients, staff and the public; and protect assets and reputation; and maintain strong relationships with partners and stakeholders where possible.

1.5 Successful risk management involves;

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

1.6 The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the trust to operate within the systems and structures outlines in the strategy, escalating any risk where required.

2 Scope

2.1 This strategy applies to all Trust staff, either permanent or temporary and to those working within, or for, the Trust such as contractors, and other third parties. Risk management is the responsibility of staff and managers at all levels who are expected to take an active lead to ensure risk management becomes an integral part of their operational area.

2.2 Although the management of key strategic risks is monitored by the Board, all operational risks are managed on a day to day basis by employees throughout the Trust and monitored by Managers. This is done by:

- Involving the workforce and influencing their behaviour;
- Documenting clear responsibility for actions;

- Monitoring and updating actions taken to establish implementation and sustainability;
- Providing and promoting accessible advice and support;
- Ensuring coherent, up-to-date policies and procedures are in place and accessible;
- Ensuring operations, personnel, buildings and equipment comply with relevant legislation and standard;
- Ensuring supplies are sourced from accredited suppliers and equipment is properly maintained;
- Using a single system of assessing the level of risk, recording risk assessments and a single repository for risk information (the risk register);
- Supervising, instructing and/or training in accordance with an individual's level of work activity and responsibility.

2.3 Risk management is something that everyone within the Trust undertakes daily in varying degrees. Although it is difficult to draw clear boundaries around risk management areas because of the overlapping nature of risk, risk management within the Trust falls into seven main categories

- Clinical Quality/Patient Safety risk;
- Patient Experience risk;
- Health and Safety risk;
- Information risk;
- Project risks: - both physical and strategy related (e.g. Development of a new service/ reconfiguration of pathways, refurbishment / major works);
- Operational risk: risks arising from the core business operation of the Trust that could prevent the Trust achieving standards, targets and priorities;
- Financial risk.

2.4 The risk management process that supports this strategy applies to all categories of risk.

3 Definitions

TERM	DEFINITION
Acceptable/ tolerable Risk	is 'the mitigated risk remaining after all reasonable controls have been applied to associated hazards that have been identified, quantified, analysed, communicated to the appropriate level of management and accepted after proper evaluation'. **Inherent** risks identified at operational level with an inherent risk rating that does not require escalation will be the responsibility of the individual Division/Directorate/Department to decide what level of risk is 'acceptable'. In respect of strategic and higher risks, it is the responsibility of the Chief Executive supported by the Executive Directors and other key individuals with delegated responsibility. Acceptability is defined in accordance with the Trust's defined risk appetite.

Adverse event	is any event or harm or circumstance leading to unintentional harm or suffering.
Board Assurance Framework	The Board Assurance Framework (BAF) provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its objectives. It also provides a structure for the evidence to support the Chief Executive's Annual Governance Statement.
Clinical Risk	is the chance of something happening to a patient during NHS care that could have or did lead to unintended or unexpected harm, loss or damage. This is a broad definition that may range from dissatisfaction, to undergoing the wrong operation, or suffering permanent disability or death.
Consequence (Impact/ Severity)	is the level of harm that has, or may be suffered and is measured at the Trust on a scale of 1 to 5, 1 being negligible or no harm and 5 being severe harm.
Controls	are arrangements and systems that are intended to minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.
Controls Assurance	is a holistic concept based on best governance practice which conforms with the Combined Code of Practice on Corporate Governance and the Turnbull guidance on Internal Control. It is a process designed to provide evidence that NHS organisations are doing their 'reasonable best' to manage themselves to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. Managers need to put in place control strategies which will offer the best chances of identifying and correcting errors at a reasonable cost.
Gap in control	is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective. A negative assurance (a poor internal audit report for example) highlights gaps in control.
Gap in assurance	is deemed to exist where there is a failure to gain evidence that the controls are effective.
Hazard	is something which has the potential to cause harm, e.g substances, equipment, methods of work, and other aspects of work organisation.
Inherent risk	is the risk linked to the activity itself without the application of controls.
Inherent Clinical Risk	is the permanent or currently unavoidable clinical risk that is associated with a particular clinical investigation or treatment. It is the risk from undergoing a particular procedure in ideal conditions and performed by competent staff using the most up-to-date research, equipment and techniques. It can be considered permanent or currently unavoidable when used for the purpose of risk assessment. The risk that should be targeted by clinical risk assessment is the risk that is added to the inherent risk and results

	from, for example, a poor safety culture, poor communication and teamwork, inadequate supervision of inexperienced staff, unreliable equipment or an unsuitable environment.
Internal Control	is the process effected by the Board designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations.
Likelihood	is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.
Mitigated Risk (Target Risk)	is the remaining risk when **all** reasonable controls have been applied (as much as possible has been carried out to control the risk), when the additional controls to mitigate the Residual Risk have been applied and are effective. This equates to the **Tolerable Risk.** The added benefit of additional controls must be weighed against the cost.
Patient Safety Incident	is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.
Principal (Strategic) Risks	are those risks that can adversely affect the achievement of the Trust's corporate objectives and are identified, assessed and monitored by the Board Assurance Framework.
Probability	is the chance that something will happen, calculated statistically.
Residual Risk (current risk)	is the risk remaining with the current controls in place i.e. the risk remaining after the controls put in place to mitigate the inherent risk are fully effective.
Risk	is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets. Risks differ from their hazard in that the former is the calculated probability of the event occurring whilst the consequences or impact measure the effect of the risk being realised as a hazard. Put simply, hazards represent risks that have been realised.
Risk Appetite	at the organisational level, is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept/retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.
Risk Assessment	is the process by which risks are prioritised and then categorised through the application of a 5 by 5 calculation to produce a composite score out of a maximum of 25 (25 being the most severe). The risk assessment is based on the probability (likelihood) of a hazard occurring on a scale of 1 to 5, multiplied by its likely consequence or impact (severity) which is measured on a similar 1 to 5 scale. An account of the criteria for obtaining accurate measures

	of risk and severity of consequence or impact can be found in the Risk Management Procedure.
Risk Management	is the systematic identification, assessment, treatment, monitoring and communication of risks. This process is followed by the application of current or planned resources to effectively control, monitor and minimise the overall likelihood (and in some instances, impact) of the identified risk.
Risk Owners	are staff within the organisation in accordance to the accountabilities and responsibilities. The Corporate Risk Register is owned by the Executive Directors and the Board Assurance Framework is owned by the Trust Board.
Risk Register	is a management tool that allows the Trust to understand its comprehensive risk profile. It is simply a repository of risk information linking risks and controls for the whole organisation

4 Roles and Responsibilities

4.1 Assurance Structures - Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the Board. The Trust assurance committees receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with milestones. The Trust assurance committees are responsible for providing assurance on the management of corporate risks to the Board and are identified at Appendix 1. Duties Are:

4.1.1 **The Board** – The Board is responsible for ensuring that there is an effective system of integrated governance, risk management and internal control across the whole of the trusts activates. The Board has specific responsibility for reviewing and approving the Board Assurance Framework.

4.1.2 **Audit Committee** - The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the entirety of the Trust's clinical and non-clinical activities, both generally and in support of the Annual Governance Statement. The function of the Audit Committee is to monitor and provide assurance to the Board on the adequacy and effective operation of the Trust's overall system of risk management and internal control. The Audit Committee reviews specifically the work of other committees of the Board whose work can provide relevant assurance on the Trust's overall system of governance. The Audit Committee reviews the corporate risk assurance framework and its associated processes as part of monitoring arrangements against the objectives of the annual plan **The Finance and Performance Committee** - reviews the financial, operational, information and technology and estates risks and own their inclusion and updates on the Board Assurance Framework (BAF); The committee ensures the agreement and regular review of a trust-wide risk appetite for financial and performance risks as part of the annual review of the risk management strategy.

4.1.3 **Quality Governance Committee** - The Quality Committee functions as the Trust's umbrella clinical governance committee. The purpose of the committee is to provide the Trust Board with assurance on the three dimensions of quality set out in High Quality Care for All and enshrined through the Health & Social Care Act 2014 which are required for a high quality service. This includes providing assurance on the

management of quality and clinical risks and their inclusion and update on the Board Assurance Framework. The Quality Governance co-ordinates the agreement and regular review of the trust risk appetite for quality and patient safety risks as part of the annual review of the risk management strategy

4.1.4 **People and Organisational Development Committee** - provides assurance to the Board of Directors on the development and delivery of the Trust's People Strategy including the review of people and organisational development risks and own their inclusion and updates on the Board Assurance Framework (BAF). The committee co-ordinates the agreement and regular review of a trust-wide risk appetite for people and OD risks as part of the annual review of the risk management strategy

4.1.5 **Governance Oversight Group -** The Group has been established to ensure the effective review and escalation of risk in relation to patient safety, quality, compliance, patient experience and other governance issues and to provide the Executive Group with oversight of any exceptions and identified high risks (actual or emergent) to the Mid and South Essex NHS Foundation Trust. This group reports to the Corporate Management Board

4.2 Role & Responsibilities of Individuals within the Trust - Risk management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day to activities conducted by members of staff. The following sections define the organisational expectations of particular roles or groups. Duties Are:

4.2.1 **Chief Executive** - The Chief Executive is the responsible officer for Mid and South Essex Hospitals NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As accountable officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation as outlined below.

4.2.2 Non-Executive Directors are accountable to the Chair and are the custodians of corporate governance. They are responsible for ensuring that the trust manages risk effectively and that the controls and systems of risk management are robust and defensible. NED champions are identified for a number of specific areas and they play a key role in ensuring the identification and management of risks in these areas including infection control; safeguarding; Freedom to Speak up; Maternity safety; learning from deaths; end of life; and doctors remediation.

4.2.3 **Executive Directors** - are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the Board Assurance Framework (BAF). Each Director is accountable for risk management leadership including the implementation of, and compliance with current Trust policies, and for ensuring sufficient resources have been allocated to undertake effective risk management. They are responsible for ensuring corporate and strategic risk registers are reviewed on a monthly basis. Leading by example, they are fundamental in establishing and sustaining an environment of openness on risk management within the Trust.

4.2.4 **Chief Nursing Officer** - is the designated Clinical Governance lead for the Trust. They are accountable for ensuring risk management systems are in place to identify, assess risks and that there are processes in place for effective planning, organisation, control,

monitoring and review of preventative and protective measures. They are responsible for fulfilling the statutory duty of quality improvement and the overall implementation of Clinical Governance across the Trust. They report monthly to the Trust Board on governance, risk and compliance also oversee the proposed escalation of risks to the Site Leaders and Governance Oversight Group for consideration of inclusion in the corporate risk register or the Board Assurance Framework. The Chief Nursing Officer has delegated specific responsibilities for managing risks associated with safeguarding adults and children, patient experience and patient safety to the site Directors of Nursing.

4.2.5 **Chief Medical Officer** - is accountable for implementing systems of internal control to manage the key risks emanating from clinical activity throughout the Trust, employment of doctors and their practice, training, supervision and revalidation and the actions being taken to control them. They are accountable for advising the Board of the risks and effectiveness of controls and provide written advice to the Accounting Officer on the content of the Annual Governance Statement in regards to the management of these risks.

4.2.6 **Chief Financial Officer** – is accountable? for implementing financial systems of internal control including the reporting of fraud to NHS Protect. They are responsible for informing the Board of the key financial risks within the Trust, the actions being taken to control them, and provide written advice to the Accounting Officer on the content of the Annual Governance Statement regarding financial risk.

4.2.7 **Chief Information Officer (CIO)** – is accountable? for risks associated with information systems and contracts. The CIO is also the Trust Senior Information Risk Owner (SIRO) with ownership and champion of the Trust's Information Governance Policy. The CIO provides written advice on information risk to the Accounting Officer for the Annual Governance Statement.

4.2.8 **Chief Commercial Officer (CCO)** – is accountable for risks associated with commercial strategy.

4.2.9 **Chief Estates and Facilities Officer** - is the Executive Lead for Health and Safety and is accountable for ensuring systems are in place for the identification, review and management of health and safety risks to employees, patients and those affected by the Trust's activities, including risks associated with clinical equipment and medical devices. They provide a report to the Board on the management of health and safety risks.

4.2.10 **Site Managing Directors** - are accountable to the Chief Executive for the maintenance of effective systems of internal control within their areas of responsibility. They are responsible for ensuring that risk action plans from serious incidents and risks are implemented in a timely manner as agreed.

4.2.11 **Site Leadership Teams** - are responsible for the maintenance of effective systems of internal control within their areas of responsibility. They are responsible for ensuring that risk action plans from serious incidents and risks are implemented in a timely manner as agreed. The Site Leadership Teams are responsible for reviewing risks for escalation to the corporate risk register.

4.2.12 **Group Director of Governance, Risk and Compliance** – is accountable to the Chief Nursing Officer for the strategic leadership of risk management. He/she is responsible for promoting a safety culture throughout the organisation to deliver all elements of the clinical governance and risk agenda and to lead risk management

across the group and ensuring that strategies, policies and risk management frameworks are robust. **Associate Director of Risk and Compliance** – is accountable to the Group Director of Governance, Risk and Compliance and is responsible for professional leadership and overseeing and managing the Trust processes for governance including risk management and the board assurance framework. He/She is responsible for the risk management strategy and day to day management of the Board Assurance Framework and Corporate Risk Register.

4.2.13 **Directorate/Divisional/Care Group Directors** - are responsible for ensuring the agreed risk management procedures, systems and processes are implemented, embedded and effective in the areas for which they are accountable. They are responsible for ensuring clinical risks, health and safety risks, emergency planning and business continuity risks, relevant project and operational risks are identified and managed. The have a responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls. Directors delegate operational management decision-making and responsibility for the day-to-day management of health and safety and risk to their respective Deputy Directors and Associate Directors.

4.2.14 **Deputy Directors / Associate Directors / Divisional General Managers** - The risk management and health and safety policies, strategies, objectives and relevant information are distributed through the management structure for each area. Deputy Directors and Associate Directors are responsible for preparing plans to reduce identified hazards, allocating resources and setting local risk and safety targets relevant to Board objectives, for their own team employees, and monitoring employee achievement against them. They shall at all times ensure compliance with CQC Fundamental Standards; health and safety policies/procedures and all relevant legislation and regulation. Deputy Directors, Associate Directors and Divisional General Managers are also responsible for establishing and sustaining an environment of openness on risk management within their areas. They have a responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls.

4.2.15 **Associate Directors/Heads of Nursing / Head of Midwifery / Non-clinical Departmental Managers** are responsible for ensuring that the systems and processes within the Divisions/Directorates in respect of risk management are in accordance with the principles of this Strategy. They will ensure that robust information is provided to the relevant Governance meetings in order that mitigating action can be taken. From the information provided, information will be collated and report trends and actions required from incidents, claims, complaints, legal claims, risk management reports and any internal risk management reports. They are responsive for establishing and sustaining an environment of openness on risk management within their areas and have a responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls.

4.2.16 **Clinical Leads / Heads of Department/Service Managers / Lead Nurses / Matrons / Non-clinical Managers** are responsible for ensuring the approach, policy and plans are known in each area, and for the day-to-day management of all risk types. Managers are charged with ensuring that risk assessments are undertaken on a proactive basis and that preventative action is carried out where necessary. They are also responsible for the ongoing maintenance and review of their respective risk register, escalating risk when appropriate to the Divisional /Directorate triumvirate and sharing any lessons learned across each area. Managers are expected to seek advice where necessary about implementation of risk reduction plans from the available specialists within the Trust. They all have a

responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls.

4.2.17 **Divisional / Directorate Governance Facilitators** are responsible for supporting Divisional Leads and Service Managers in the day-to-day management of risks within their area. Governance Facilitators play a pivotal role in the coordination, monitoring and reporting of risk and clinical governance activities to Trust Committees and work stream groups. In particular:

- Working with divisional / directorate leads to ensure risk registers are complete, accurate and robust including risk descriptions, controls, assessments and action plans;
- Quality assessing risk assessments and ensuring these are consistent, up to date, and proportional to the relative level of risk across the Division/Directorate; Seeking advice about the implementation of risk reduction plans from relevant Trust risk management specialists;
- Undertaking training in the Trust's risk management software and identifying additional training needs to the Risk and Compliance Team;
- Helping to reinforce a positive risk management culture within their area with all incidents and near misses graded, reported and investigated within the specified time limits;
- Coordinating assurance reporting on the management of risk with particular reference to risk registers, incidents, safety alerts, claims and complaints and ensuing these are reviewed at appropriate meetings
- Working closely with the Risk and Compliance Team to develop best practice and address challenges.
- Correctly identifying risk, the scoring of risk and compliance with Trust controls.

4.2.18 **Ward/ Departmental Managers** - have a responsibility to identify and assess risks, ensuring controls are applied to mitigate the risks and of ensure compliance with Trust controls. Managers are responsible for maintaining their ward/ departmental level risk registers and for using this information to inform the decision making process. Managers should also use risk registers and risk prevention guidance to manage systems and processes within their areas of control. Managers also have a responsibility to escalate risks which are beyond their control. They are responsible for ensuring all staff are aware of the safety hazards in their area of work and for supervising the implementation of safe working practices. Managers should liaise with Governance Leads and specialist advisors to identify and control hazards via inspection and assessment. Managers are also responsible for establishing and sustaining an environment of openness on risk management within their directorates.

4.2.19 **All Employees (Permanent, Temporary, Voluntary, Contract)** - have a duty and a responsibility to be 'safety aware' and co-operate in the identification and minimisation of risks. Staff are responsible for ensuring they are familiar with

significant local hazards and know and use safe systems of work. If staff identify hazards or risks in the workplace they are responsible for taking immediate action to reduce the risk, (for example wiping up a spillage, warning others or removing and reporting a piece of equipment identified as not working properly). At all levels, this will be best achieved by harnessing a culture of honesty and openness whereby any incidents involving acts or omissions which could otherwise have been prevented may be identified quickly and corrected in a positive and responsive way. All Trust employees have a responsibility to correctly identify risk, the scoring of risk and compliance with Trust controls.

4.2.20 **Risk Management Specialists** - The Trust has risk management specialists who possess and maintain appropriate qualifications and experience sufficient to ensure that competent advice is available to staff. The specialists are responsible for creating, reviewing and implementing policies, procedures, protocols and guidelines for the effective control of risk. Where responsibilities are assigned within the following roles the Trust shall regularly review the training needs analysis to ensure that competence sufficient for the discharge of any duties is acquired and maintained by the duty holders. Details of Trust risk management specialists are provided below

Specialist/ Advisor

Caldicott Guardian

Chief Pharmacist/Accountable Person Controlled Drugs

Company Secretary

Designated Individual Human Tissue Act

Emergency Planning Liaison Officer

Fire Safety Advisor

Health Safety Advisor

Associate Director of Patient Safety

Head of Risk and Compliance

Moving & Handling Advisor

Information Governance Manager

Local Counter Fraud Specialist

Local Security Management Specialist (LSMS)

Senior Information Risk Owner (SIRO)

5 Aims and Objectives of Risk Management

5.1 Aims

5.1.1 The Trust aims to incorporate evidence-based risk management activity into everyday working practices and incorporate into its management arrangements accountability for the identification, assessment, response, monitoring, reporting and review of risks.

5.1.2 The Trust adopts a simple method to analyse and assess the potential and likelihood of harm or loss and, by careful control setting, ensure risks are effectively prevented or, if they occur, that harm/loss is effectively detected and mitigated.

5.2 Objectives

5.2.1 The objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks which may adversely affect patients, staff and the public are identified, assessed, documented and effectively managed locally thereby providing a safe environment in which patients and service users can be cared for, staff can work and the public can visit;
- Risks to the achievement of corporate objectives are identified, assessed, monitored, documented and correctly managed locally and corporately thereby protecting the reputation of the Trust and trust assets;
- Risks are regularly reviewed and updated within Departments, Directorates, Divisions and Corporately by accountable managers;
- Risks and issues not being controlled locally are escalated appropriately;
- Risks are managed to an acceptable level as defined by the Trust's risk appetite (see intranet for details) and escalated appropriately (appendix 4);
- All staff have a clear understanding of the Trust's risk appetite, risk exposure and the action being taken to manage significant risks;
- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, monitor and manage risks effectively;
- All staff are empowered to 'stop the line' if safety is compromised;
- All staff can work in a safe environment;
- All staff recognise their personal contribution to effective risk management;
- Assurance on the operation of controls is provided through audit or inspection and gaps in control are identified and actively managed.

6 Type of Risks

6.1 Risks to patients

6.1.1 The Trust recognises that there is inherent risk as a result of being ill or injured, and that the responsibility of the Trust is to inform patients, service users and relatives and work to reduce that risk where possible.

6.1.2 The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good health care and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery.

6.1.3 In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

6.2 Organisational risks

6.2.1 The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct or escalate system weaknesses.

6.2.2 The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance arrangements whilst maximising our performance in line with value for money.

6.2.3 A programme of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

6.3 Reputational risk

6.3.1 The Board models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment.

6.3.2 The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

6.4 Relationship risk

6.4.1 The Trust is increasingly engaging with external parties to conduct business processes or services, which inevitably introduces new risks to be managed. It will be important for the Trust to understand the origin of these risks and establish clearly who has ownership to ensure effective oversight of risks.

6.4.2 A framework will be used to support the assessment of risks arising from third-party relationships, evaluate risks to identify the highest risks and monitor and assess risks using performance data.

6.5 Opportunistic risks

6.5.1 The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in business plans, whilst respecting and abiding by its statutory obligations.

6.5.2 Taking action based on the Trust's stated and agreed risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure that safety and quality is maintained.

7 Risk Appetite

7.1 Risk Appetite Description

7.1.1 The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an initial evaluation. Risk is unavoidable, and every organisation needs to take action to manage risk in a way

that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the “risk appetite”.

7.1.2 Risk appetite is therefore ‘the extent of risks that the organisation is willing to take in achieving its objectives’ (HMT, 2020) It can be influenced by personal experience, political factors and external events.

7.1.3 Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance and its reputation.

7.1.4 In order for the trust to oversee risk management effectively, there must be a clear understanding of what constitutes the trust’s risk appetite and this should be clearly communicated and applied. There is a danger that if the organisation’s collective appetite for risk is set at a certain level and the reasons are not known, communicated or applied, then this may lead to erratic or inopportune risk taking, thereby exposing the organisation to a risk it cannot tolerate. Conversely an overly cautious approach can be taken which may stifle growth and development. If the leaders of the organisation do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected.

7.1.5 The Trust will review its appetite for and attitude to risk on an annual basis, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The risk appetite review will consider risk leadership; people; risk policy and strategy; partnerships; risk management process; risk handling; and outcomes.

7.1.6 The risk appetite statement will be communicated to all staff and stakeholders to formalise and clarify the trust’s overall approach to risk. Training on risk management and the risk appetite will be provided to relevant individuals to help understand the trust’s risk appetite and its impact on day-to-day activities, and to promote desired behaviours.

7.2 Risk Appetite Statement - See the Trust intranet for the current Risk Appetite Statement

7.2.1 The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation’s risk appetite should address several dimensions:

- The nature of the risks to be assumed
- The amount of risk to be taken on
- The desired balance of risk versus reward

7.2.2 On an annual basis the Trust will publish its risk appetite statement in respect of each of the principal risks that together contribute to the Board Assurance Framework. The risk appetite is reported in the risk and control framework statement within the Annual Governance Statement. Risks throughout the organisation should be managed within the Trust’s risk appetite, or where this is exceeded, action taken to reduce the risk.

7.2.3 The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and will be published on the Trust intranet sites.

8 Risk Management Process

8.1 The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks and the controls by which the risks are managed and where possible mitigated
- Completion Management and review of risk registers and, thereby identifying additional actions
- Escalation and de-escalation of risks (see appendix 2)

8.2 Governance structure to support risk management

8.2.1 There are different operational levels ensuring the governance of risk in the Trust;

- Board and Executive level
- Site Director level
- Divisional / Directorate / Departmental level

8.2.2 The governance structure can be seen in appendix 1

8.2.3 Risk management by the board is underpinned by a number of interlocking systems of control. The board reviews risk principally through the following three related mechanisms.

- The **Board Assurance Framework (**BAF) sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the board agenda.
- The **Corporate Risk Register** (CRR) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
- The **Annual Governance Statement,** signed by the Chief Executive as the accountable officer, sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and approved by the board with the accounts.

8.2.4 Additionally, the Audit Committee and other board sub-committees provide assurance of the robustness of risk processes and support the Board. They may gain assurance through "deep dives" into risk management arrangements and may seek and gain assurances through a range of internal and external reviews.

8.2.5 Each division / directorate will have a management forum where risk is discussed, including their risk register, actions, and any escalation required to the corporate risk register.

8.2.6 The process by which risks are operationally managed at Mid and South Essex NHS Foundation Trust can be found within the Risk Management Policy.

9 Horizon Scanning

9.1 Horizon scanning focusses on identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the operational and business activity of the Trust.

9.2 Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

9.3 By implementing formal mechanisms to horizon scanning, the Trust will be better able to respond to changes or emerging issues in a planned, structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider on-going risks to services.

9.4 The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- NHS England publications
- Local demographics
- Seeking stakeholders views
- Risk Assessments

9.5 All staff have the responsibility to bring to the attention of their managers, potential issues identified in their areas which may impact on the Trust delivering on its objectives.

9.6 Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

10 Risk Management Activities

10.1 The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by ongoing training including:

- Risk Management Policy
- Incident Policy and Serious Incident Policy
- Health and Safety Policy
- The Complaints Policy and Procedure
- Information Governance Policy
- Corporate Business Continuity Plan
- All policies and procedures associated with Healthcare Acquired Infections
- The Management of Violence and Aggression
- Safeguarding policies and procedures (Adult and Child)

10.2 The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the Annual Plan;
- Evaluate the nature and extent of risks;
- Manage all risks effectively, efficiently and economically;
- Enable the completion of the Annual Governance Statement.

11 Knowledge and Skills (Training)

11.1 **Awareness:** Staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.

- **Risk identification**: Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks. Refer to the Trust whistleblowing policy.
- **Accountability:** Staff will be identified to own the actions to tackle risks
- **Communication**: There will be active and frequent communication between staff, stakeholders and partners.

11.2 **Competence: s**taff will be competent at managing risk. This will be achieved through appropriate levels of training provided to nominated leads and managers.

- **Training** – staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally. Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register(s).
- **Board Training** – the Trust Board will be provided with training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed Regulations. Risk awareness sessions are included as part of the board's development programme. Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

11.3 Management: Activities will be controlled using the risk management process and staff are empowered to tackle risk.

- **Risk assessment and management** – risks will be assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans will be put in place where required.
- **Process** - the process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.
- **Measuring performance** - exposure to risk will be measured with the aim of reducing this over time. The culture of risk management will also be measured and improved.

12 Delivering the Strategy

12.1 The Strategy will be delivered by focussing on key themes of activity, linking the Trust's overarching commitments, strategic objectives outlined in the Annual Plan and local objectives agreed within Divisional/ Care Group/ Corporate Directorate service plans.

12.2 Directors, Senior Management Teams and Departmental Managers within the Trust will:

- Be clear about the Trust's quality priorities and strategic objectives;
- Promote awareness and understanding of the benefits of proactive risk management, therefore developing a positive risk and patient safety culture;
- Manage risk through their own Clinical/Corporate Division, Clinical Service Unit and Departmental structure by identifying, assessing, controlling, monitoring and reviewing risks; ensuring the controls and action plans are sustainable, effective and fully implemented;
- Distribute and disseminate, to their teams results of complaints, incidents, audits and lessons learned;
- Support compliance with appropriate legislation and standards including national and CQC requirements.

12.3 The Trust will:

- Ensure corporate ownership and accountability throughout the organisation of risk management and the need to mitigate risk along with the mechanisms for reporting and sharing learning across the organisation;
- Promote and support the development and implementation of risk management policies in general practice;
- Provide training and ongoing support to ensure that all risks are reported and that all staff are aware of mechanisms to report incidents and near misses;
- Ensure that all staff receive training on health and safety and risk assessment;
- Establish and implement a plan to develop and strengthen the organisation's risk management culture.

12.4 The Strategy will be reviewed annually by the Board according to good governance practice.

13 Process for Monitoring Compliance with the Strategy

13.1 The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed, through among other things, the annual review of the risk management system and the Internal Audit review on the effectiveness of the system of internal control.

13.2 Assurance will be sought through the evaluation of risks that the Board sub-committees have discharged their responsibilities appropriately with regards to the review and approval of updated BAF risks and that the Board Assurance Framework has been presented to the Board as required.

13.3 Operational key performance indicators in relation to risk management are described within the associated risk management policy and procedures. Assurance will be obtained on the effectiveness of the risk management strategy from the review of risk management reports, including key performance indicators, to the Audit Committee and Governance Oversight Committee.

13.4 The Terms of reference of the Board and sub-committees will be reviewed on an annual basis and the review of the terms of reference will ensure that responsibilities in relation to risk management are discharged appropriately.

13.5 The annual governance statement provides assurance that the system of internal control is managing organisational risks to a reasonable level.

14 Approval and Implementation

14.1 The Trust's Risk Management Strategy will be disseminated and made available:

- Internally – Divisional / Directorate Managers/Heads of Department are expected to communicate the strategy as part of local induction procedures. All staff are introduced to the principles outlined in the strategy at corporate induction. Risk management training will refer to the strategy. The strategy is available on the Trust

Intranet. Amendments to the strategy will be communicated as and when they occur.

- Externally – The strategy will be shared as appropriately with key stakeholder and is freely available on request. The annual governance statement and Board Assurance Framework are published as part of the trust Board papers. The internal system of control is reported externally within the Annual Governance Statement.

14.2 This strategy will be reviewed annually by the Board or sooner if circumstances dictate.

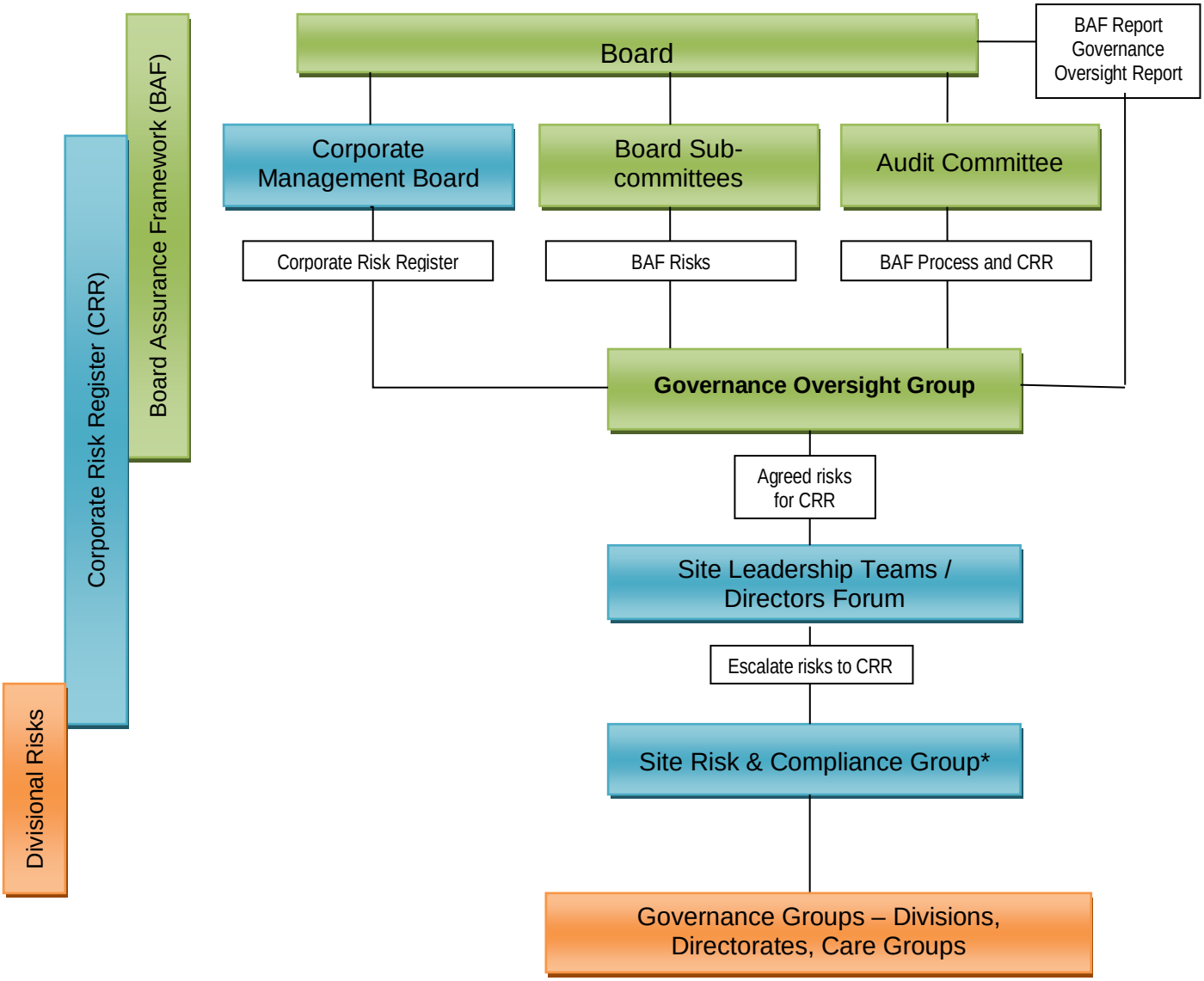
15 References

1. HMT 2020, The Orange Book, Management of Risk – Principles and concepts – www.gov.uk/government/publications/orange-book

16 Equality Impact Assessment

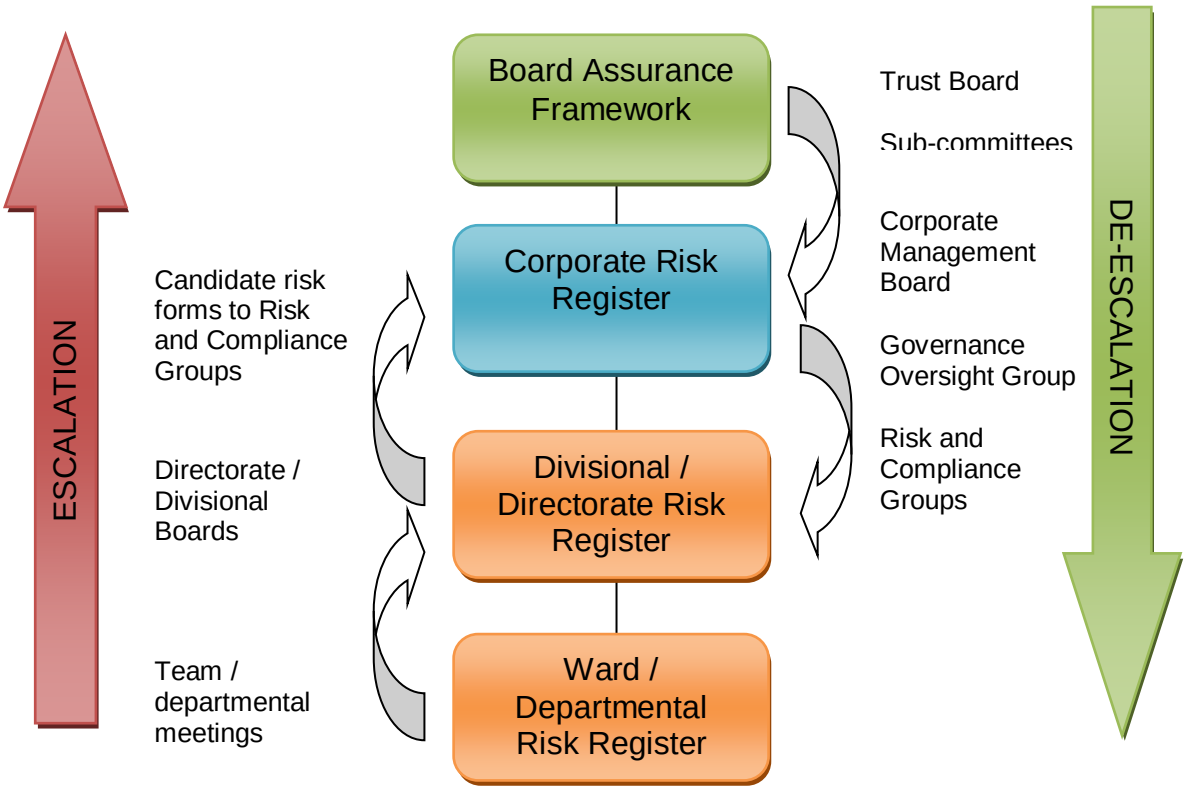
16.1 As part of its development, this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

Appendix 1: Risk Reporting Structure



* Site based Divisions / Directorates will report into their own site Risk & Compliance group. MSE wide services and Care Groups will formally report into their hosted site R&C group in addition to escalating any local issues to the relevant site R&C group.

Appendix 2 – Risk escalation and de-escalation framework



Appendix 3: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

A change in a service to patients		A change to an existing policy		A change to the way staff work	
A new policy		Something else (please give details)		Updated Strategy	

Questions	Answers
1. What are you proposing to change?	**Slight change to risk reporting structure**
2. Why are you making this change? (What will the change achieve?)	**Following the creation of the new Trust**
3. Who benefits from this change and how?	**All staff**
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	**No**
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	**N/A**

Preliminary analysis completed by:

Name	**Tracy Turner**	**Job Title**	**Associate Director for Risk and Compliance**	**Date**	**01/06/20**