Belfast Health and Social Care Trust

RISK MANAGEMENT STRATEGY

2013 – 2016

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RISK MANAGEMENT POLICY STATEMENT [1]

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy

[1] Belfast HSC Trust Board Assurance Framework Document 2013-2014

1 Introduction

This strategy sets out the approach to risk management in the Belfast Health and Social Care Trust over the next three years, and builds on work already underway within the Trust in relation to risk management.

The Risk Management Strategy is closely linked to the Trust's strategic themes. It will inform the management planning process and assist us in achieving corporate and Directorate objectives. In endorsing this strategy the Board of Directors recognises the importance of risk management in ensuring that the Trust does its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising from its undertakings.

The management of risk is the responsibility of staff at all levels within the Trust. Patients, service users and the public also have an important part to play in improving the risk management processes of the Trust by supporting staff in adhering to local, regional and national policy guidance and by proactively participating in their care.

2 Strategic Context

The Board of Directors aims to take all reasonable steps in the management of risk to ensure that the organisation's objectives, as outlined in the Corporate Plan, are achieved.

The Trust has five long-term corporate objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.
- Continuous Improvement - We will seek to be a leading edge Trust through innovation at all levels in the organisation
- Partnerships - We will work collaboratively with all stakeholders and partners to improve health, social care and well being and tackle inequalities and social exclusion
- Our People - We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce
- Resources - We will work to optimise the resources available to us to achieve shared goals

The Trust will manage risks by:

- Undertaking a quarterly assessment of the organisation's objectives and identifying the principal risks to achieving these objectives. These will create the Principal Risk Document;

- Ensuring there are appropriate systems to monitor and review risks which are delegated below Corporate level;

- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified;

- Regular monitoring and review of the effectiveness of the Board Assurance Framework by the Board of Directors, the Assurance Committee and the Audit Committee;

- Integrating risk management into the annual planning process, ensuring that objectives are set across the organisation with specified plans to manage risk;

- Developing an "open and fair" culture. Whilst recognising that individuals are accountable for the delivery of safe and effective care and other services; it is accepted that systems and processes can contribute to both the prevention and occurrence of incidents. An "open culture" that is fair in its approach to staff and avoids blame can better encourage learning when things go wrong

There are a number of factors, which will influence the development of this strategy, most significantly:

2.1 Service User and Public Expectations

The growing interest and reporting by the media of what goes wrong in health and social care can be alarming for the public and often paints an unrealistic picture. Yet it does make service users far more aware of the risks associated with healthcare.

High profile adverse incidents in health and social care also rightly raise public awareness and expectations. Learning lessons from incidents and following the recommendations and guidance from the ensuing reports are fundamental to the proactive management of risk.

The Trust values the input of patients/clients and service users in risk management and the strategy aims to strengthen this.

2.2 Modernisation

A number of Human Resources and other initiatives provide the opportunity to modernise and improve the working environment, pay and reward and organisational facilities. Appropriate risk assessment and management processes will ensure that these initiatives will enhance organisational effectiveness.

The implementation of the Knowledge and Skills Framework (KSF) supports staff development, knowledge and competency in relation to risk and ensures that the individual's role in risk management is linked to their job profile and incorporated within their KSF Post Outline under the Core Dimension for Health, Safety and Security. The KSF and its associated development review process apply across the whole Trust for all staff (except medical and dental). Medical and Dental staff will participate in appraisal via their existing processes.

2.3 Financial Constraints

The Trust continues to operate in a challenging financial environment. Consequently, many developments need to be made within existing resources. Efficiency and investment plans can either minimise or contribute to organisational risk. The continued identification and proactive management of risk is vital to ensuring patient/client and staff safety and quality of service in the current financial climate.

3. Objectives

The Trust has a number of key objectives in relation to risk. These are to:

- raise staff awareness of the principles and practice of risk management;
- establish an "open and fair culture" encouraging lessons to be learned and good practice to be maintained;
- achieve improved patient outcomes and experience through the implementation of effective governance arrangements;
- protect the health and safety of patients, clients, staff, visitors and others who may be affected by the Belfast HSC Trust activities;
- establish priorities for the control of risks, based on a suitable assessment process;
- minimise financial liability through effective Controls Assurance;
- minimise potential loss or damage to the assets and reputation of the Belfast HSC Trust;
- involve the public and users of our services in the application of risk management and assurance to the Trust's undertakings.

4 Responsibilities

To achieve these objectives, everyone must be clear about their responsibilities. Responsibilities for risk and governance are set out in the Trust's Board Assurance Framework document[2].

In addition the responsibilities of other key stakeholders are detailed below:

4.1 Senior Managers - Risk and Governance (Medical Directorate) and Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for collecting data on performance and providing reports on collated data for use by the Board of Directors, executive team, Directorate management and staff. These managers must ensure investigation of adverse incidents and complaints, according to agreed procedures and provide reports which identify learning and recommendations for action. They will also act as a resource for expert advice.

4.2 Co Directors, Managers and Clinicians

All clinicians, managers and co directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produce risk registers and action plans, to address identified risks which are linked to corporate objectives. Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

4.3 Employee Responsibility

All members of staff must accept responsibility for maintaining a safe environment for patients, staff and service users. In doing so, each member of staff has the responsibility and the right to highlight their concerns about any risk issue, either directly to their manager or through the risk management processes in the Trust. They are required to co-operate with this strategy, to take any reasonable action

[2] Belfast HSC Trust "Board Assurance Framework –2013 -2014" Section 6 & 7

to minimise any perceived risk and adhere to Trust policy and procedure.

4.4 Patient/Client/Carer Responsibility

Patients and clients have a role to play in identifying and reducing risk. They are expected to co-operate with Trust staff to reduce risk. They have a responsibility to identify any issue or information that may place them at risk when receiving care within the Trust.

Patient and clients are encouraged to share knowledge in relation to their condition/care which may minimise the likelihood of an adverse incident.

4.5 Contractors, Other Employers and Agency Staff

It is essential that Contractors, other Employers (sharing/using Trust premises) and Agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that management of risk is an individual as well as collective responsibility.

For Agency and Locum staff, the local line manager will conduct a formal induction as per Trust guidelines. Agency and Locum staff must expect to receive a local induction so they can work safely, if this does not happen they should report this to the employing agency.

Contractors are required to comply with the contractual arrangements that will specify health, safety and risk management activities that must be observed while working in the Trust.

5 Committee Structure

The Trust has put in place a comprehensive assurance framework which details the proposed organisational arrangements for governance and assurance[3]. The framework shows how the various elements of this structure interrelate to ensure that the board is kept fully informed. An important element of the Trust's arrangements is the need for robust governance within directorates. This will be tested through the accountability review process.

The existing committee structure for risk will be reviewed as part of the implementation of this revised strategy to ensure that all groups/committee/bodies that support the Trust in the management of organisational risk are identified and their lines of accountability are clearly defined.

[3] Loc. Cit Appendix 3

6 Risk Management Process

6.1 Definition of risk and risk management

The organisation needs to have a common understanding of the definition of risk. The following definition is used by the Trust:

> *"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood".*[4]

Risk management is the process of identifying potential variations from what we plan and managing these to maximise opportunity, improve decisions and outcomes and minimise loss. It is a logical and systematic approach to improve effectiveness and efficiency of performance. Risk management is an integral part of everyday work.

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk. Risks must be evaluated in a consistent manner. The Trust has adopted a standard methodology consistent with DHSSPSNI guidance[5] and the Australian/New Zealand Risk Management Standard AS/NZ 4360: 2004 for identifying and measuring risks (see Appendix 1). This standard methodology will be applied where appropriate in directorates and in Trust wide assessments of risks. This methodology incorporates the following key measures:

- Consequence descriptors that cover different domains/areas of risk;
- Likelihood descriptors for frequency and probability;
- A matrix to identify the risk evaluation score that uses consequence and likelihood scales;
- Management authority for each level of risk (extreme, high, medium and low).

[4] AS/NZ Risk Management Standard 4360:2004
[5] How to classify incidents and risk. DHSSPS April 2006

7 Delivering successful risk management

To ensure the implementation of an effective strategic framework, the Trust must address the following core elements of risk management:

- Identification, assessment and reporting of risk;
- Learning lessons from incidents and risk management processes to ensure continuous improvement;
- Communication with staff, service users and the public;
- Education and training for risk management and related issues for staff, service users and public;
- Partnership working with staff, service users and public to ensure continuous improvement;
- Evaluation, monitoring and audit of policies, procedures and systems.

Each of these elements will be dealt with in further detail below. The proposed work programme required to achieve the strategic vision is outlined in Appendix 2.

7.1 Identification, Assessment and Reporting of Risk

7.1.1 Risk registers

The identification of risk within the Belfast HSC Trust must be addressed in a proactive, as well as, a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic risk registers at all levels of the organisation. This will enable the Board of Directors to prioritise risk and allocate funding accordingly.

A risk register is a means of documenting the risk profile and treatment plans for controlling and minimising risk. The outputs from organisation wide risk assessment processes, which are both dynamic and iterative, will create the Corporate/ Directorate/Service Area risk registers. As such a risk register becomes a management tool as well as an audit and assurance process.

Directorates are required to develop and maintain a register of all identified risks specific to their own activities and circumstances, maintaining ongoing monitoring and progression of associated actions/action plans as appropriate. It is expected that Directorates will use Datixweb for risks to facilitate the maintenance of the risk registers. Directorates are expected to review their risk registers at least four times a year.

Risk Tolerance

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

Risk Appetite

Risk appetite is the extent of exposure to risk that is judged tolerable. The concept may be looked at in different ways depending on whether the risk being considered is a threat or an opportunity.

Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1) for detail.

7.1.2 Principal Risk Document

The purpose of the Principal Risk Document is to provide the Trust with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting its objectives.

The Principal Risk Document differs from the corporate risk register in that it is a high level assessment of risk to delivery of key objectives that focuses on evidence of action on control. The risk register is a comprehensive account of the risks identified and actions required.

The ongoing development and review of the Assurance Framework including the Principal Risk Document provides robust processes within the organisation to escalate concerns and risks adequately and supports the need to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

7.1.3 Corporate Risk Register

A risk which remains at 'Almost certain' x 'Catastrophic'(25) following immediate action will be recorded in the Corporate risk register and be subject to regular review by the Assurance Committee.

The corporate risk register is further populated by application of particular criteria applied to risks from a number of internal sources including the Directorate risk registers, the concerns of Directors, Chairs of Trust Committees and other initiatives such as risks identified within the planning process.

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

- Has been evaluated as 'Almost certain' x 'Catastrophic'(25) is evaluated as below 25 but:
- The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
- The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
- Existing standards and guidance ignore or contribute to the risk;
- The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

The corporate risk register is used to support ongoing review and update of the Principal Risk Document. The Principal Risk Document provides an assurance to the Board of Directors as to the identification and management of the organisations principal risks. Both the Principal Risk Register and Corporate Risk Register will be reviewed and reported to Assurance Committee four times a year.

7.1.4 Incident reporting

The Trust relies upon the accurate reporting of incidents by its entire staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and ensuring lessons are learned from adverse incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as source data for the identification and reporting of risk.

Any media interest in reported incidents will be managed in a positive way, by reassuring the public that adverse incident reporting is

essential to the prevention of serious incidents and a high level of incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff, service users and carers are supported and receive feedback on all incidents reported within the Trust. The degree of feedback being dependent on the nature of the risk associated with the incident reported.

7.2 Learning Lessons from Incidents to Prevent Reoccurrence

The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The Trust expects the level of incident reporting to remain high. It is anticipated that this should be offset by systems that prevent incidents occurring in the first place. These systems also include proactive management and analysis of complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the Trust. A system of sharing and benchmarking risk issues associated with reported incidents across directorates will be maintained. The development of an infrastructure to ensure that lessons are learned from risk reporting, identification and analysis depends upon maintaining of an open and fair culture, where the organisation accepts overall responsibility for having safe and effective systems. This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. The Trust accepts the potential for human error. Only where staff act outside their professional standards or in a reckless manner in disregard of organisational systems, policies and procedures are they likely to face disciplinary action. This will result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Where results of detailed investigations have shown there are clear case of negligence, unprofessional and unacceptable practice this will be addressed in line with relevant professional and personnel guidance.

The Trust will monitor lessons learnt, by improvements in patient/client care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

7.3 Communication with Staff, Service Users and Public

The Trust must ensure that the processes to identify and report risk are open and accessible to all service users, staff and the public. It is important that communication relating to risk management is both transparent and effective for patients, clients, carers and staff. The assurance framework structure is the cornerstone of this communication. Each Directorate has established and will maintain a local infrastructure to support the communication and feedback process to and from the Executive Team and Trust Board. The communication of risk management issues will be through the Board's

regular performance reports and specific reports. The Medical Director's Directorate will support this communication.

The Trust will consider how to work with service users to identify ways of communicating general risk issues to patients/clients and the public. On a day to day basis clinicians and managers must discuss relevant risk issues related to care with the patient or client and incorporate these issues into care plans, care packages and care pathways.

The Trust has a large number of external partners including the DHSSPSNI, Commissioners and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is maintained. The RQIA and Internal Auditors have an established role in monitoring and evaluation of organisational risk management issues. The Trust will continue to work collaboratively with these agencies and others including the NI Health and Safety Executive and the MHRA in the continuous improvement of risk management and risk reduction.

7.4 Education, training for risk management and related issues for staff, service users and public

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, service users and the public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The management of risk will be incorporated in the appraisal process for Doctors and Dentists and is reflected in the Knowledge and Skills Framework for other staff under the Core Dimension for Health, Safety and Security.

A range of training and education relating to risk management is and will continue to be developed and available within the Trust aimed at the specific needs of staff members. This starts at induction. The education of the public in relation to their role in risk is important. The Trust will engage with the public in developing information and educational opportunities for patients, clients, carers and other service users.

Managers, clinicians and staff have a responsibility for ensuring that they have the necessary skills to undertake their roles and that these skills are up to date.

7.5 Evaluation, monitoring and audit of policies, procedures and systems

The Trust monitors the improvement in patient/client care via the action plans developed following adverse incident trend analysis. In some instances the establishment of "working groups" will be necessary to address major organisational risk issues. The progress of such groups will be monitored via the Assurance Group.

The Risk Management, Governance and Finance Controls Assurance standards are monitored on an annual basis, the annual compliance scores will be reported to the Assurance Committee, a subcommittee of the Trust Board. Gaps in control will be linked, to an appropriate risk register and action plans will be monitored via the Controls Assurance Committee and the Assurance Group. This will ensure organisational learning and improvement.

8 Conclusion

The Belfast HSC Trust has made sustained progress in the identification and reporting of risk. This strategy sets the vision for the next three years, which will build on this work and ensure that improvements are sustained. The Trust will focus on "closing the loop" and utilising the information that risk profiling and reporting can provide. Ultimately this approach will provide sustained improvement in patient/client care, staff well-being and safety and contribute to protecting the Trust's resources.

The implementation of this strategy will be reviewed on an annual basis. This will enable the Trust to regularly review and update the strategy, ensuring that it remains dynamic and pertinent to the delivery of safe and effective care.

Analysing & Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that on Datixweb, step 3 above is automatically completed once the consequence and likelihood scores are entered.

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSC[illegible]pact Table – with effect from April 2013

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

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BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013

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Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

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Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

➢ Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

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RISK MANAGEMENT STRATEGY WORK PROGRAMME 2013/2014

APPENDIX 2

Area	Action	Responsibility	Timescale	Status
Assurance Framework	Maintain a comprehensive assurance framework reflective of all aspects of Trust business. Ensure the Assurance Framework structure optimises learning from patient experience and events.	Directors	June 2013	Complete
Risk Registers	Roll-out of Datix risk register module to key Directorate staff and support its use with training.	Co Director Risk & Governance/ Senior Manager Corp Governance	Dec 2013	Risk register roll out progressing with last Directorate now engaged. New date for completion Dec 2013 Roll out commenced with training and support available including regular reports providing progress updates for Directorates.
	Complete a three-year implementation plan using the BRAAT (Belfast Risk Audit & Assessment Tool) promoting best practice in the management of safety and risk, and influence the provision of a safer working environment and compliance with relevant audit standards.	Directorates Co Director Risk & Governance R&G Senior Managers	Jan 2014	
	Implement use of regional risk matrix for all analysis and evaluation of risks and incidents.	Directorates Co Director Risk & Governance R&G Senior Managers	Oct 2013	Included in Strategy documentation June 2013 For consultation in June 2013
	Develop risk register guidance for population, monitoring and review of risk registers	Directorates Co Director Risk & Governance R&G Senior Managers	Sept 2013	

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Area	Action	Responsibility	Timescale	Status
Patient/Client and Service Users	Implement actions from the Trust post Francis action plan	Medical Director	Apr 2014	Draft action plan to be approved by Assurance Committee June 2013
Management of adverse incident reporting policy	Contribute to proposed revision of HSCB SAI procedure Revise policy in line with proposed new DHSSPS SAI procedure. Deliver training programme included in Learning and Development brochure and TAS and revise e learning package.	Co Director Risk & Governance R&G Senior Managers Co Director Risk & Governance R&G Senior Managers	Sep 2013 Nov 2013 Dec 2013	Delayed by HSCB to Sept 2013 Revision of has policy commenced in preparation to revised HSCB procedure. Monthly Incident training established and available for all staff. E learning currently being updated.
Incident reporting systems	Web-based reporting to continue to be rolled out across the Trust aiming to achieve 90% reporting via the web.	Senior Manager Corp Governance	Apr 2014	79% of incidents reported via the web at end April 2013
Committee Structures	The assurance committees' infrastructure will be continually reviewed. Terms of Reference and Work Programmes will be submitted to the Assurance Group for validation annually.	Assurance Group Committee Chairs	June 2013	Complete
Communication	Explore an electronic solution for dissemination and monitoring of external standards. Establish a Risk and Governance site on Belfast Hub to support good communication.	Medical Director's Directorate Governance & Quality Corporate Nursing Co Director Risk & Governance R&G Senior Managers	Feb 2014 May 2013	 Complete

Area	Action	Responsibility	Timescale	Status
Education and Training	Develop in house training (including e learning) to further support management of risks.	Co Director Risk & Governance/ Senior Manager Corp Governance	Jan 2014	
Evaluation, Monitoring and Audit of Policies	An annual review of the implementation of the Risk Management Strategy and Action Plan will be undertaken.	Co Director Risk & Governance	Jun 2013	Complete

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Assurance Sub-Committee Structure

to be inserted when agreed

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