North East Ambulance Service NHS
NHS Foundation Trust

Risk Management Strategy

Document Control Sheet

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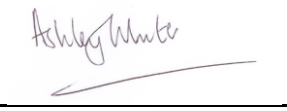
Signature of Chairman of Ratification Committee	
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Table of Revisions

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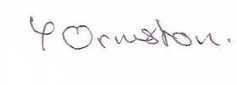
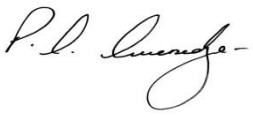
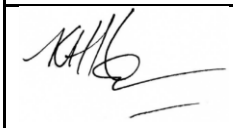
002	Live	All	Document updated following further feedback, new version with separate risk management policy and annual risk management plan written.	Alan Gallagher	21 October 2015

Executive Directors Signature

Directors signature	Print name	Date
	Yvonne Ormston	17/03/2016
	Paul Liversidge	17/03/2016
	Joanne Baxter	16/03/2016
	Roger French	15/03/2016
	Caroline Thurlbeck	17/03/2016
	Kyee Han	17/03/2016

Executive Directors who will be responsible for ensuring staff within their directorates abide by the Policy should sign here to evidence they have seen the Policy and agree to its content.

Contents

1. Introduction

North East Ambulance Service NHS Foundation Trust is committed to the provision of high quality care in a setting that puts the safety of patients and staff first. However it is acknowledged that all activities contain inherent risks.

The Trust regards risk management as a mutual objective for management and employees at all levels. The Trust will meet its commitment through a system of risk management that is understood and implemented at all levels of the organisation.

The Risk Management strategy promotes the philosophy of integrated governance and requires all risk management to be systematic, robust and evident. This strategy requires that risk management processes are applied to business planning at all levels and that risk management issues should be communicated to key stakeholders where necessary. The strategy covers clinical, organisational, operational and financial risk, and identifies the key management structures and processes defining objectives and responsibilities within the Trust.

Risk Management is not about risk elimination in its entirety; it is about encouraging appropriate risk-taking, i.e. those risks that have been evaluated and which are understood as well as is possible with currently available information. It is recognised that only through appropriate risk-taking will the Trust be able to operate safely and appropriately. Successful organisations are by their nature successful risk takers and aware of their risk appetite.

2. Purpose

The purpose of the Risk Management strategy is to detail the framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, Monitor Terms of Authorisation, key regulatory requirements set out by the Care Quality Commission and deliver strategic objectives.

It articulates the holistic approach planned by the Trust over the next 3 years to provide an environment which mitigates or accepts risks and therefore manages risk effectively. This will be delivered through a comprehensive system of internal and external controls, assessing and developing the Trust's risk appetite and maximising the potential for flexibility, innovation and best practice in delivery of the Trust's strategic objectives.

2.1 Promoting a Fair and Open Culture

All members of staff have an important role to play in identifying, assessing and managing risk. To support staff the Trust is fostering a fair, open and consistent environment and does not seek to apportion blame. In turn, this will encourage a willingness to be open and honest and to report any situation where things have, or could go wrong. Exceptional cases may arise where this is clear evidence of wilful or gross neglect contravening the Trust's

policies and procedures and/or gross breaches of professional codes of conduct which will referred in line with Trust Policies.

3. Scope

This Risk Management strategy is intended for use by all directly employed staff, agency workers, volunteers and external contractors.

The strategy will be communicated to all levels of the Trust via the Trust's Q-Pulse Policy system

All external stakeholders will be informed of its location and will be published on the Trust's internet site.

All trust employees will be expected to adopt the principles of the Strategy, incorporating it into their day to day role and processes.

Managers will be expected to support and encourage staff in adopting the principles of the strategy by promoting an open and fair culture and improved incident reporting and management.

Risk Management will be a statutory component of all induction programs and mandatory training delivered by the Trust. This will include members of staff at all levels within the Trust and will include familiarisation with the Strategy.

4. Roles & Responsibilities/Duties

The following section details the responsibilities of specific individuals and groups involved in compliance with this document.

4.1 The Trust Board

The Board has a collective responsibility to ensure that the risk management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

4.2 Chief Executive

The Chief Executive has overall responsibility for risk management.

4.3 Executive Lead for Risk Management

The Director of Clinical Care and Patient Safety is designated as the Executive Lead for risk management and is responsible for ensuring that there are robust systems and processes in place for effective risk management and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

4.3 Executive Directors

The Executive Directors are accountable and responsible for ensuring that the Corporate Directorates are implementing the Risk Management Strategy and related policies as listed in sections 8 and 9 of this document. They also have specific responsibility for managing the Trust's principal risks, which relate to their Directorates. For example:

- the Director of Finance and Resources for managing the Trust's principal risks relating to ensuring financial balance;
- the Director of Clinical Care and Patient Safety for managing the principal risks relating to quality;
- the Director of Strategy, Transformation and Workforce is responsible for managing the Trust's principal risks relating to workforce planning, strategy and training;
- the Chief Operating Officer is responsible for managing the principal risks relating to service delivery and operations;
- the Medical Director is responsible for managing risks associated with clinical strategy and clinical performance.

These designated directors sit on the appropriate assurance committees which cover their area of risk. Each Executive Director is responsible for updating the Board Assurance Framework as well as presenting the document at the assurance committees. Executive Directors are also responsible for ensuring the effective identification and management of risks in their functional areas of responsibility and providing the Board and committees with this assurance.

4.4 Executive Risk Management Group

The Executive Risk Management Group ensures that all the areas of risk are properly managed. It has strategic responsibilities, to set standards, monitor risk related policies ensuring that are clear and up-to-date, and check that the Trust is meeting these standards and operating accordingly. Responsibility for meeting standards and implementing these are delegated to all staff and overseen by Trust Managers.

4.5 Council of Governors

The Council of Governors is responsible for holding the Non-executive Directors individually and collectively to account for the performance of the Board, including ensuring the Board of Directors acts so that the Trust does not breach the terms of its authorisation. The Trust will ensure that it supports governors in this role by proactive notification to governors of the following:-

- any issues identified by the Trust which put the Trust at risk of breaching its terms of authorisation;

- any serious incident, media interest or similar issue which may impact upon the Trust's reputation and which is also notified to the CQC and Monitor;
- any corporate risk which has the potential to impact on the achievement of the Trust's Corporate Objectives.

4.6 Trust Managers

Trust Managers are accountable and have authority to ensure appropriate risk management processes are implemented within their respective directorates and areas of authority. Each Trust Manager is required to:

- work proactively to achieve the Trust's Key Performance Indicators for risk management;
- understand and implement the risk management strategy and related policies;
- ensure that appropriate and effective risk management processes are in place within their delegated areas;
- ensure directorate activity is compliant with national risk management standards and safe practices, alerts etc;
- develop specific objectives within their service plans which reflect their own risk profile and the management of risk;
- risk assess all business plans/service developments including changes to service delivery;
- ensure that risk assessments, both clinical and non-clinical, are undertaken throughout their areas of responsibility. The risks identified will be prioritised and action plans formulated. These action plans will be monitored through the performance meetings (Delivering Consistently) with key risks also being reported to the Executive Risk Management Group;
- maintain a service/directorate risk register (clinical, non-clinical and financial). Formally reporting high and extreme risks via the performance meetings and Executive Risk Management Group;
- report all incidents, including near misses, in accordance with the Adverse Events Reporting Policy (CO-POL-94) and identify action taken to reduce or eliminate further incidents;
- undertake investigation into all serious incidents, in accordance with the Serious Incident Policy providing evidence of local resolution and learning.
- disseminate learning and recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their areas of responsibility;
- monitor and report on the implementation and progress of any recommendations made which fall within their area of responsibility i.e. within the directorate;
- ensure that all staff are made aware of risks within their working environment and their personal responsibilities within the risk management framework;
- identify own training needs to fulfil the function of managing risk as a senior manager;
- ensure that Trust-wide corporate/organisational risks are communicated to all staff within the department/directorate. The role of directorate staff in

contributing to the overall management of the risk should be clearly communicated, where applicable.

4.7 Staff Responsibilities

Management of risks is a fundamental duty of all staff and should be recognised as an integral part of good practice whatever an individuals' grade or designation. All staff must ensure that identified risks are reported to their immediate line manager in order that effective controls may be considered and action taken where necessary.

All employees of the Trust have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by Trust business. It is the duty of all employees to be familiar with the Trust Risk Management Strategy and comply with Trust rules and regulations and instructions to protect health safety and welfare of anyone affected by the Trust's business. The Trust cannot condone any intentional or reckless interference with or misuse of any equipment provided for their protection, health and safety.

All Staff are required to:

- be conversant with the Risk Management strategy and have a working knowledge of all related risk polices;
- comply with Trust policies, procedures and guidelines to protect the health, safety, and welfare of any individuals affected by Trust activity;
- acknowledge that risk management is integral to their working practice within the Trust;
- raise risks/incidents on the Ulysses risk management system when identified and also update risks on a timely basis where responsibility has been assigned to them (either in relation to the risk itself or associated mitigating actions).
- report all incidents and near misses in accordance with the Adverse Events Reporting Policy and take action to reduce or eliminate further incidents;
- report any risk issues to their line manager and report via the Ulysses Safeguard system;
- participate in the investigation of any adverse events as requested;
- attend mandatory training appropriate to role.

Staff may be worried about raising issues or may want to keep concerns to themselves, perhaps feeling it's none of their business, that it's only a suspicion or they would be being disloyal to colleagues, managers or the organisation.

The Trust has a Whistleblowing and Raising Concerns at Work Policy in place (CO-POL-91). Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrong-doing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public) either in the past, present or future. Whistleblowing concerns are distinct from grievances, which by contrast are about the staff member's own employment position and have no additional

public interest. The Trust would rather staff raise their concerns when they are just concerns rather than wait until further problems have occurred.

4.8 Head of Risk and Regulatory Services

The Head of Risk and Regulatory Services is responsible for monitoring the delivery of this strategy and associated policy and is responsible for;-

- ensuring the Trust has a comprehensive and dynamic risk register and working with directorate management teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;
- ensuring information is provided on incident data to Directorate Management Teams, the Experience Complaints Litigations Incidents and PALS (ECLIPS) group,
- ensuring risk reports are available for the ERMG;
- producing and coordinating risk management training programmes in conjunction with the Risk Manager/Local Security Management Specialist (LSMS) and training school and gaining assurance from training school on delivery and quality of same;
- the development of the Annual Risk Management Plan which will be monitored by the Trust Board annually against full delivery of this Strategy;
- for facilitating and ensuring compliance with core risk standards;
- chairing and working in collaboration with the members of the Health and Safety Committee to ensure compliance with Health and Safety Standards.

4.9 Chief Internal Auditor

The Chief Internal Auditor is responsible for verifying the accuracy of the Statement on Internal Controls.

5. Strategy Content

5.1 Compliance & Assurance

Monitor has a very clear risk assessment framework which ensures that all NHSFTs are able to demonstrate that they are remaining within their agreed provider license. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

5.2 Board Assurance Framework

The Trust's Board Assurance Framework (BAF) underpins the delivery of its key objectives and incorporates the highest risks faced by the organisation. It therefore aligns the Trust's principal risks with the key controls and assurances for each of the Trust's key objectives. Where gaps in assurances are identified, mitigating actions are developed to reduce the risk of the non-delivery of these key objectives. In summary it informs the Board where the

delivery of principal objectives is at risk due to a gap in control and/or assurance. This allows the Trust to respond rapidly.

The BAF is reviewed by the Board on a quarterly basis. Each strategic risk on the BAF has an assigned Executive lead and Board committee. The Board committee undertakes a review of the strategic risk, controls and assurances at each meeting, triangulating it against other information received to determine whether the appropriate levels of assurance are being received.

5.3 NHS Bodies

All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Board Assurance Framework brings together this evidence.

5.4 Performance Management Reporting Framework

In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Assurance Framework and remedial action agreed.

5.5 Designated Assurance Committees

The designated Assurance Committees of the Trust Board are the Quality Committee (Clinical, Quality and Health and Safety Risk), the Finance Committee (finance, environmental and IT risks), and the Workforce Committee (HR, workforce and organisational development risks). The Audit Committee monitors the risk management process overall on an annual basis (see structure Appendix G).

The purpose of the Executive Risk Management Group (ERMG) is to champion and promote the development of highly effective risk management across the Trust. The Group meets monthly and is responsible for establishing a strategic approach to risk management across the organisation, ensuring that the approach is pro-active. The Group is also responsible for the overall co-ordination of risk management activity. It ensures that the necessary processes are in place to achieve compliance with statutory requirements and to protect patients, staff and assets. ERMG reviews the BAF and the Organisational Risk Register at each meeting and also receives reports from directorates and services on their most significant risks. Business continuity risks are also reported directly to ERMG.

5.6 Identifying Gaps & Risks

It is the responsibility of the assurance committees to report to the Trust Board on any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported

immediately via the Executive Directors. Reporting should be via the assurance and escalation reports which are completed after every meeting.

5.7 Evaluating Quality & Robustness

It is important for the Trust Board to be able to evaluate the quality and robustness of the BAF and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements.

5.8 Business Planning Cycle

The Head of Risk and Regulatory Services shall work closely with all Executive Directors to ensure that the BAF remains dynamic and is integral to the Business Planning cycle.

5.9 Exception Reporting

If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify Monitor via an exception report.

5.10 The Trust Risk Registers

5.10.1 Each Department/Service

Each Department will continue to carry out risk assessments which feed into the directorate risk registers. A single framework for the assessment, rating, and management of risk is used throughout the Trust via the Ulysses risk management system. This process is described in detail within the Ulysses' Safeguard Risk Register Web System standard operating procedure which is accessible via the system.

5.10.2 Each Directorate

Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed on a rotational basis at the Executive Risk Management Group (ERMG). At these meetings the directorates will be expected to report on their risk registers (risks scoring 12 or above), highlight any new or emerging risks to service delivery and present action plans for minimising and managing these risks. The ERMG should identify those departmental risks which also pose a corporate threat (those scoring 15 and above) and so require inclusion on the Organisational Risk Register. Any risks scoring 15 and above will be automatically included on the Organisational Risk Register for scrutiny by the ERMG. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place.

5.10.3 Risk Identified at ERMG

The departmental and directorate risks identified at the ERMG meetings which impact on the corporate objectives are combined with the corporate risks thus allowing for a bottom up top down approach to identifying the Trust's principal risks and informing the Assurance Framework. This proactive

approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisational, health and safety, business, marketing and financial.

5.11 The Annual Risk Management Plan

Each year the Trust will review and update the annual risk management plan to ensure each objective contributes to the overall 3 year Strategy.

The plan appended at appendix 'H' is to promote Risk Management as an integral part of the work of NEAS. This involves 4 key themes and a number of associated core objectives.

5.11.1 Monitoring

The Annual Risk Management Plan will be developed by the Head of Risk Management and will be agreed and monitored by the Trust Board annually against full delivery of this Strategy.

5.11.2 Key Risk Issues

The Annual Plan will include objectives to address key risk issues in order to ensure continuity and progression in the Trust's strategic direction for risk management. This includes issues relating to business, financial, clinical and non-clinical risks.

5.12 Ensuring Compliance with National Standards

The Risk and Regulatory Services Team is responsible for facilitating and ensuring compliance with core risk standards. The Risk Management Annual Plan identifies how compliance will be assured and its progress monitored by the Executive Risk Management Group.

The Head of Risk and Regulatory Services works in collaboration with the Head of Clinical Care and Patient Safety, Consultant Paramedic and Compliance Officer to ensure compliance with the Care Quality Commission outcomes, and formulates and monitors action plans pertinent to risk.

The Head of Risk and Regulatory Services chairs and works in collaboration with the members of the Health and Safety Committee to ensure compliance with Health and Safety Standards.

5.13 Monitor & Review

This Strategy shall be reviewed every 3 years by the Executive Risk Management Group and ratified by the Trust Board.

The overall implementation of this Strategy shall be monitored through the annual internal audit review.

5.14 Risk Appetite

Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives.

The Trust recognises the importance of a robust and consistent approach to determining risk appetite in order to ensure:

- The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic or inopportune risk taking, or an overly cautious approach which may stifle growth and development;

- Managers in the Trust know the levels of risks that are legitimate for them to take, as well as appropriate opportunities when they arise, in order to ensure service improvements and patient outcomes are not adversely affected.

In order to value and compare the relative merits and weaknesses of different risks, the Trust Board will determine the level of risk the organisation is willing to tolerate in different areas.

This will include deciding whether the Trust will Eliminate, Reduce, Transfer or Accept a risk and what the organisation's '*target risk*' should be. Operating within risk tolerances provides the Trust Board with greater assurance that the organisation will remain within its risk appetite and, as a result, achieve its strategic objectives.

Risk appetite will thus be quantified for each organisational risk in the first instance, with the aim of all risks having a target risk informed by risk appetite by the end of the longevity of this Policy and Strategy.

The Trust Board will put systems in place to manage risks to an acceptable level within its level of tolerance. The parameters of this tolerance are set within the Risk Tolerance Matrix below, as shown in appendix 'E'.

In setting risk appetite levels, the Trust Board will take account of risk tolerance and opportunity risk.

The Executive Management team will recommend to the Board whether to tolerate certain risks from the point at which they are identified. The Executive Directors will provide ongoing assurance to the Trust Board that existing controls are sufficient to mitigate risks above the tolerance levels, particularly where the cost of treating the risk is more than the potential benefits.

In formulating the Trusts Risk Appetite the Board have agreed to utilise a Risk Appetite Matrix (Appendix E) which assesses the Trusts risk appetite and complements other risk management tools. This matrix was initiated and designed by Southwark Clinical Commissioner Group and the Good Governance Institute and is now widely used by other NHS Organisations.

Risk appetite is '*the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point of time'*. Risk therefore needs 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. NEAS commits in its formal risk appetite statement to review this statement on an annual basis. The statement provides direction and boundaries on risk that can be accepted at various levels of the organisation, how the risk and any associated reward are to be balanced and the likely response.

5.15 Risk Appetite Statement

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

The Trust Board is committed to ensuring a robust infrastructure is in place to manage risks from operational level to board level, and that where risks crystallise, demonstrable improvements can be put in place.

North East Ambulance Service NHS Foundation Trust's appetite is currently assessed as Moderate (see risk appetite matrix Appendix F) the risk to the delivery of our Strategy within the Trust's accountability and compliance frameworks whilst maximising performance within value for money frameworks.

The Trust may take considered risks, where the long term benefits outweigh any short term losses. Well managed risk taking will ensure that the skills, ability and knowledge are there to support innovation and maximise opportunities to further improve services. The Trust commits to review its risk appetite statement on an annual basis and/or following any significant changes or events. The strategy will plan to move the Trust to mature by 2018.

5.16 Risk Maturity

Figure 1 (below) shows a Risk Maturity scale, which shows the different levels of risk maturity that the Trust can aim to achieve as risk management becomes more embedded in the organisation.

An internal self-assessment of the Risk Maturity of the Trust indicates that NEAS is currently between **'*Risk Aware''* and *'Risk Defined'***

It is the intention of the Trust Board to embed the risk maturity of the organisation as '*Risk Managed'* throughout 2015, and to move towards '*Risk Enabled'* status by 2018, depending on the prevailing appetite of the Trust Board to invest any resources required for this achievement.

The Board will review its risk maturity on annual basis, as part of the Annual Risk Plan and Governance Statement disclosure

The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Executive Risk Management Group will monitor the implementation of recommendations arising from this audit.

Figure 1: Risk Maturity 1

Risk Maturity	Key Characteristics
Risk Naive	No formal approach developed for risk management
Risk Aware	Scattered silo based approach to risk management
Risk Defined	Strategy and policies in place and communicated. Risk appetite defined
Risk Managed	Enterprise wide approach to risk management developed and communicated
Risk Enabled	Risk management and internal control fully embedded in the operations

5.17 Risk Identification

The Trust operates two systems to facilitate the identification, analysis and treatment of risks:-

Pro-actively: - Production of risk registers and treatment action plans at department, directorate and organisational level, with the organisational risks reported to the Board through dynamic risk assessment.

Reactively: - The Reporting and Investigation of Adverse Events requiring all incidents to be recorded investigated and recommendations acted upon.

6. Glossary of terms

This Policy uses the following terms:

Hazard	A hazard is anything with the potential to cause harm
Risk	A risk is the likelihood that a hazard will cause a specified harm to someone or something
So Far as is Reasonably Practicable	Take action to control the health and safety risks in your workplace except where the cost (in terms of time and effort as well as money) of doing so is "grossly disproportionate" to the reduction in the risk
Risk Management	The systematic identification, reduction and/or elimination of risks
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time
Risk Management Maturity	The level of skills, knowledge and attitudes displayed by people in the organisation, combined with the level of sophistication of risk management processes and systems in managing risk within the organisation.
Risk Matrix	The mechanism through which all risks are rated and scored
Board Assurance Framework	The documentation that provides the Trust Board with assurance(s) that the key risks associated with not achieving the Corporate objectives are being mitigated
Risk Register	The method used to record identified risks, their rating, scores, control measures and where evidence of controls can be located
High Level Risks	Risks that are rated and scored at 15 or above
Risk Treatment	Proposed control measures that may reduce the risk of an identified hazard
Residual Risk	Level of acceptable risk following implementation of risk treatment solutions
Risk Management Sub Committees/Groups	Delegated committees/groups of the Trust Board responsible for ensuring that identified risks are appropriately managed within the Trust

7. Monitoring

7.1 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response
Who will perform the monitoring?	The Head of Risk & Regulatory Services and Risk Manager/LSMS
What are you monitoring?	▪ Compliance with the Policy and Strategy and annual plan delivery ▪ Risk Registers and associated action plans. ▪ Trust specific reporting dashboards and other bespoke reports generated via the Ulysses Safeguard system. ▪ Board Assurance Framework ▪ Risk Management Culture ▪ Risk Maturity ▪ Risk Appetite
When will the monitoring be performed?	Monthly
How are you going to monitor?	Executive Risk Management Group
What will happen if any shortfalls are identified?	Any matters shall be escalated to the ERMG and subsequently the Trust Board
Where will the results of the monitoring be reported?	Executive Risk Management Group
How will the resulting action plan be progressed and monitored?	Executive Risk Management Group
How will learning take place?	Executive Risk Management Group shall monitor performance

7.2 Key Performance Indicators (KPI)

Standards/Key Performance Indicators are continually monitored via the Trust's Executive Risk Management Group; the statistics/figures contained in this report are submitted and collated on a monthly basis by ERMG.

To monitor the effectiveness of the Risk Management processes and policies the following agreed KPIs shall be monitored via the ERMG:

- achieve an overall Monitor financial risk rating of 2 or above;
- maintain full registration with the Care Quality Commission;
- all departments/staff proactively report adverse events using the Ulysses Safeguard system;
- to remain above average reporters of incidents when benchmarked against Trusts of a similar size (NRLS Report);
- evidence that dynamic Risk Registers are held within all departments covering key risks;
- 100% completion of a full root cause analysis for all Serious Incidents.
- evidence of a decreasing trend in incidents resulting in moderate harm and above;

- maintain a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Surveys/Cultural Surveys;

- compliance with contractual requirements associated with the reporting and management of SIRI's;

- cascade and Timely response to NHS England Patient Safety Alerts;

- all significant risks (scored 15 and above) are reported to and reviewed as a standing agenda item at each meeting of the ERMG;

- local risk registers show details of control, assurances, location, owner, action plan (where necessary) and 80% of risks are within review date and show the source of the risk;

- the risk profiles (for risks ≥8) for all services and directorates are reviewed by the ERMG at least annually;

- there is evidence to demonstrate that the BAF is updated at least on a monthly basis.

8. References

This document refers to the following guidance, including national and international standards:

The Trust uses the NHS Executive endorsed Australian / New Zealand Risk Management Standard – AS/NZS 4360:1999.

National Patient Safety Agency, risk matrix for Risk Managers.

Good Governance Institute, Risk Appetite Matrix for NHS Organisations

9. Associated Documentation

This document refers to the following Trust policies and procedures:

- Ulysses' Safeguard Risk Register Web System standard operating procedure;
- Reporting and Investigation of Serious Incidents (CO-POL-85);
- Adverse Events Reporting Policy (CO-POL-94);
- Claims Handling - Clinical Negligence, Liabilities to Third Parties and Property Expenses Scheme Claims (CO-POL-21);
- Being Open and Duty of Candour Policy (CO-POL-9);
- Identifying and Managing Serious Incidents (CL-PRO-40);
- Business Continuity Policy (CO-POL-69);
- Whistleblowing (Raising Issues of Concern) Policy (CO-POL-91).

Appendices

Appendix 'A' Equality Screening

Equality screening which must be conducted to determine if there is a potential differential impact. If there is, a full Equality Impact Assessment must then be carried out.

Date of screening	17 July 2015
Name of assessor	Alan Gallagher
Job title	Head of Risk and Regulatory Services
Signature of assessor	

Equality Group	Does this document have a potential impact on any of the equality groups?	If yes, please describe the potential impact	Is this impact legal and justifiable? If yes, please explain how
Age	No		
Disability	No		
Gender	No		
Gender reassignment	No		
Marriage and civil partnership	No		
Maternity and pregnancy	No		
Race	No		
Religion or belief	No		
Sexual orientation	No		

Equality Impact Assessment required?	No
1. Identify the aims of the document	
From the screening, what are the key issues and which equality groups are affected?	
What is the aim of the document?	
What are the intended outcomes of the document	
How will you measure the outcomes?	
Who is intended to benefit and how?	
2. Legislative compliance	
Does the document prevent the promotion of equality of opportunity or good relations between different equality groups? Please state how.	
Does the document/service provision infringe an individual's human rights? Please state how.	
3. Considering alternatives	
Can changes be made to the document/service to reduce the impact? (such as amending the wording of a Policy or changing a procedure) If Yes, please detail the changes and proceed to	

Section 6. If No, proceed to section 4	
4. Gathering information	
Please state the relevant qualitative information that is already available that is being used for this EIA.	
Please state the relevant quantitative information that is already available that is being used for this EIA.	
Are there any gaps in your information and if so how are you going to address those?	
5. Partnership working, consultation and involvement	
Do you need to involve, consult or work in partnership with any community group? Y / N If Yes, please state which community group(s).	
Do you need to involve, consult or work in partnership with any staff groups? Y / N If Yes, please state which staff group(s).	
Do you need to involve, consult or work in partnership any specialist services, groups or practitioners? Y / N If Yes, please state which services, groups or practitioners.	

Action		Benefits / Rationale	Lead	Timescale	Measures of Success	Age	Disability	Gender	Gender reassignment	Marriage and civil partnership	Maternity and pregnancy	Race	Religion or belief	Sexual orientation
1.														
2.														
3.														
4.														

Appendix 'B' Review Process Checklist – Author to complete

Compliance Checks	Author to Complete			
	Yes/ No	Details	Comments	Action Needed
Has the document been consulted upon? (please detail stakeholders that have been consulted)	Yes	Executive Risk Management Group	22nd December 2015	
Has the document been agreed by a sub group of the relevant Approval Committee? (if so, please specify the subgroup(s) here and confirm the date the document was endorsed by the group.	Yes	Executive Risk Management Group	22nd December 2015	
Approval: JCC (if appropriate)?	N/A			
Why has this document been amended? i.e. full review, particular section/new etc.	F/R			
Has table of revisions been completed?	Yes			
Has the document author clearly identified?	Yes			
Has the document sponsor been identified and consulted with	Yes			
Has the date of the Ratifying Committee meeting to which the document will be submitted been specified?	Yes			
Has the Ratifying Committee been correctly identified?	Yes			
Has the Originating Directorate been notified?	Yes			
Has the scope of the document been identified?	Yes			
Content: intended outcomes clearly described?	Yes			
Has the date the Document will next be reviewed been noted? (If less than the standard 3 years, please provide an explanation why)	Yes			
Has the monitoring table been correctly completed?	Yes			
Has the Equality Impact Screening been completed?	Yes			
If warranted from the above has the Equality Impact Assessment been completed?	Yes			
Has the financial implications been considered?	Yes			
Has the Document been assessed as to whether its circulation should be restricted/unrestricted? If so, the outcome of this assessment should be noted on the front sheet	Yes			
Does the Policy need to be available to the public? If so once ratified Communication team need a copy	Yes			
Name a member from the subgroup to be present to respond to any questions if author unavailable	Yes			

Date of Policy Review Group Submitted to	22nd December 2015
Authors Name	A Gallagher
Authors Signature	

Appendix 'C' Compliance Checklist – Policy Review Group

Approving Sub Committee:	Policy Review Group to Complete		
Compliance Checks	Yes/No	Comments	Actions Needed
Has the front page document been completed fully?	Yes		
Has the author completed checklist? And has this been checked by the group?	Yes		
Style and Format			
Has the correct template been used?	Yes		
Procedural Documents must use the Arial font style bold text size 12	Yes		
Section and paragraph heading should be numbered and in bold.	Yes		
Is it the EIS and EIA if applicable the latest version?	Yes		
Is the title of the Document clear and unambiguous?	Yes		
Has the new version number been amended on the Control Sheet, and Footer of each section?	Yes		
Has the version control/revision table been updated?	Yes		
Has the Document type been identified? (Policy/Procedure?)	Yes		
Explanation of Terms Used			
Acronyms are first used with explanation.	Yes		
Glossary of Terms used if helpful to the procedural documents understanding.	Yes		
Consultation & Review Arrangements			
Is it clearly apparent that the document has been consulted upon?	Yes		
Has the monitoring table been completed?	Yes		
If the monitoring of this document involves members of other teams or Health Groups, have they been informed?	Yes		
Has the name/job title of the Non Executive Chairman of the Approval Committee been correctly identified?	Yes		
Associated documents and supporting references			
Are there full references to other Trust Policies that the Policy refers to or is associated with.	Yes		
Following satisfactory review by Policy Review Group			
Has the ratification Committee been identified and is this the right committee?	Yes		
Is there timescales identified for monitoring and reporting to appropriate committee?	Yes		

Policy Review Group Outcome	Reviewed successful

Appendix ‘D’ Quality Team Checklist

Quality Team Checklist	Yes/No	Comments
Document Control Sheet complete with signatures?	yes	
Table of revisions complete?	yes	
All footers and watermark updated?	yes	
Page numbers updated?	yes	
Review process checklist and compliance checklist complete?	yes	
Previous version of Policy archived?	yes	
QPulse upload date complete?	yes	
Policy available to relevant staff groups?	yes	Live on q-Pulse
Process completed: Quality Team	Date 15/04/2016	Signature P McFarlane

Appendix 'E' Risk Matrix

It is very important to accurately define the risks identified to ensure that they are appropriately understood and scored so that the necessary controls can be highlighted and implemented. The definition of a hazard is something that has the potential to cause harm and a risk is the likelihood that the harm will be caused.

In order to ensure that risk are appropriately worded and recorded on the Trust's risk registers the following guidance should be followed. It is acknowledged that risk is inherently negative, implying the possibility of *adverse* consequences therefore: -

- Risks should always describe the potential **consequences** if the risk were to materialise
- Risks should also describe the causal factors that could make the risk materialise
- It may be that the risk has more than one consequence and these should be recorded separately so that the risk can be accurately scored and control measures applied.

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Risk Matrix

Once the risks are identified and the wording agreed that accurately reflects the issue raised, they are assessed and quantified using two criterion; likelihood of occurrence and consequence outcome.

The definitions for the consequence of risk are detailed in Tables 1 and 4 and are provided to enable a degree of consistency to be achieved. Either table can be used to assess the consequence of the risk identified however in general:-

Table 1 are for future risks taking into account general knowledge and potential outcomes and
Table 4 are for those risks which the Trust has already experienced and there is a history of likelihood

The risk descriptors are very specific and can be utilised by practitioners/managers to score incident and then ensure the appropriately management/mitigation is utilised to reduce the impact.

Likelihood can be assessed against two sub elements namely:-

- **Frequency** where there is evidence and knowledge to determine the frequency or
- **Probability,** where there is no current evidence or knowledge to support the assessment of likelihood, table 2 provides guidance to make this judgement.

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 3 or page 6) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (page 5) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Risk scoring = Consequence x Likelihood (C x L)

Table 1 Consequence Score **(C)**

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Table 2 Likelihood score **(L)**

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Overall risk score

Once the risk has been worded, the consequence and likelihood scores decided, multiply the two scores together to give an overall risk score. This quantifies the “risk” and its place on the table below indicates the level of risk.

Table 3: Risk scoring = Consequence x Likelihood (C) x (L)

		Likelihood				
Consequences		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
	Insignificant	1	2	3	4	5
	Minor	2	4	6	8	10
	Moderate	3	6	9	12	15
	Major	4	8	12	16	20
	Catastrophic	5	10	15	20	25

Table 4 Specific Risks	Specific Risk/Incident Descriptors (but are not exhaustive)				
	1	2	3	4	5
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Medication error	Incorrect medication dispensed but not taken	Wrong drug or dosage administered, with no adverse effects Wrong route	Wrong drug or dosage administered with potential adverse effects Wrong route	Wrong drug or dosage administered with adverse effects Wrong route	Unexpected death or permanent incapacity Incident leading to long-term health problem
Physical Violence/ Aggression	Minimal or no impact	Physical attack/assault such as pushing, shoving, pinching, slapping, hair pulling etc causing minor injury (not requiring immediate medical assessment or treatment)	Assault on patients, public or staff which may have physical health / psychological implications on the victim. Injury may require A&E or GP assessment but no further treatment	Serious Assault resulting in physical injuries that require hospital treatment.	Homicide or attempted homicide resulting in death or serious prolonged injury or disability
Moving/Manual Handling	Malfunction / fault with equipment	Minor injury as a result of moving or handling	Moderate injury to staff as a result of moving or handling requiring more than 7 days sick leave (RIDDOR reportable)	Serious injury to staff resulting in long term damage (RIDDOR reportable)	Unexpected death or permanent incapacity Incident leading to long-term health problem
Hostage Situation		Threats to prevent staff member leaving property but is persuaded and allows exit	Deliberate delay in the departure of staff using minor threats or physical obstruction	Deliberate delay in the departure of staff using significant threats or physical obstruction	Staff member held hostage using physical force
Slip, Trip, Fall	Slipping, falling with no injuries	Slipping, falling with minor injuries requiring first aid only	Slip/trip/fall resulting in injury such as a sprain, requiring medical attention	Slip/fall resulting in injury such as dislocation/fracture/blow to the head requiring medical attention and hospitalisation	Unexpected death or permanent incapacity Incident leading to long-term health problem

Confidentiality /Security	Patient information or other confidential information left unattended or was visible to unauthorised staff Computer left logged into a person account but no one was using the computer NEAS networks receive minor "hacking" attempts that are safely blocked	Staff involved in a patients care overheard in a public area on Trust grounds speaking about a patient using the patients name Staff communicated excessive patient information to a third party as part of the care of that person, consent not having been specifically denied by the patient Computer logged into an account, but being used by a person other than the account holder. No patient information data entry, email usage or internet usage was performed	Staff communicated confidential and/or sensitive information to other members of the Trust as part of "gossip" Patients record is missing and cannot be found within a week Trust site security is breached and intruders could have had access to confidential information Computer logged into an account, but being used by a person other than the account holder. Patient information data entry, email usage or internet usage was performed	Inappropriate/Accidental communication of obviously confidential information by staff to a third party unaware that the patient or the Trust specifically denied consent to disclose Multiple patient records go missing due to deliberate actions of intruders on Trust sites Trust network security is breached but no confidential information or email accounts were accessible Diaries/Laptops/ Computers with confidential information staff or patient are lost. stolen or missing	Deliberate disclosure to third party by a staff member who was aware that the patient or the Trust specifically denied consent to disclose Publication of any patient information or confidential information that was not specifically authorised by the patient or the Trust Trust network security is breached and confidential information or email accounts were accessible
	Restricted or security sensitive information left unattended or was visible to unauthorised staff		Attempt by malicious third party to gain access to restricted information via Trust internal networks no information lost Local Media Interest	national security initiatives Successful attempt by malicious third party to gain access to restricted information via Trust internal networks small amount of information lost Local/National Media interest	Deteremental effect to key national security initiatives. Successful attempt by malicious third party to gain access to restricted information via Trust internal networks large amount of restricted information lost National Media interest & Deteremental effect to key national security initiatives

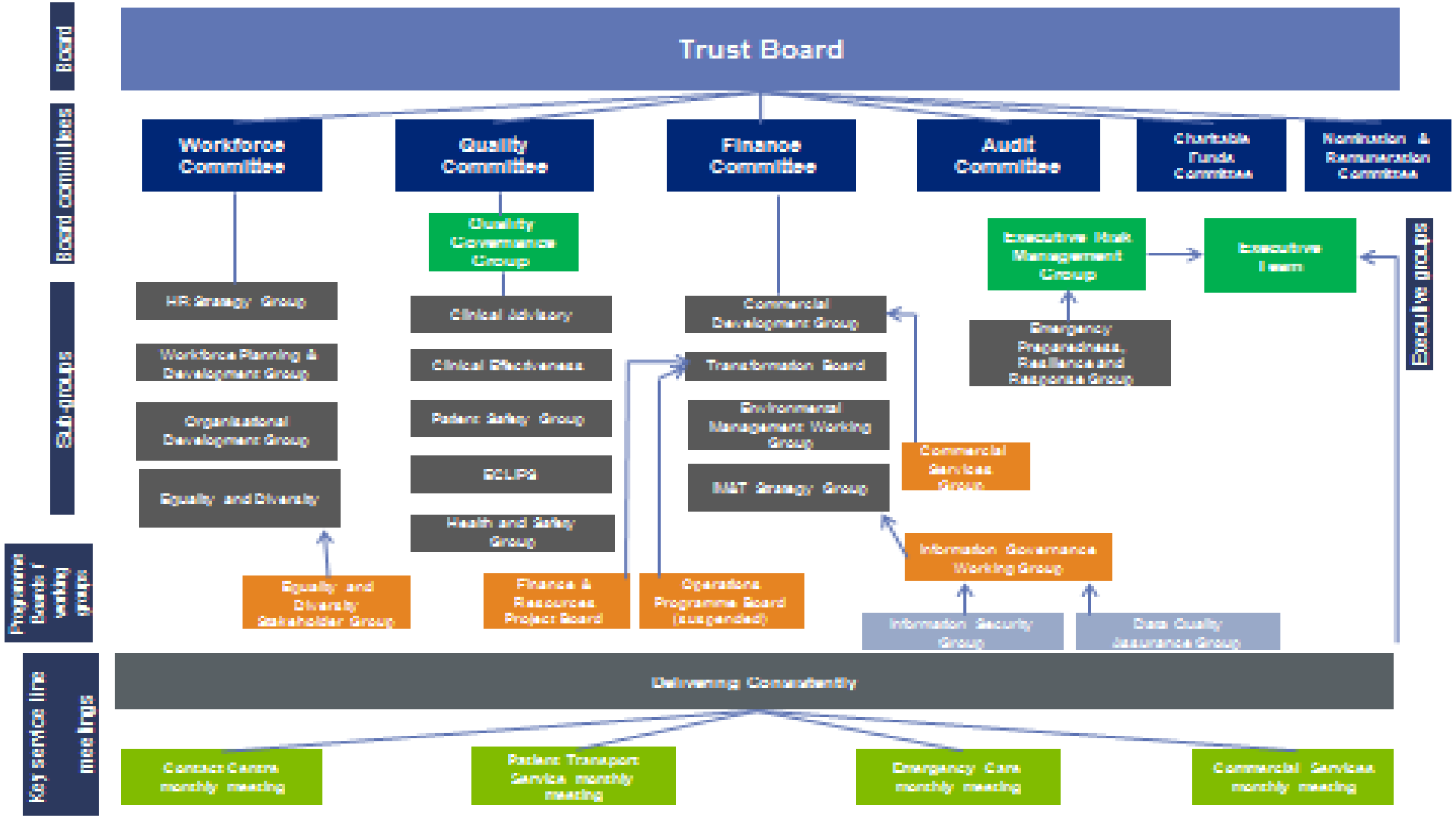
Coroner's Inquest	Inquest with no Trust involvement very unlikely to bring any allegations against Trust or employees	Non Contentious Inquest No allegations against Trust or employees Simply fact finding enquiry No risk of criminal or civil litigation No risk of reputational damage	Contentious Inquest Some allegations made against Trust and or employees Does not raise significant individual or Trust Policy failings Defendable Low level risk of civil litigation claim (i.e. damages not in excess of £20,000) Low level risk of reputational damage (local level)	Contentious Inquest Some allegations made against Trust and or employees Raises individual employee failings and or Trust Policy concerns Potential to issue Rule 43 Report against person or organisation Some issues defendable Medium level risk of civil litigation claim (i.e. damages not in excess of £100,000) Reputational damage (local level)	Contentious Inquests/Public Enquiries Allegations against Trust and or employees Raises issues of national importance Potential to result in public national enquiry (i.e. London Bombings, Mid Staffordshire enquiry) Potential for criminal prosecution and high level award (civil litigation claim i.e. in excess of 100,000 to unlimited damages) Reputational damage (national level)
Security	Signs of unauthorised personnel around site / vehicle or Trust property but no evidence of any forced entry into premises, attempted thefts nor criminal damage.	Evidence of access into premises / vehicle or Trust property without forced entry no evidence of items stolen or criminal damage.	Evidence of forced entry onto site/ into Trust property and items stolen and/or criminal damage committed. (items under £1,000 personal or Trust) Trust property stolen from staff members personal or Trust vehicle or home (less than £1,000)	Evidence of forced entry into premises and items stolen and/or criminal damage committed (items more than £1,000 personal or Trust) Trust property stolen from staff members personal or Trust vehicle or home (more than £1,000)	Unauthoirsed access on site and ambulance vehicle stolen Unauthoirsed access to site in which staff member / contractor assaulted. Multiple items of Trust property stolen from staff members personal or Trust vehicle or home.

Fire	False fire alarm activation – faulty system.	Fire on site – fire extinguished – building evacuated, no damage to property, building occupants or others. .	Fire on site – minimal damage to building or neighbouring property. (less than £1,000) No injury to building occupants or others.	Fire on site – significant damage to building or neighbouring property. (more than £1,000)	Fire on site – significant damage to building, neighbouring building or building in direct vicinity. Injury to building occupant(s) or others.
Driving-Collisions	Minor collisions where minimal damage is caused to property or the vehicle, *i.e. reversing, scratch or minor dent*	Collisions generally at lower speed where there is damage to vehicles and/or property but no injuries are sustained *i.e. broken mirror, obvious dent to wing etc*	Collisions where there are minor injuries to staff or members of the public (patient, pedestrian or other road user) *i.e. A&E assessment or GP, but no further treatment*	Collisions, usually at higher speeds where there are serious injuries to staff or members of the public (patient, pedestrian or other road user) *i.e. serious trauma resulting in medical attention and hospitalisation*	Serious collisions, usually at higher speed resulting in the death or permanent incapacity of a member of staff or the public *i.e Fatal road traffic collision which could result in a criminal prosecution*

Appendix 'F' Risk Appetite Matrix for NHS Organisations

Risk levels / Key elements	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior Management. Systems/ technology developments limited to improvements, protection of current operations	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 'G' Governance Structure



Appendix 'H' Annual Delivery Plan 2015/16

Theme	Timescale	Responsible
1. Developing risk management within the organisation		
a) Continue to develop an integrated approach to managing risk across all activities; b) Ensure that all risks are identified, assessed, minimised and wherever practicable, eliminated; c) Promote active stakeholder involvement in risk management; d) Engender a consistent approach to Risk Assessment; e) Continue to embed partnership working with the 3 Police Forces and look towards extending into the local fire authorities	July 2016 April 2016 July 2016 November 2016 May 2016	Risk and Regulatory Services team, led by the Head of Risk and Regulatory Services
2. Embedding key risk management system and process		
a) Satisfy the risk management requirements of the Annual Governance Statement; b) Fully integrate the risk management system to facilitate robust data capturing and reporting; c) Provide a robust Board Assurance Framework; d) Embed the use of Risk Registers across NEAS; e) Continue to develop vehicle risk management/accident reduction processes with the Trusts motor insurers f) Initiate a systematic and consistent approach to learning lessons and promoting continuous improvement; g) As far as is reasonably practicable, minimise costs associated with risk.	March 2016 April 2016 October 2015 April 2016 May 2016 April 2016 March 2017	Risk and Regulatory Services team, led by the Head of Risk and Regulatory Services.

Theme	Timescale	Responsible
3. Ensuring compliance with regulation and monitoring		
a) Achieving and improving performance against all externally and internally regulated risk management activities; b) To ensure compliance with Legal and Statutory requirements; c) Review security/health and safety provision at all sites across the Trust as part of a rolling programme; d) Produce and implement a Corporate Health and Safety Strategy and Plan e) Reduce the number of litigation, specifically clinical negligence, public liability and employer's liability claims; f) Ensure all adverse events are recorded, investigated, monitored and lessons learnt; g) Fully comply with the requirements under Duty of Candour	March 2017 March 2017 September 2016 February 2016 March 2016 April 2016 April 2016	Risk and Regulatory Services team, led by the Head of Risk and Regulatory Services.
4. Embedding a culture where the Trust is 'risk managed'		
a) Raise awareness of risks and their management through a programme of communication b) Continue to work in collaboration with the Training Department to ensure the delivery of risk management and health and safety training c) Foster an environment whereby all staff understands that risk management is their responsibility. d) Aim to work with internal stakeholders to improve the overall Health and Safety Culture; e) To enhance the risk maturity of the Organisation over the next 12 months from Risk Aware/ Risk Defined to Risk Managed	April 2016 April 2016 March 2017 March 2016 March 2017	Risk and Regulatory Services team, led by the Head of Risk and Regulatory Services.