Policy Number	SA02-A
Policy Name	Risk Management Policy
Policy Type	Trust-wide Non-clinical Service
Accountable Director	Director of Patient Safety
Author	Ray Walker
Recommending Committee	Executive Committee
Approving Committee	Executive Committee
Date Originally Approved	October 2015
Next Review Date	January 2018

This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover

Terminology used in this Document	New terminology when reading this Document
Divisional Governance Board	Relevant Operational Management Board

FOR OFFICE USE ONLY (Work Stream submission check)

This document is compliant with current best practice guidance ☐

This document is compliant with legislation required in relation to its content ☐

What change has this document undergone in the policy alignment process relating to the South Sefton Transaction?

☐ None ☒ Minor ☐ Major ☐ This is a new document

☐ This document has been reviewed and is no longer required

Minor amendments to diagrams on pg 12 & p18 and front cover reflecting South Sefton Community Division inclusion.

Does this document impact on any other policy documents?

☐ Yes , **if yes, which policies are effected?** Click here to enter text.

☐ No

Signed: **J Bridge** **Date: 15.05.2017**

Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL / NON CLINICAL POLICY

RISK MANAGEMENT POLICY

Policy Number:	SA02-A
Scope of this Document:	All Staff
Recommending Committee:	Risk Management Group
Appproving Committee:	Executive Committee
Date Ratified:	February 2016
Next Review Date (by):	January 2018
Version Number:	Version 3
Lead Executive Director:	Executive Director of Nursing
Lead Author(s):	Head of Risk and EPRR

TRUST-WIDE CLINICAL / NON CLINICAL POLICY

Version 3

Striving for perfect care
for the people that we serve

Mersey Care NHS
NHS Foundation Trust

RISK MANAGEMENT POLICY

Further information about this document:

Document name	**Risk Management Policy (SA02-A)**
Document summary	**This Risk Management Policy outlines how risks should be recorded and overseen for inclusion in the trust-wide Risk Register**
Author(s) Contact(s) for further information about this document	**Ray Walker** **Executive Director of Nursing** **Telephone: 0151 473 2965** **Email: ray.walker@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Risk Management Strategy (SA02)** **Health and Safety Policy (SA07)** **Incident reporting policies and procedures (SA03)** **Induction and Mandatory Training and Training Needs Analysis (HR28)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Note	Until October 2015 the Risk Management Policy was an integral part of the Risk Management Strategy	
Version 1	Draft No 1 – for consultation (Not yet adopted)	October 2015
Version 2		January 2016
Version 3		March 2017

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1 INTRODUCTION

1.1 This Risk Management Policy should be read in conjunction with the Risk Management Strategy (SA02), in which the Trust Board acknowledges that:

(a) the services it provides, and the way it provides these services, carries with it unavoidable and inherent risk;

(b) the identification and recognition of these risks - together with the proactive management, mitigation, acceptance (if appropriate within its Risk Management Strategy) and (where possible) elimination of these risks - is essential for the efficient and effective delivery of safe and high quality services;

(c) effective risk management is not an end in itself, but an integral part of the trust's quality, governance and performance management processes;

(d) all staff have a role in considering risk and helping to ensure it does not prevent the delivery of safe and high quality service; and finally that

(e) the Trust Board, with the support of its committees, has a key role:
(i) in ensuring a robust risk management system is maintained and effectively resourced,
(ii) in encouraging a culture whereby risk management is embedded across the trust, and

(f) Through its plans, in setting out its appetite and priorities in respect of the mitigation of risk when delivering a safe and high quality service.

1.2 In accepting that risk occurs the Trust Board has adopted the following ***risk management statement***:

> Mersey Care NHS Trust is committed to delivering high quality services which are safe, provide the opportunity for recovery and promote the wellbeing of service users, their relatives and carers, staff and other stakeholders, supported by a risk management system which is open and transparent and continually seeks to improve the quality and safety of the services provided by the trust.

2 DEFINITIONS

2.1 Definitions about the terminology used in risk management, and throughout this document, can be found in **Appendix A**.

3 SCOPE

3.1 This policy is a **trust-wide** document and it applies equally to all members of staff, either permanent or temporary and to those working within, or for, the trust under contracted services.

4 RISK MANAGEMENT SYSTEM

4.1 Definition

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

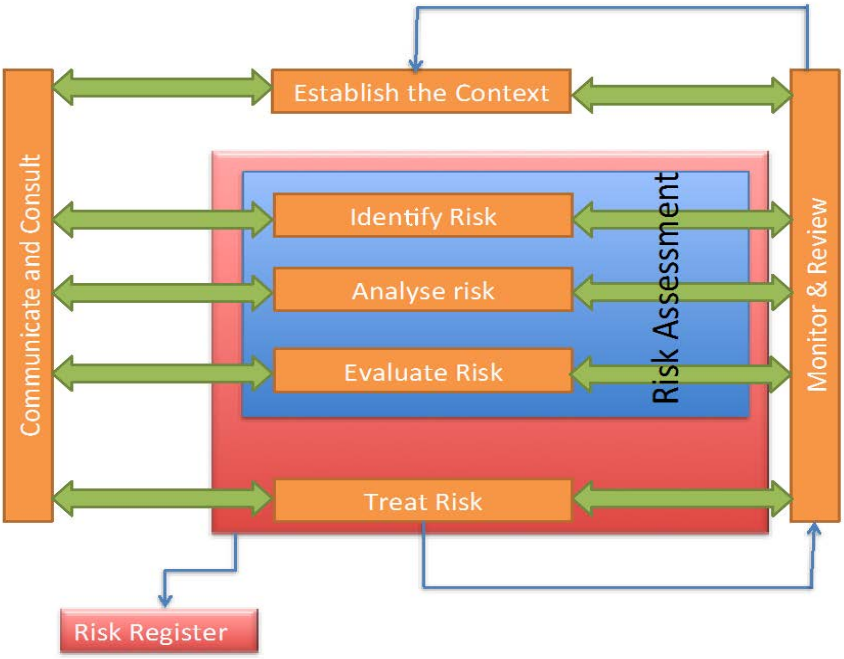


Figure 1 – Risk Management Process

4.2 Identifying Risks

4.2.1 Risks facing the organisation will be identified from a number of sources, e.g.:

(a) risks arising out of the delivery of work related tasks or activities;

(b) the review or strategic or divisional objectives;

(c) a result of incidents and the outcomes of investigations

(d) following complaints, claims, patient feedback, health and safety inspections, audit reports, external reviews or ad hoc assessments;

(e) national requirements and guidance

4.2.2 The Trust Board has delegated to directors, managers, divisions and ward / teams the identification, assessment and control of their own risks, together with their subsequent entry on the trust-wide risk register[1].

[1] For a full description of these roles and responsibilities please see **section 8** below

4.2.3 To identify a risk, directors and managers are required to anticipate what is stopping them, or could stop them, from achieving their objectives / delivering their service. As a minimum risks should be reviewed on an annual basis.

4.3 Analysing / Assessing Risks

4.3.1 The purpose of assessing and scoring a risk is to estimate the level of exposure to a particular risk, which will then help to inform where responses to reduce or better manage a risk can be taken. In assessing how significant of the risk to an event (the hazard) occurring is, you will need to:

(a) identify **who** is affected and **what** is the potential ***impact*** should the risk occur (i.e., the *consequences* (how bad) a risk occurring would be);

(b) estimates the ***likelihood*** (how often) of a risk occurring once plans to control or mitigate the impact of a risk have been put in place;

(c) consider whether this is a standalone risk or whether this risk could combine with other potential risks;

(d) assess or score the trust exposure to that risk (using the *risk scoring matrix* outlined below);

(e) document your risk assessment using the *risk assessment template* (see **Appendix F**) and escalate it to your division's *risk management lead* for inclusion in the *trust-wide risk register*. Follow the process in **Appendix G.**

4.4 Risk Categories

4.4.1 Mersey Care is exposed to a range of risks relating to the clinical and non-clinical activities undertaken by the trust. When identifying a risk, a risk can be identified by one of more of the following risk categories (Mersey Care has adopted a process for categorising risk produced by the Good Governance Institute):

Type of Risk	Definition
Compliance / Regulatory	Risks which may impact on the ability of the trust to deliver high quality of care in accordance with the requirements of regulators and national standards
Financial / Value for Money	The risk that a weakness in financial controls could result in a failure to safeguard assets, impacting adversely on the trust's financial viability and capability for providing services
Innovation / Quality / Outcomes	Risks that threaten the day to day delivery of clinical care and services
Reputation	Risks that the organisation receives negative publicity which impacts on service user and public confidence in the trust

4.5 Evaluating / Scoring Risk

4.5.1 Risks are scored using a *risk scoring matrix* which has been adopted by many NHS organisations based on an Australian / New Zealand standard, with the risk scores taking account of the *impact* and *likelihood* of a risk occurring - see paragraph 4.5.4 below. The scoring of risk is a 3-step process.

4.5.2 **Step 1** – evaluating the consequences or ***impact*** of a risk occurring as if no plans exist to control, mitigate or reduce the impact of a risk occurring. The impact (consequence) score has five descriptors:

Score	Impact Descriptor	Impact Description
1	Negligible	Descriptions of these descriptors can be found in **Appendix C**, based on different types of risks covering, e.g., • safety • quality / complaints / audit • finance (including claims) • human resources • statutory duty / inspection • business objectives
2	Minor	
3	Moderate	
4	Major	
5	Catastrophic	

4.5.3 **Step 2** – evaluating the ***likelihood*** (how often) a risk may possible occur once plans and controls to mitigate (reduce / remove) a risk have been put in place The table below gives the descriptions of the likelihood of a risk occurring.

Score	Likelihood Descriptor	Likelihood Description
1	Rare (Less than 5%)	Will probably never happen/recur
2	Unlikely (5% to 20%)	Not expected to happen/recur but it is possible it may do so
3	Possible (21% to 50%)	Might happen or recur occasionally
4	Likely (51% to 80%)	Will probably happen/ recur, but not a persistent issue
5	Almost Certain (81% to 100%)	Will undoubtedly happen/ recur. Possibly frequently

4.5.4 **Step 3** – to calculate the *risk score* you then multiply the following scores

Impact score x likelihood score = risk score

		IMPACT should a risk occur →				
LIKELIHOOD of the risk occurring (score subject to controls in place)		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
	Almost certain (5)	5	10	15	20	25
	Likely (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Rare (1)	1	2	3	4	5

RISK Low (1-3) Moderate (4-6) High (8-12) Extreme (15-25)

4.5.5 Each risk will be assigned 3 risk scores:

(a) ***Opening Risk Score*** – the initial risk score, prior to any assessment of the effectiveness of the controls / mitigating actions proposed;

(b) ***Current Risk Score*** – the latest risk score, which will include a partial / complete assessment of the effectiveness of the controls / mitigating actions;

(c) ***Target Risk Score*** – the risk score which should be the objective of the trust's controls / mitigating actions (taking account of the Board's *risk appetite*).

4.5.6 Depending upon the *risk score* – see paragraph 4.5.4 above - a risk will then be rated as having a low, medium, high or extreme *risk rating*.

4.5.7 **Instructions for use**

a) Define the risk(s) explicitly in terms of the impact that might arise from the risk.

b) Use table in step 1 to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.

c) Use table in step 2 (above) 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.

d) Calculate the risk score the risk multiplying the impact by the likelihood: I (impact) x L (likelihood) = R (risk score)

4.5.8 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.

4.6 Risk Escalation

4.6.1 This risk rating will determine how a risk will be managed and escalated from ward / team to Board dependent, as can be seen in the table below

Risk Rating	Management
LOW - between 1 and 3	Managed at a service level by the *Team Risk Owner* via the Trust-wide Risk Register. Assurance will be provided to the *Risk Owner* on the management of this risk (Note - not normally escalated to Board level)
MEDIUM – between 4 and 6	Managed at a service level by the *Team Risk Owner* via the trust-wide Risk Register. The *Risk Lead* will monitor the deliver of any actions (Note - not normally escalated to Board level)
HIGH – between 8 and 12	Managed by the *Risk Owner*. Actions prioritised and agreed with the *Executive Risk Owner*. (Note – not normally included in the Board Assurance Framework)
EXTREME – between 15 and 25 ***(Strategically significant risks)***	Managed on a day-to-day basis by the *Management Risk Owner* and reviewed as a minimum on a monthly basis with the *Executive Risk Owner*. Actions prioritised / agreed on a monthly basis and subject to scrutiny by the appropriate Board Committee / Board (Note – included in the Board Assurance Framework)

Note – for a description of *Risk Owners* please see paragraph 8.9 below

4.6.2 Those risks which normally score between ***15 and 25*** will be regarded as ***strategically significant risks*** and will be included in the Board Assurance Framework which is considered by the Board and its Committees. However other risks with an *impact* score of 3, 4 or 5 may be recommended by a Board Committee (with advice from the Risk Management Group) or proposed by the Board for inclusion on the Board Assurance Framework on the basis that the nature of the impact of the risks means that the Board should have continued oversight - even though a high level of controls / mitigation are in place.

4.6.3 **Figure 2** overleaf outlines how risks will be escalated to the Board via its committees, outlining the key role the Risk Management Group will play in coordinating between the Board and it committees and the rest of the trust.

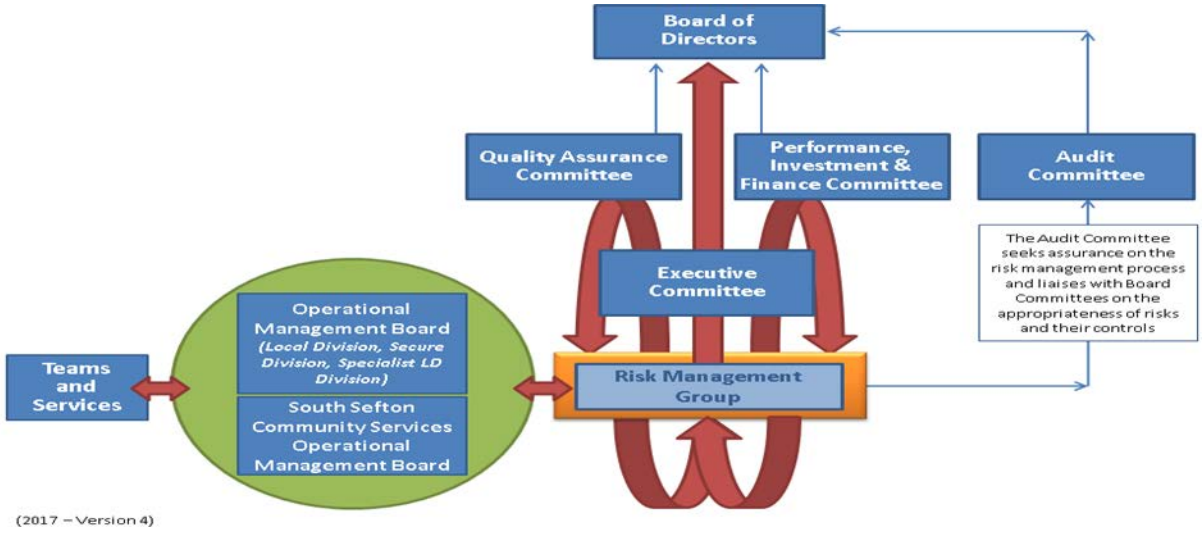


Figure 2 – Risk Escalation Process

4.7 Treating Risk (Controls and Mitigation)

4.7.1 When considering the *likelihood* of a risk occurring, staff need to develop and consider those action(s) that can be put in place which will mean:

(a) the ***avoidance*** of the risk (e.g. by not proceeding with the action which produces a risk); or

(b) the ***reduction*** of the likelihood of a risk occurring or, should it occur, the reduction of the potential impact (consequence or harm) of the risk occurring; or

(c) the ***transfer*** of risk to another party, either in part or in whole; or

(d) the ***retention*** of risk, after they have been reduced or transferred, there may be some residual risks which are retained (although plans to control and mitigate these risks will still be required); or

(e) the ***removal / elimination*** of risk (although it is accepted that the complete removal of a risk, especially when related to service provision, is rarely possible)

4.7.2 These plans to avoid or reduce risk are more commonly referred to as the ***risk action plan*** or ***risk treatment plan***.

5 RISK APPETITE (RISK TOLERANCE) & RISK APPETITE STATEMENT

5.1 *Risk Appetite* is the level at which the Trust Board determines whether an individual risk, or a specific category of risks, is deemed acceptable or unacceptable based upon the circumstances / situation facing the trust. This determination may well impact on the prioritisation of resources necessary to mitigate or reduce the impact

of a particular risk and / or the time the timeframe required to mitigate a risk.

5.2 Using the Good Governance Institute (GGI) *risk appetite matrix* (see **Appendix D**), the Trust Board has adopted a ***risk appetite statement*** which is the amount of risk it is willing to accept in pursuit of its strategic objectives. As well as the overall *risk appetite statement*, separate statements are provided for each of the *risk categories* show in paragraph 4.4.1 above.

Mersey Care NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff the public and strategic partners. As such, Mersey Care will not accept risks that materially provide a negative impact on patient safety. However, Mersey Care has a greater appetite to take considered risks in terms of their impact on organisational issues. Mersey Care has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. Further detail on the statement is provided below. The *risk appetite* is shown in **BOLD** text (using the GGI's risk appetite matrix see **Appendix D**)	
Compliance and Regulatory	• There is a **LOW** risk appetite for risk, which may compromise the Trust's compliance with its statutory duties and regulatory requirements. Oversight of risks by executive committee.
Financial and Value for Money	• Mersey Care has a **LOW** risk appetite to financial risk in respect of meeting its statutory duties. • Mersey Care has a **MODERATE** appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. • Mersey Care has a **MODERATE** appetite for investments which may grow the size of the organisation. Oversight of risks by performance and investment committee.
Quality, Innovation and Outcomes	• Mersey Care has **NO** appetite for risk that compromises patient safety. • Mersey Care has a **LOW** risk appetite for risk that may compromise the delivery of outcomes, that does not comprise the quality of care • Mersey Care has a **SIGNIFICANT** risk appetite to innovation that does not compromise the quality of care. Oversight of risk by quality assurance committee.
Reputation	• Mersey Care has a **LOW** risk appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patient in our care may affect the reputation of the organisation. Oversight of risk by Trust Board.

5.3 When scoring risks staff should consider the trust's risk appetite statement. Support will be provided on this from your divisional risk management lead and to

this lead from the Risk Management Group.

6 ASSURANCE

6.1.1 A key component of the trust's risk management system is providing assurance, not only about the overall risk management system (which is the domain of the Audit Committee) but as importantly on the effectiveness of the controls and their application (action plans) being put in place to mitigate the impact of any risk. (which will be consider by the Board and its committees). As **Figure 3** below shows three lines of assurance are proposed in respect of the application of controls.

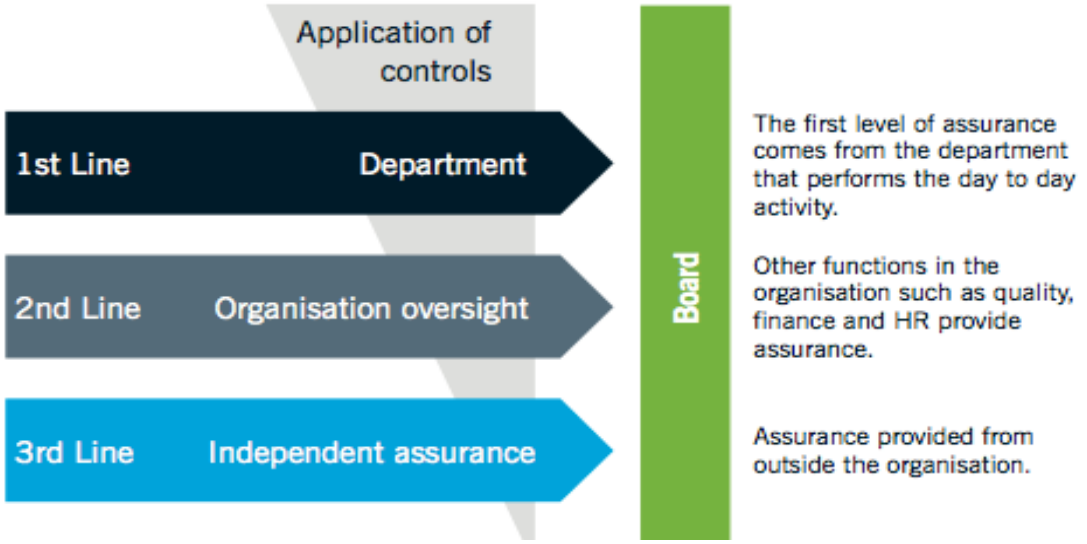


Figure 3 – 3 lines of assurance

(Source: NHS Providers / Baker Tilly – Board Assurance: A toolkit for health sector organisations)

6.1.2 The table below outlines the types of assurance that will be that will be applied for each of these 3 levels.

Line of Assurance	Examples of Assurance
Level 1 – Department	• 1-1 meetings between a *Team Risk Owner* and a *Management Risk Owner* • Peer review of a piece of work (facilitated by the Risk Management Group) • Self assessment return
Level 2 – Organisation Oversight	• 1-1 meetings between a *Management Risk Owner* and a *Executive Risk Owner* • Reports to a Board Committee (i.e., Care at a Glance, Quality Report, Financial Report, Management report) • Recommendation to a Board Committee from the Risk Management Group • Recommendation to the Board, from a Board Committee, and incorporated into the Board Assurance Framework) • Key Performance Indications • Quality Accounts • Annual reports on committees to the Trust Board
Level 3 – Independent assurance	• MIAA internal audit reports • Benchmarking with another organisation • Independent well-led governance framework review • External audit report • National Staff Surveys • National Patient Satisfaction Surveys • CQUINS (Commissioning for Quality & Innovation) • National Audits • Information Governance Toolkit • Care Quality Commission Inspections

6.1.3 The Risk Management Group will pay a key role in working with the Board and its committees to identify the appropriate types of assurance and, particularly in respect of Levels 1 and 2, standardising and moderating their application across the trust, making recommendations to the relevant Board Committees and cascading out good practice to divisions, teams and service across the trust

7 RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

7.1 Trust-Wide Risk Register

7.1.1 The Trust has in place a T*rust-wide risk register* which is populated from the risk assessments carried out at all levels and across all divisions with the trust. The trust has only one risk register; although divisions / teams / services will be able to access information only relevant to them should they choose to do so. Access can

be arranged through your divisional risk management lead.

7.2 Board Assurance Framework

7.2.1 The Board Assurance Framework will include those ***strategically significant*** risks which either:

(a) have a risk score of 15 and over; or

(b) have an impact risk score of 3,4 or 5 and have been judged by the Board to be strategically significant.

7.2.2 The Board Assurance Framework will be presented to each of the Board public meetings. It will take account of the recommendations from the Audit, Executive, Performance & Investment and Quality Assurance Committees as to what should be included, amended or removed as these committees of the Board undertake the detailed scrutiny and receive assurance to inform their recommendations.

8 ROLES AND RESPONSIBILITIES

8.1 **Trust Board** – has overall responsibility for:

(a) ensuring robust systems of internal control are in place and appropriately resourced;

(b) encouraging a culture whereby risk management is embedded across the trust;

(c) routinely considering risks and collectively being assured that risks are being effectively managed; and

(d) through its plans, in setting out its appetite and priorities in respect of the mitigation of risk when delivering a safe and high quality service.

8.2 **Board and Other Committees** – the following committees have the key risk responsibilities:

(a) *Executive, Performance & Investment and Quality Assurance Committees* – on behalf of the Trust Board undertaking the detailed scrutiny of those *strategically significant* risks that fall within their terms of reference, as well as recommending the inclusion of new or revised risks (and action plans) for matters were further assurance is required;

(b) *Audit Committee* – on behalf of the Trust Board, being assured on the robustness of the trust's risk management system and the adequacy of the underlying assurance processes and controls used to inform the Board and its Committees about the management of risk;

(c) *Risk Management Group* – although accountable to the Executive Committee, this group:
(i) oversees the trust's *Risk Register* (advising on the completeness and

standardisation of risks, their controls, mitigation, action plans and assurance through the trust's governance systems) and ensures the risks recorded take account of the Trust Board's risk appetite,

(ii) taking account of the *Risk Register*, advises the Board (via the Audit, Executive, Performance & Investment and Quality Assurance Committees) on the *strategically significant* risks for inclusion or review in the trust's Board Assurance Framework (taking account of the risk appetite);

(iii) The terms of reference for the Risk Management Group can be found at **Appendix E**.

(d) *Relevant Operational Management Boards and Other Sub-Committees* – responsible for the identification and collation of risks relating to their terms of reference for inclusion in the trust's *Risk Register*.

A diagram of the trust's governance arrangements and quality governance framework can be found in **Appendix B**.

8.3 **Chief Executive** – as the trust's Accountable Officer, has overall responsibility for the risk management process and this strategy, ensuring that it meets statutory and regulatory requirements (including necessary regulatory submissions) and meets the needs of the trust. Liaising with stakeholders and regulators where the management of issues / risks has a wider impact.

8.4 **Executive Director of Nursing** – delegated by the Chief Executive with responsibility for the delivery of this strategy and the trust's risk management system.

8.5 **Executive Team** – accountable to the Chief Executive, they are responsibility for:

(a) ensuring that all risks related to their portfolios (see **Figure 4** below) are identified, assessed, recorded and reported, and that appropriate measures are in place to manage any risks and provide assurance on their effectiveness;

(b) understanding, championing and adhering to the risk management system;

(c) with their management teams, for identifying a **Risk Owner** for each risk.

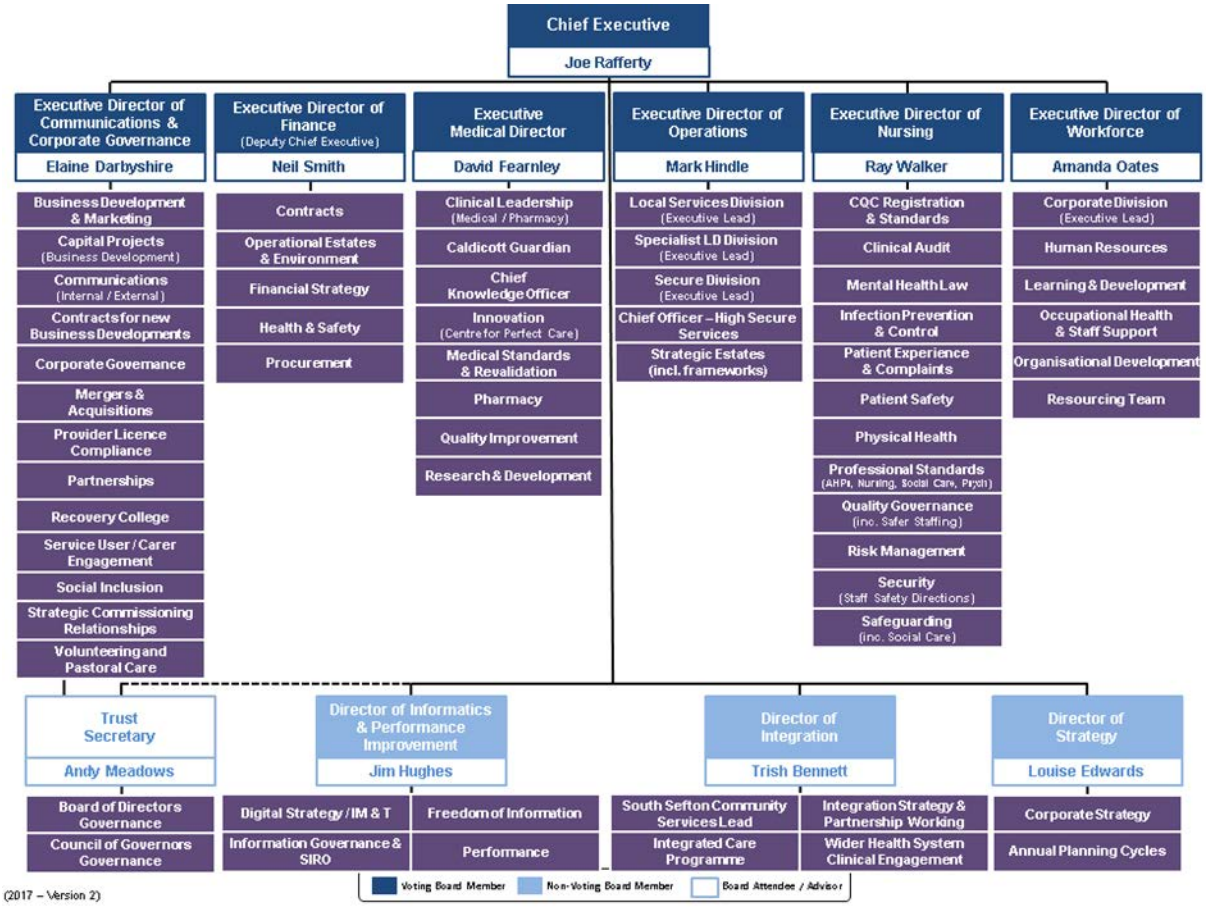


Figure 4 – Executive Team's Responsibilities

8.6 **All Senior Managers / Managers** – accountable to a member of the Executive Team, are responsible:

(a) through the relevant governance process, for ensuring that all risks related to their areas of responsibility are identified, assessed, recorded and reported, and that appropriate measures are in place to manage any risks and provide assurance on their effectiveness;

(b) understanding, championing and adhering to the risk management system;

(c) with their Executive Lead, for identifying a **Risk Owner** for each risk.

8.7 **Director of Patient Safety** – in addition to paragraph 8.6, as the Nominated Individual with the Care Quality Commission, the Director of Patient Safety will liaise with the Head of Risk & EPRR on risk management issues.

8.8 **Head of Risk and EPRR** – supports the Director of Patient Safety and the Executive Team and is responsible for leading and coordinating all aspects of the trust's risk management function and activities and supporting risk management functions at Board level and within the four Divisions.

8.9 **Risk Owner**

8.9.1 ***Action Lead*** – identified by a senior manager or manager, this is the officer within a particular team who, on a day-to-day basis, will take lead responsibility for the documentation and assessment of a risk that has been identified and added to the trust's Risk Register (as defined in the trust's Risk Management Policy).

8.9.2 ***Accountable Manager*** – the officer, normally a senior manager, who supports the *Team Risk Owner* and is responsible for overseeing the management of a risk on behalf of an Executive Director and for providing assurance on the effective management of this risk (and action plan) through the relevant line management / trust governance arrangement.

8.9.3 ***Executive Owner*** – the Director with lead responsibility for the management of this risk; for seeking assurance from the *Management Risk Owner* on the effectiveness on the controls and management of a risk; for ensuring that the appropriate assurance on the effective management of this risk is provided to the trust's Board / Board Committee(s) as appropriate.

8.10 **All staff and contractors (including Locums, Temporary Staff and Bank Staff)** – are expected to be familiar with the trust's risk management system and take responsibility when conducting their duties in accordance with the principles laid out in trust's policies and procedures. Everyone has the responsibility – and indeed is encouraged – to report concerns / incidents.

9 RISK MANAGEMENT TRAINING AND SUPPORT

9.1 Members of the Risk Management Group will be supported in their development by tailored and dedicated training. Risk Owners will also be made aware of their responsibilities through dedicated workshops. The Director of Patient Safety will also review the training and awareness raising for all staff in respect of the trust's risk management system.

9.2 The risk management system will also take account of the development opportunities resulting from Mersey Care being part of the Collaborative for Evidence Based Risk Management, which is being coordinated by The Risk Authority at Stanford. The Medical Director is the trust's executive lead for this Collaborative and will work closely with the Executive Director of Nursing on sharing learning and innovation.

10 MONITORING, REVIEWING AND AUDITING

10.1.1 The Risk Management Group will seek to continually review and monitor the trust's risk management system, playing a key role in standardising and moderating risks that are added to the trust-wide Risk Register.

10.1.2 Mersey Internal Audit Agency provides an audit opinion annually of the trust's Board Assurance Framework, but will also be asked to review the trust's revised risk management system by the end of February 2016.

Appendix A

Definitions for Risk Management Terminology

The following table provides definitions for some of the most frequently used terminology within risk management.

Term	Definition
Adverse Incident	Any event or circumstance leading to unintended harm and/or suffering which results in admission to hospital, prolonged hospital stay, or significantly disability at discharge or death
Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are: specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Complaint	Action taken by a patient/client of a healthcare facility, or his or her agent, to communicate dissatisfaction or concern about any aspect of care/treatment or experience during a stay or visit
Compliance	Act in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Control	Action taken to reduce likelihood and or impact of a risk.
Corporate Governance	The system by which Boards of Directors direct and control Organisations in order to achieve their objectives.
Cost	Activities, both direct and indirect, which result in a negative outcome or impact for an individual or the organisation – cost includes money, time, labour, disruption, goodwill, political and in tangible losses
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
Evidence	Information that allows a conclusion to be reached.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.

Term	Definition
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Frequency	A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time
Hazard	A source of potential harm or a situation with the potential to cause loss
Impact (consequence)	The result of a threat or an opportunity.
Incident	Any unplanned event or circumstance resulting in, or having a potential to cause loss
Information	Knowledge that is gathered as a result of processing data.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent Risk	The level of risk involved in an activity before controls are applied.
Integrated Risk Management	a process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks.
Key Risk/Key Control	Risks and controls relating to strategic objectives.
Likelihood	A qualitative measure/description of probability or frequency. Any negative impact, financial or otherwise
Mitigation/ treatment of risk	Actions taken to reduce the risk or the negative impact of the risk.
Near Miss	A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to patient
Policy	A document setting out the corporate plans for achieving a strategy
Probability	The likelihood of a specific event or outcome occurring. This is measured by the ratio of specific events or outcomes to the total number of possible events outcomes to the total number of possible events or outcomes. Probability is expressed along a scale ranging from impossible to certain
Quality	Treatment and care that is safe, effective and provides a positive patient experience.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of impact and likelihood

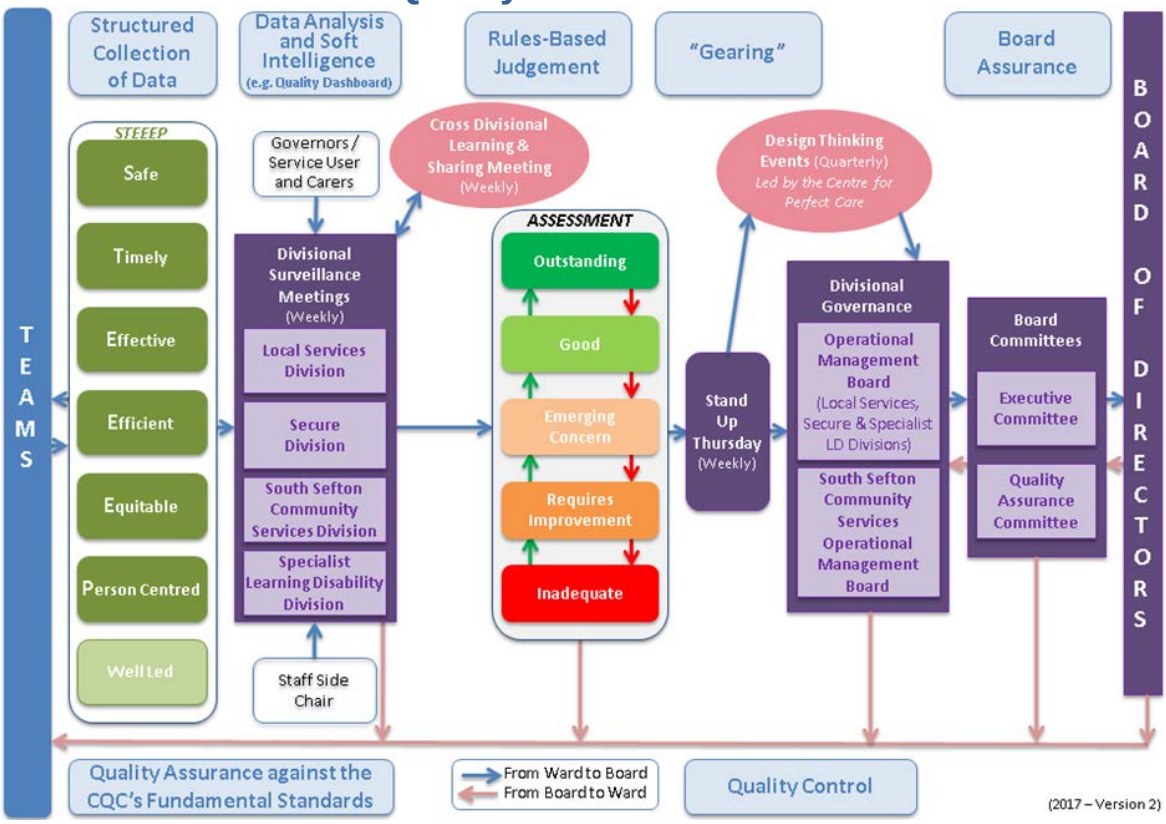
Term	Definition
Risk Appetite	An informed decision taken by the Trust Board to accept the identified impact and likelihood of a particular risk or group of risks
Risk Analysis	A systematic use of available information to determine how often specified events might occur and the magnitude of their impact
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Control	That part of risk management, which involves the development and implementation of policies, standards, procedures and/or physical changes to eliminate or minimise adverse events or risks
Risk Evaluation	The process used to determine risk management priorities by comparing the level of risk against predetermined standards, target risk levels and other criteria
Risk Identification	The process of determining what can happen, why and how
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and/or adverse effects
Risk Management System	Systematic application of management policies, procedures and practices to the tasks of establishing the context of risk and then, identifying, analysing, evaluation, treating monitoring and communicating risk
Risk Matrix	A grid that cross references impact against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the impact and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them. Risk Tolerance: the boundaries
Risk Reduction	The application of appropriate techniques and management principles to reduce either the likelihood of an occurrence or its impact or both
Risk Tolerance	The boundaries of risk-taking outside that the organisation is not prepared to go beyond.
Risk Transfer	Shifting the responsibility of burden for loss to another party through legislation, contract, insurance or other means. Risk transfers can also refer to shifting a physical risk or part thereof elsewhere
Risk Treatment	Selection and implementation of appropriate options and action plans for dealing with risk
Stakeholders	Those people and organisations who may affect, be affected by or perceive themselves to be affected by, a decision, action or activity

Term	Definition
System Failure	A non-conformance with, malfunction of or deviation from a defined management system. A system failure may also be defined as inadequate performance, non-participation in or non-application of a defined management system of process

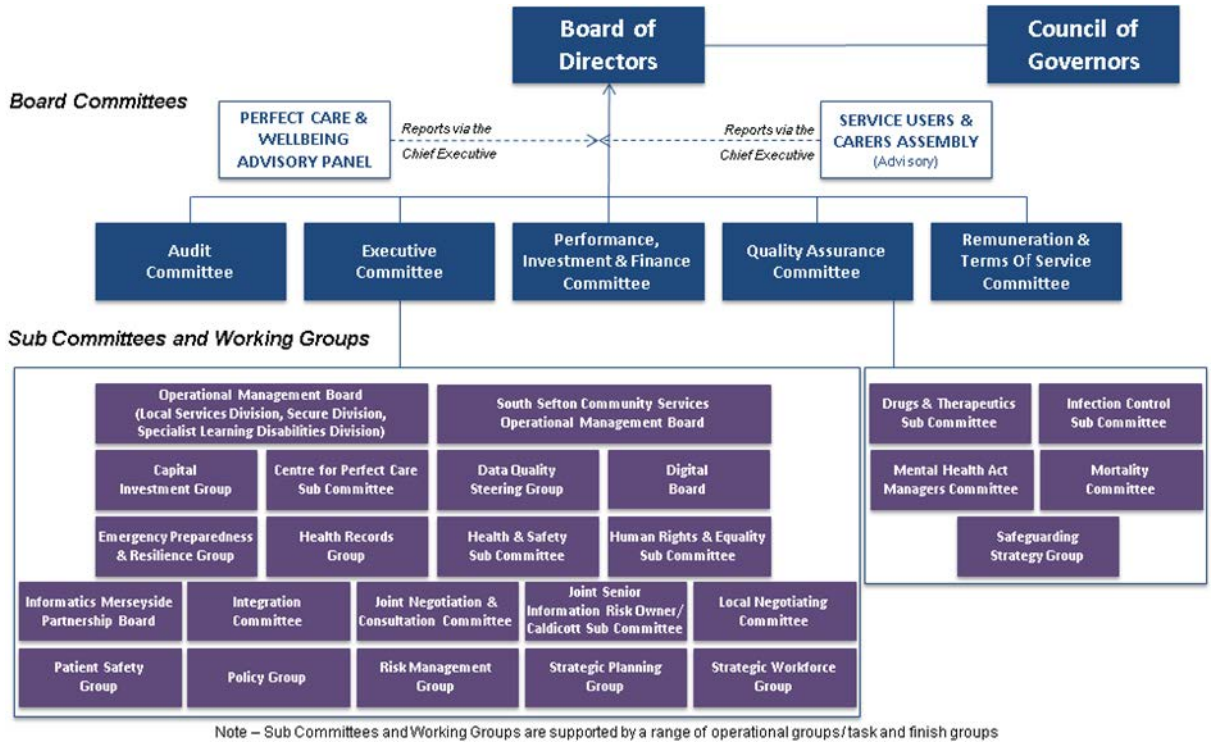
Appendix B

Mersey Care's Governance Arrangements

Trust Surveillance for Quality Process



Trust Governance Structure



Note – Sub Committees and Working Groups are supported by a range of operational groups/task and finish groups

1 Roles and responsibilities of main committees re Risk

1.1 **Executive Committee** (reports to the Trust Board) - The Board has delegated responsibility to advise / make recommendations on the contents of both the Board Escalation & Assurance Framework and the Strategic Risk Register to the Executive Committee. The Executive Committee, through its Risk Management Group, undertakes a detailed scrutiny of all the strategic risks facing the Trust and makes recommendations to the Trust Board via papers brought by the Medical Director. The terms of reference for the Executive Committee can be found in the Scheme of Reservation and Delegation.

1.2 **Risk Management Group** (reports to the Audit Committee, Executive Committee, Performance & Investment Committee and Quality Assurance Committee) - provides more detailed scrutiny of the strategic and significant risks facing the trust, as well as ensuring that the four Divisions are adequately managing their key risks. Its role is not to determine the risks and their risk scores, but rather provide assurance to the Board Committees on the appropriateness of controls and mitigation for the risks that have already been identified. It is then for the appropriate Board Committee to consider this when providing its own assurance and recommendations on the risks faced by the trust to the Board. The terms of reference for the Executive Committee's Risk Management Group are available from the Trust Secretary.

1.3 **Quality Assurance Committee** (reports to the Trust Board) - delegated by the Board to identify risks relating to the quality of care provided by the Trust. The Quality Assurance Committee is chaired by a Non Executive Director. Risks identified or changes requested by the Quality Assurance Committee will be brought to attention of the Board through the minutes of the Committee and by the Board Assurance Report. The terms of reference for the Quality Assurance Committee can be found in the Scheme of Reservation and Delegation.

1.4 **Audit Committee** (is accountable to the Trust Board) - acts as the central means by which the Board is assured that effective internal control arrangements are in place and provide a form of independent check upon the executive arm of the board. It will achieve this by:

(a) concluding upon the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

(b) reviewing the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

(c) reviewing the adequacy of underlying assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of

principal risks and the appropriateness of the above disclosure statements.

The terms of reference can be found in the Scheme of Reservation and Delegation.

1.5 **Relevant Operational Management Boards** (report to the Executive Committee) - each of the four divisions within the trust, has a Operational Management Board which has responsibility for managing and monitoring risks within its area of operations. The terms of reference for these Operational Management Boards are available from the Trust Secretary. The (draft) minutes of these Operational Management Board meetings shall be formally recorded by the Committee Secretary and submitted to the Executive Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

1.6 **Health & Safety Sub-Committee** (reports to the Executive Committee) - a statutory obligation to have a Health & Safety Committee as set out in the Safety Representatives and Safety Committee Regulations 1977. The role of the Sub-committee is to monitor standards relating to health and safety at work and to provide a forum for consultation between staff and management. The Health and Safety Sub-committee will provide assurance to the Trust Board (via the Executive Committee) that the Trust is discharging its health and safety legislative responsibilities by establishing and maintaining standards. The (draft) minutes of the Health and Safety Sub-committee meetings shall be formally recorded by the Committee Secretary and submitted to the Executive Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

1.7 **Mental Health Act Managers Sub-Committee** (reports to the Quality Assurance Committee) - provides assurance to the Trust Board (via the Quality Assurance Committee) that the Trust is discharging its legislative responsibilities in fulfilling the duties and obligations of the Managers under the Mental Health Act 1983 (as amended), the Memorandum and the Code of Practice in respect of the Trust's Mental Health Act activities. The (draft) minutes of the Mental Health Act Managers Sub-committee meetings shall be formally recorded by the Committee Secretary and submitted to the Quality Assurance Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

1.8 **Infection Control Sub-Committee** (reports to the Quality Assurance Committee) - provides assurance to the Trust Board (via the Quality Assurance Committee) that the Trust is discharging its infection control legislative responsibilities by establishing and maintaining standards. The (draft) minutes of the Infection Control Sub-committee meetings shall be formally recorded by the Committee Secretary and submitted to the Quality Assurance Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

1.9 **Drugs & Therapeutics Sub-Committee** (reports to the Quality Assurance Committee) - provides assurance to the Trust Board (via the Quality Assurance Committee) that the Trust is discharging its legislative responsibilities relating to medication as a clinical intervention, but also within the wider therapeutic context, by establishing and maintaining standards. The (draft) minutes of the Drugs and Therapeutics Committee meetings shall be formally recorded by the Committee Secretary and submitted to the Quality Assurance Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

1.10 **Perfect Care And Wellbeing Sub-Committee** (reports to the Executive Committee) - provides assurance to the Trust Board (via the Executive Committee) that the Trust fully complies with the requirements of the Department of Health's Research Governance Framework for Health and Social Care by establishing and maintaining standards. The (draft) minutes of the Perfect Care and Wellbeing Sub-committee meetings shall be formally recorded by the Committee Secretary and submitted to the Executive Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

1.11 **Information Governance and Caldicott Sub-Committee** (reports to the Executive Committee) - provides assurance to the Trust Board (via the Executive Committee) that the Trust acts lawfully, specifically in relation to the Data Protection Act 1998; Freedom and Information Act 2000 and relevant Codes of Practice.The (draft) minutes of the Information Governance and Caldicott Sub-committee meetings shall be formally recorded by the Committee Secretary and submitted to the Executive Committee, supported by a Chairs Report highlighting:

(a) key risks identified through the work of the committee which are recommended for inclusion in the corporate risk register;

(b) the impact of assurance reports received relating to existing risks in the corporate risk register;

(c) any enhanced controls related to existing risks in the corporate risk register;

(d) any issues that require disclosure to the full Board via an exception report.

The terms of reference are available from the Trust Secretary.

2 **Other Committees, Sub-Committees And Working Groups** - all of the Trust's Board committees, sub-committees and working groups may raise matters for inclusion on the relevant risk register through both the Trust's governance arrangements and / or the Trust's management arrangements.

Appendix C

Risk Scoring – Impact

	impact 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

	impact Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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
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

	impact Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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
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

Appendix D

Good Governance Institute's Risk Appetite Matrix

Source: Risk Appetite for NHS Organisations: A Matrix to support better risk sensitivity in decision taking
(January 2012 http://www.good-governance.org.uk/wp-content/uploads/2014/02/Risk-Appetite-for-NHS-Organisations.pdf)

Risk Levels	0 – Avoid	1 – Minimal (ALARP)	2 – Cautious	3 – Open	4 - Seek	5 - Mature
Key elements	Avoidance of risk and uncertainty is a Key Organisational objective	(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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.
Financial / Value for Money	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.
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 to 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 withbenefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix E

Risk Management Group's Terms of Reference

1 CONSTITUTION

1.1 The Executive Committee hereby resolves to establish a sub-committee to be known as the Risk Management Group (referred to as the "Group" below). The Group has no powers, other than those specifically delegated in these terms of reference.

2 ACCOUNTABILITY

2.1 The Group is accountable to the Executive Committee and the Executive Committee must approve any changes to these terms of reference.

3 PURPOSE

3.1 Its purpose is to:

(a) provide assurance and advice to the Executive Committee, Performance & investment Committee and Quality Assurance Committee in respect of the risks facing the trust and plans to mitigate these risks;

(b) assist the Executive Director of Nursing in providing assurance to the Audit Committee that the trust has an effective risk management system in place;

(c) ensure the trust-wide risk register and the board assurance framework are fit for purpose and adequately reflect the risk profile of the organisation;

(d) scrutinise, challenge, consider and moderate the description of risks, risk scores, risk mitigation and treatment plans provided by executive leads / divisions / project leads to ensure they meet trust-wide risk management standards and take account of the Trust Board's risk appetite and requirements;

(e) oversee the trust's risk management systems to ensure they are embedded across the trust and, where necessary, to clarify the responsibility for managing risks and delivering mitigation plans;

(f) oversee the appropriate escalation and / or de-escalation of risk(s) from wards / teams to the Trust Board and from the Trust Board to wards / teams;

(g) review and update the trust's Risk Management Policy, making recommendations as necessary to the Executive Committee.

4 MEMBERSHIP

4.1 The Group shall comprise the following voting members:

(a) Director of Patient Safety (Chair);

(b) Representatives from each Relevant Operational Management Boards, i.e., risk lead from (i) the Corporate Division (ii) the Local Services Division (iii) the Secure Division (iv) the Specialist Learning Disabilities Division and (v) the South Sefton

Community Services.

(c) Director of Patient Safety;

(d) Trust Secretary / Deputy Trust Secretary;

(e) Head of Risk and Resilience.

4.2 The Director of Patient Safety will chair the Group, with the ability to nominate a deputy chair from the membership if they themselves are unable to attend. The membership of the Group will be disclosed in the annual report.

4.3 Members of the Group are permitted to nominate deputies, but deputies from divisions have to attend their Relevant Operational Management Board.

5 ATTENDANCE

5.1 The following non-voting members will attend meetings of the Group:

(a) Minute Secretary.

5.2 The Chair of the Group may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to enable it to deal with matters before the Group.

6 QUORUM

6.1 A quorum shall be four members, one of who should be the chair / deputy chair. Appropriate deputies in attendance for members shall be considered when considering if the meeting is quorate.

7 FREQUENCY

7.1 Meetings shall be held as a minimum twelve times a year. Members of the Group may request a meeting if they consider that one is necessary.

8 AUTHORITY

8.1 The Group is authorised by the Executive Committee to:

(a) investigate any activity within its terms of reference;

(b) make recommendations to the Executive Committee;

(c) to act in accordance with the trust's *Scheme of Reservation and Delegation*;

(d) approve policies for which the Group is the responsible body;

(e) establish and approve the terms of reference of such sub-reporting groups, or task and finish groups as the Group believes necessary to fulfil its terms of reference.

8.2 The Executive Committee also delegates decisions that are not of a significant nature. In practice, what is significant will depend upon the judgement of members but the Group must refer the following types of issue to the Executive Committee, i.e., any matter which will:

(a) change the strategic direction of the trust;

(b) conflict with strategic obligations;

(c) contravene national policy decisions or Government directives;

(d) have significant revenue implications;

(e) is likely to arouse significant public or media interest;

9 REPORTING

9.1 The Group will have the following reporting requirements:

(a) that it prepares regular reports providing advice (including recommendations for risks to be included in the board assurance framework) and assurance in respect of risk management and the trust's risks and mitigation plans to the Executive Committee, Performance & Investment Committee and Quality Assurance Committee;

(b) that is assists the Executive Director of Nursing in preparing regular reports that provide assurance to the Audit Committee that the trust has an effective risk management system in place;

(c) on behalf of the Executive Committee, Performance & Investment Committee and Quality Assurance Committee (and where appropriate the Audit Committee), to provide regular reports to the Trust Board on proposals in respect of the risks and mitigation plans recorded in the board assurance framework and trust-wide risk register, reflecting the recommendations made by these committees to the Trust Board;

(d) that it provides feedback to Board Committees, Divisional Governance Relevant Operational Management Boards and through the trust's other governance arrangements on the Trust Board's requirements and feedback on the risks and mitigation plans presented to the Trust Board;

(e) to ensure that the action notes of its meetings are formally recorded and submitted to the Executive Committee;

(f) to ensure that any issues that require disclosure to a Board Committee are brought to the appropriate Board Committee's attention;

(g) to ensure that any issues that require disclosure to the Trust Board are brought to the appropriate Board Committee's attention.

9.2 The Group will report to the Executive Committee annually on its work.

9.3 The Group will outline its work to the Executive Committee through an annual work plan and will provide assurance to the Executive Committee of compliance with the requirements of these terms of reference through the development and presentation of an annual report, presented within 3 months of the end of the financial year.

9.4 The Group may establish sub-groups if required, with terms of reference approved by, and action notes of sub-group submitted to, the Group.

10 RESPONSIBILITY OF GROUP MEMBERS AND ATTENDEES

10.1 Members of the Group have a responsibility to:

(a) attend a minimum of 75% of meetings a year, having read all papers beforehand;

(b) attend training in respect of their role on the Group as identified by the Executive Director of Nursing;

(c) agree an annual business cycle for the Group;

(d) act as 'champions', disseminating information and good practice as appropriate.

11 ADMINISTRATIVE ARRANGEMENTS

11.1 The Head of Risk and EPRR will ensure:

(a) that the Group receives sufficient resources to undertake its duties;

(b) action notes are taken and once agreed by the chair that they are distributed to the members;

(c) the action notes from meetings are distributed within 10 working days of the meeting taking place;

(d) a record of matters arising is produced with issues to be carried forward;

(e) an action list is produced following each meeting and any outstanding action is carried forward on the action list until complete;

(f) conflicts of interest are recorded along with the arrangements for managing those conflicts;

(g) appropriate support to the chair and Group members to enable them to fulfill their role;

(h) that advice is provided to the Group on pertinent areas;

(i) the agenda is agreed with the chair prior to sending papers to members no later than five working days before the meeting;

(j) management of the Group's annual business cycle;

(k) the papers of the Group are filed in accordance with the trust's policies and procedures.

11.2 The Head of Risk and Resilience (or their nominee) will collate the Group's annual

report and agree the ways of working to enable the Group to meet the wide range of responsibilities set out in these terms of reference.

12 REVIEW

12.1 Terms of reference will be reviewed at least annually. Date for the next review will be July 2017.

Appendix F

Risk Assessment Template

Risk Title – In plain English and avoiding acronyms identify your risk starting the sentence with “if” and build to “then” (if x happens, then y).

Date Raised	Risk Category	Next Review Date
Date the risk was raised	Finance Quality Reputation Regulatory (choose one)	Review Date should reflect risk score (higher the score the more frequent the review)

Original Risk			Current Risk				Target Risk			
Impact	Likelihood	Rating	Impact	Likelihood	Rating	Movement	Impact	Likelihood	Rating	Target Date
1=Insignificant 2= Minor 3=Moderate 4=Major 5=Catastrophic	1=Rare 2=Unlikely 3=Possible 4=Likely 5=Almost Certain	Impact x Likelihood	1=Insignificant 2= Minor 3=Moderate 4=Major 5=Catastrophic	1=Rare 2=Unlikely 3=Possible 4=Likely 5=Almost Certain	Impact x Likelihood	-	1=Insignificant 2= Minor 3=Moderate 4=Major 5=Catastrophic	1=Rare 2=Unlikely 3=Possible 4=Likely 5=Almost Certain	Impact x Likelihood	Date targets will be achieved

Cause	Effect	Assurances	Assurances Rating
Description of the event which causes the Risk	Adverse impacts should the risk materialise	Controls in place to mitigate the risk	Please see note

Actions

Actions Code & Title	Actions Latest Note	Status	Due Date	Assigned To
Action 1: Action which you plan to put in place to help mitigate the risk.	Use this space to provide updates on the action;	Assigned On track Overdue completed	Date action will be completed	Responsible for managing the action
Action 2: ... (you can add as many actions as necessary)		As above		

Notes & History Latest Note	Action Lead	Accountable Manager	Executive Owner
Use this space to provide any further information	Responsible for managing the risk	Responsible for the Service Line (Director / Head of Service)	Executive owner of the Risk

*Note: Assurances are split into 3 levels depending on the scoring of the risk:
Score 1 to 6 Level 1 – Managed Locally (e.g. within a team, function or project)
Score 9 to 12Level 2 – Assurance given through reporting up to gov boards and committees.
Score 15+Level 3 - 15+ strategic risks, External Assurance e.g. MIAA

Appendix G

Process for Managing the Division's Risk Register

The Division's Risk Register documents all the risks we carry as a Division and what we are doing to eliminate or mitigate those risks. Risks can be clinical, environmental, financial, political or affecting public perception and reputation.

Risk Identification

1) **Anyone can identify a risk** - communications are sent out periodically advising staff of the Risk Register, its contents and asking them if there are any risks missing from the Register. Staff are directed to make contact with the Division's Risk Lead, who is the point of contact for developing a risk item for inclusion on the risk register.

Risk Assessment

2) **A new risk entry proposal form is completed for each new risk identified.** The Risk Lead or manager supports staff to complete the form, which provides all the known information, at that time, regarding the risk. This information is then uploaded onto Covalent (the Trust's web based risk management system) so there is a central record of the risk.

3) **Each risk is given an opening risk score.** This is an assessment of the likelihood and impact of the risk occurring, taking account of the Trust's current arrangements to mitigate occurrence. The Trust's Risk Management Strategy provides guidance for defining and assessing likelihood and impact. Risks will be prioritised depending on the likelihood, impact and overall risk score with the most severe risks being addressed first.

Plan

4) **For each risk there will be a risk response** - either to treat the risk (i.e. take action to reduce the likelihood or impact of the risk) or to tolerate the risk (i.e. make a conscious decision to tolerate the risk).

5) **The Risk Lead seeks approval of the assessment of the risk and proposed risk response.** The new risk is presented to the relevant meeting for discussion and endorsement before submission to the Relevant Operational Management Board for ratification/oversight of the division's risks.

6) **All risks are allocated an Executive Owner, Executive Director, an accountable Manager (Senior Manager) and an Action Lead.** This provides accountability for each risk for ensuring the controls identified remain effective and the remedial action required is progressed.

7) **All risks will have measures for monitoring effectiveness of the controls in place and delivery of any actions, known as assurances**. Performance against these measures will provide positive assurance the risk is being managed. Non compliance confirms gaps in assurance.

8) **All risks will be given a level of assurance** – this defines the level of oversight of the risk, generally the greater the risk score the higher the level of oversight of the risk. Level 1 is departmental assurance (e.g. department's self assessment of compliance), Level 2 is organisational oversight (e.g. Trust Performance Team's

assessment of compliance) and Level 3 is independent assurance (e.g. external audit).

9) **All risks are given a target risk score and target date of achievement.** This reflects the position the Division wants to achieve through its controls and remedial action by an agreed date.

Implement & Review

10) **The Action Lead has day to day responsibility for managing the risk.** They will be a named individual responsible for carrying out remedial action by the target completion date and reporting to the relevant governance committee (on an agreed basis) progress through to completion.

11) **A governance committee is assigned to monitor risks relevant to its area of work** to ensure that the risk is regularly reviewed at a senior level and is being progressed. The committee is responsible for ensuring that actions do not lapse and controls are adequate. All new risk items are reviewed in the first three months for assurance that the actions are under way.

12) **Each time a risk is reviewed by the relevant governance committee, they will agree the current risk score**, based on the information provided by the Team risk owner in their progress report.

13) **The Relevant Operational Management Board receives a quarterly report on the risk register**, which focuses on the highest scoring risks, risks overdue for review, risks due for review in the next quarter.

14) **A risk will remain on the Risk Register as long as it is a live risk.**

15) **All risks that no longer present a threat and are being considered for removal from the Risk Register should have a substantive level of assurance** (evidence that it is no longer a risk). This evidence is submitted to the Relevant Operational Management Board for agreement to make the risk inactive on the Division's Risk Register.

Further Information:

If you want to discuss any aspects of Risk Management/the Risk Register or want to raise a new risk please contact:

Secure Division

- Ian Murphy, Deputy Service Manager, via email Ian.Murphy@merseycare.nhs.uk telephone on ext. 2221.
- Sarah Cain, Secure Services Administrator, via email Sarah.Cain@merseycare.nhs.uk, or telephone ext. 2626

Local Division

- Suzi Lloyd Ellington, Risk and Governance Manager, via email Suzi.Lloyd@merseycare.nhs.uk or telephone ext. 0151 527 3444
- Louise Gange, Service Governance Coordinator, via email louise.gange@merseycare.nhs.uk or telephone 0151 527 3471

Corporate Division

- Frank Westhead, Program Manager via email

Frank.Westhead@Merseycare.nhs.uk or telephone ext. 0151 472 4084

Specialist Learning Disabilities Division

- Jon Tynan, Divisional Head of Risk and Patient Safety, via email Jonathan.Tynan2@merseycare.nhs.uk or telephone 01254 821 867

South Sefton Community Services

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March 2017