RISK MANAGEMENT POLICY

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RATIFYING COMMITTEE	**Board of Directors**	
DATE RATIFIED	**October 2025**	
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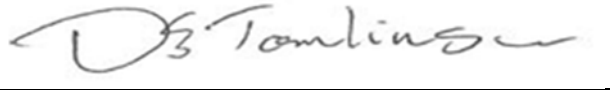
EXECUTIVE DIRECTOR	**Executive Director of Finance**	
POLICY LEAD	**Associate Director of Corporate Governance**	
POLICY AUTHOR *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Previously Reviewed:	**June 2023**	**Sept 2024**	**Oct 2025**						
Changes Made: Yes/No:	**Yes**	**Yes**	**Yes**						

POLICY REQUIREMENT

This Policy applies to all staff - including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, agency staff, TSS/Bank staff, trainees, contractors, Trade Union colleagues, students and persons engaged in doing business or providing services on behalf of the Trust. It would be reviewed annually as there is a requirement for the Trust Board of Directors to agree on and approve the organisation`s risk appetite framework every year.

- All staff members are responsible for:
    - ensuring that risks are identified, assessed, mitigated and appropriately managed.
    - highlighting identified risks to their manager where they are unable to manage them as part of their legitimate role/responsibilities.
- All operational service areas and Executive Directors should systematically review risks on their risk registers, in a timely, dynamic and proportional way, with those scored 15 or more, on a monthly basis as a minimum while those scored 12 or less quarterly as a minimum, identify controls for mitigation and actions to implement to attain target risk score as well as evaluate their effectiveness.
- The Risk Management Group (RMG) will ensure effective risk management arrangements including controls are in place to proactively manage the escalation of risks. Risk moderation will take place at the RMG to determine appropriateness of risk scores, approve risks for escalation and ensure operational risks do not compromise the delivery of the Trust's operational objectives and business plan.
- All risks which could significantly compromise the Trust's ability to deliver its operational and strategic objectives will be reviewed on a monthly basis as a minimum via the Corporate Risk Register and Board Assurance Framework respectively, by the Quality, Patient Experience and Safety Committee, People Committee, and the Finance, Performance and Productivity Committee, as a tool for driving their meeting agendas, discussions, debates and deliberations.
- The Audit Committee will independently review, assure and advise the Board of Directors on the effectiveness of the Trust`s systems of internal control including its risk management arrangements and

that these are effectively working in ensuring the achievement of organisational operational and strategic objectives/priorities.

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1 Introduction

1.1 Rationale

The development and implementation of this Policy will be underpinned by the Trust`s values of compassionate, inclusive and committed.

Risk is the uncertainty that something may happen which may have adverse (threats) or positive impacts (opportunities) on the achievement of the Trust`s operational and strategic objectives. It is measured by multiplying the likelihood (frequency or probability of the risk occurring) by the severity/consequence (impact or magnitude of the effect of the risk occurring)

(Adapted from ISO 31000:2018)

Effective risk management will foster the Trust`s culture of safety, improve decision making and enhance the quality of patient care while ensuring robust and sustainable use of resources. The aim of this policy is to ensure that all staff are confident and empowered to recognise hazards which could develop into risks, effectively identify risks, assess, report, review, mitigate and manage them in achieving the overall aims of the organisation. This means that all staff are expected to effectively mitigate and manage risks at all levels; ranging from the delivery of our strategic priorities/aims, through to the day-to-day operational delivery of team-based objectives which in turn contribute to the bigger picture.

This is demonstrated in the pictorial diagram below: -

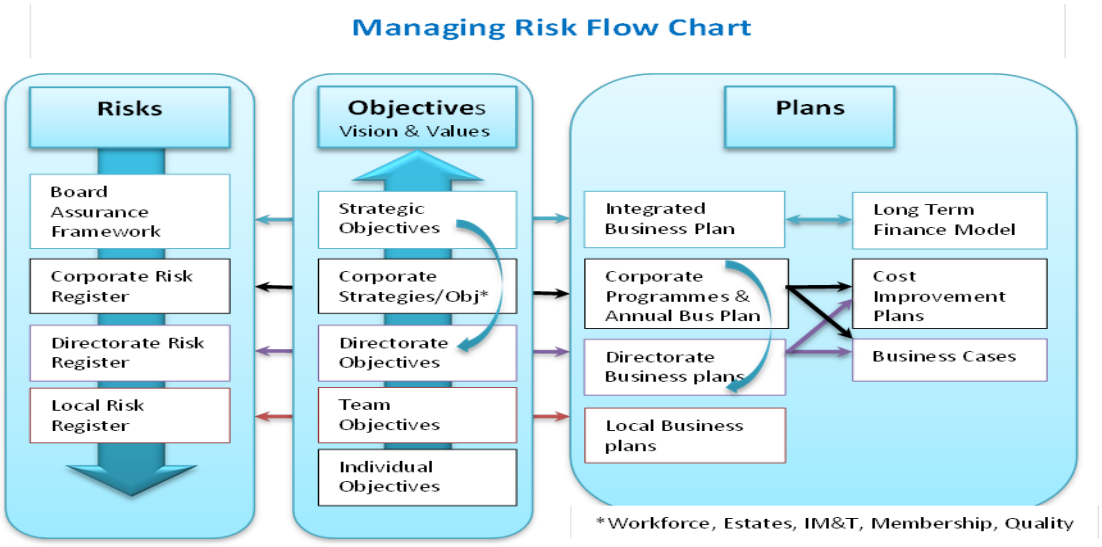


Figure 1 – Managing risks flow chart.

Good risk management is at the heart of everything we do in the Trust. We need to be open, honest, transparent and aware of the risks we are facing on a day-to-day basis as well as strategically. BSMHFT is committed to implementing an agile, dynamic, integrated, Trust-wide, proportionate and proactive approach to risk management – i.e. to identifying, assessing and managing potential risks/threats to the delivery of its operational objectives and strategic priorities.

In large complex organisations, managing risk could seem a daunting task. Risks are, however, inherent in everything that we do as the provision of healthcare entails some uncertainty, which could create new opportunities and risks. How we manage existing and emerging risks is important in helping us meet our objectives, improve service delivery, achieve value for money as well as reduce unwarranted variations, fire-fighting and unwelcome surprises.

This Risk Management Policy provides a structured and comprehensive framework for the effective, proactive and timely mitigation and management of risks. This will be underpinned by clearly established systems and processes for Services, Directorates and Divisions to identify, assess, prioritise and treat risks well as regularly monitor, review and escalate those they wish to get support with mitigating and managing.

This policy also sets out the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks. Transparency, openness and accountability including effective management and governance review, scrutiny and oversight, are hallmarks of BSMHFT`s risk management arrangements.

1.2 Scope

This Policy applies to all staff, including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, Agency, TSS/Bank staff, agency staff, trainees, contractors, Trade Union colleagues, and students and persons engaged in doing business or providing services on behalf of the Trust. Effective risk management like good governance is everyone`s responsibility from `ward to Board.

The Trust works in partnership with Birmingham Community Healthcare and other partners within the system to ensure individuals with learning disabilities have full and equal access to the full range of mental health services. Therefore, all aspects of this policy will equally apply to service provision within related learning disabilities.

1.3 Principles

The Trust’s approach recognises:

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The implementation of the risk management arrangements must be proportionate, timely, dynamic, aligned to the delivery of the Trust`s goals, comprehensive and embedded into business as usual as well as responsive to changes within the Trust`s business environment.
- There is need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create opportunities for staff to explore a risk-based approach in tackling `wicked issues` which could undermine the delivery of high-quality safety care.

Some risks will always exist as they will never be completely eliminated; hence, staff must understand the nature of risk while accepting responsibility and accountability for their effective mitigation and management.

- The Trust explores an integrated approach to risk management that combines a top-down strategic view with a complementary bottom-up operational process.

2 Policy

All staff members are responsible for ensuring that risks are identified, assessed and managed.

All staff are responsible for highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role responsibilities.

The consequence and likelihood of risk occurrence will be assessed against the Trust wide risk scoring matrix (see appendix 1 for details). Risks will be recorded on risk registers via the Eclipse electronic risk management system.

All local service areas, managers and Executive Directors should systematically review risks on their risk registers or within their portfolios on a quarterly basis as a minimum. Risks scored 15 and above, should be reviewed monthly as a minimum while those scored 12 or less should be reviewed quarterly. Regular review, presentation and discussion of risks irrespective of their scores at Local Clinical Governance Committees is a marker of good governance as it provides assurance that risks are thoroughly and appropriately managed and mitigated in related Service, Directorate or Division. However, Local service areas, Directorates and corporate support teams are expected to escalate any risks with a score of 15 or more that have been approved at their local governance meeting, signed off at the Directorate level and by the relevant Executive Director. Such risks will then be presented at the RMG for consideration and approval for inclusion onto the CRR, please see section 5 for more details on risk escalation.

Risks which could significantly compromise the delivery of the Trust's corporate objectives/business plan, once approved by the RMG, will be added onto the Corporate Risk Register (CRR). Relevant extracts of the Corporate Risk Register will be presented to the Quality Patient Experience and Safety Committee, People Committee and Finance, Productivity and Performance each time the BAF is received to ensure both the CRR and BAF complement, inform and each feed off other.

Whilst management is responsible for operationalising risk management across the Trust, Board Committees, the Board and related governance arrangements are responsible for providing scrutiny, constructive challenge and oversight. The entire CRR will be presented to the Audit Committee and Board each time they receive the BAF.

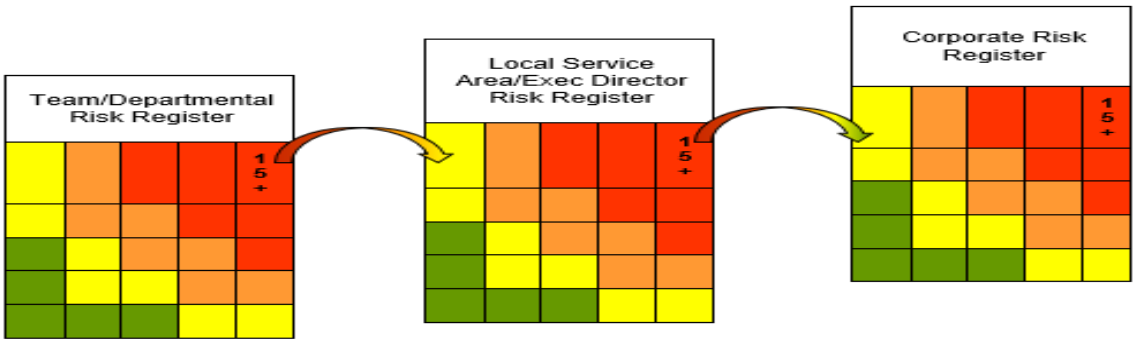


Figure 2 - Escalation in the Risk Register Hierarchy

BSMHFT`s Risk Management Policy provides a comprehensive framework to underpin how staff in all Services and Directorates across the Trust should timely and proactively identify, assess, manage and mitigate any potential risks that could compromise the achievement of their local operational objectives/goals. It thus seeks to foster standardisation, engagement, consistency and galvanise leadership in fostering effective risk management and risk escalation from `Ward to Board`.

3 Procedure

3.1. The Trust's overall approach to risk management is underpinned by the following 5 key distinct but interrelated and complementary steps: -

- Establish the Context
- Risk Identification
- Risk Analysis
- Risk Evaluation
- Risk Control/Treatment

} Risk assessment

Figure 3: BSMHFT`s approach to risk management - Five steps

3.1.1. Step 1: Establish the context

As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priorities in order to clearly identify risks and opportunities which may impact on their achievement. It is also important to consider the internal and external contexts.

3.1.2. Step 2: Risk identification

The identification of risk needs to be dynamic process, should involve all staff and ensure that appropriate action is taken before incidents/actual loss or harm have occurred. Risks may be clinical or non-clinical, including financial and reputational and may be identified from many sources, such as but not limited to:

Figure 4 - Sources of Risk Identification

Any change process implemented in the Trust should be risk assessed before, during and after it has occurred. Significant projects should be managed through the Project Management Office so that risk & issue logs including Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams.

For risks which arise in the Trust`s Emergency Preparedness, Resilience and Response (EPRR) space, BSMHFT`s Emergency Preparedness & Business Continuity (BC) Management Policy clearly sets out a strategic framework for their effective management, including emergency planning and business continuity for the Trust as this applies to all staff (both temporary and permanent). The Emergency Preparedness and Major Incident plans, as well as a range of other associated documents, are designed to ensure the resilience of the Trust in a range of scenarios that would limit its operating capacity.

Major Incident plans should be tested on a regular basis, and risks identified from any learning communicated back to the relevant groups to ensure processes are

refined. All risks relating to EPRR and BC should be captured on the Trust risk management information system (Eclipse), reviewed monthly as a minimum for those scored 15 or more and quarterly as a minimum for those scored 12 or less, as well as reported to the Business Continuity & Emergency Preparedness Committee which has responsibility for scrutinising, communicating and escalating such risks through the relevant Trust governance channels.

Staff should adhere to the Trust`s structured approach for describing risks also referred to `Cause and Effect Analysis` or the `Bow-tie` model. This model clearly identifies the event, the cause and the effect. It is helpful to frame the description of a risk into three parts by starting with these phrases:

- **There is a risk of/that/if…**(this relates to not achieving an objective as intended).
- **This may be caused by…**
- T**his may lead to an impact/effect on …**

Risk description must be clear and use concise appropriate language e.g.

- *"There is a risk that patients may not be discharged promptly from the Community Hospital.*

  This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Hence the description of a risk must clearly outline the event or objective that relates to or might not be achieved if the risk were to crystallise, what could be the cause(s) and what could be some potential impacts and/or opportunities.

3.1.3. Step 3: Risk analysis

Determine the cause and effect and analyse what could happen, where, when, why and decide who might be harmed and how. Also determine the existing controls, the likelihood and consequences as well as estimate the level of risk. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

3.1.4. Step 4: Risk Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and if the risk were to be realised (likelihood). The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix (see appendix 3 for details) in assessing and scoring the risk. Decide on the most appropriate risk response option. The following three risk scores will have to be identified during a risk assessment process: -

- **Inherent** – this refers to the uncontrolled level of risk i.e. the initial or gross risk before any controls and actions are put into place.
- **Current** – this is the residual risk after controls and action have been put into place.

- **Target** – this is the threshold at which the risk would be sufficiently mitigated such that it could be tolerated or accepted as actions have been completed and controls internalised into BAU. The target risk score is linked to the Risk Appetite Framework (see appendix 6 for details).

3.1.5. Step 5: Risk Treatment & Prioritisation

Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to reduce the risk and then identify further actions, which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan or risk treatment plan and decide on how best to manage it.

Hence, a decision should be made as to whether the Trust should avoid, reduce, eliminate, accept/retain or transfer the risk.

- **Avoid**: Whether a particular task can be undertaken a different way so that the risk does not occur.
- **Reduce**: Whether action can be taken to reduce, as far as possible, the probability or impact of the risk exposure.
- **Eliminate**: Whether definitive action can be taken to eliminate the risk exposure.
- **Accept/Retain**: Whether the level of risk is acceptable as no further mitigating actions can be taken, or the extent of actions to be taken outweighs the consequence of the risk occurring. Risks that are accepted will continue to form part of our review and reporting processes.
- **Transfer**: Whether the risk can be transferred to another organisation

Where further actions are required to avoid, eliminate or reduce a risk in order to attain its target score, such actions must be entered onto the risk register alongside their completion dates and owner responsible for their delivery.

3.2. Risk Review and Monitoring

Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales: -

- Risks scored 15 or more should be reviewed monthly as a minimum.
- Risks scored 12 or less should be reviewed at least quarterly as a minimum.

The resources deplored to mitigate and manage a risk must be proportionate to the perceived potential impact of the risk were it to crystallise. All risks must be captured on, mitigated and managed via Eclipse - the Trust`s electronic risk management information system as managing risks on papers/spreadsheets is highly discouraged by the Trust.

3.3. Types of control: Risk control techniques

Controls are measures or interventions that are implemented in order to reduce either the likelihood and/or impact of a risk were it to materialise. The following types of control are frequently used in mitigating and reducing risks: -

a. **Preventive controls** - these controls are designed to limit the possibility of a risk crystallising e.g. regular maintenance of electrical equipment.

b. **Corrective or Response controls** – These controls are designed to correct or in response to undesirable outcomes which have already been realised e.g. contingency planning.

c. **Detective controls** – these controls are designed to detect a risk before it occurs e.g. Medication reconciliation to identify potential risk of medication error or accounts reconciliation to identify potential fraud.

d. **Directive controls** – these are controls that we implement because we are directed by guidelines, regulation or legislation e.g. Requiring new staff to shadow before being allowed to work alone.

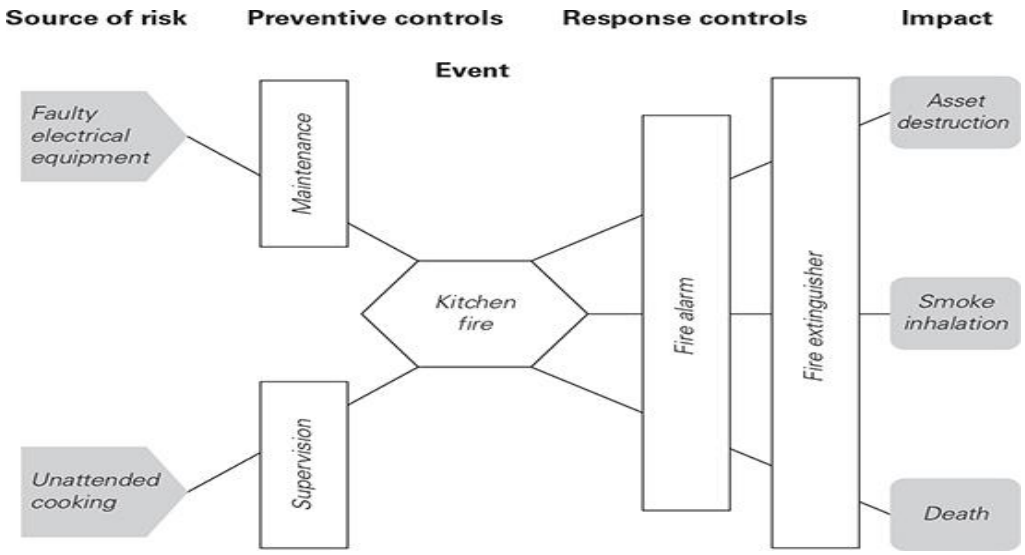


Figure 5. Types of control

While ***preventive controls*** help in reducing the ***likelihood*** of the risk crystallising, ***response controls*** reduce the ***impact*** or ***consequence*** once the risk has already occurred. Although risk owners as part of the risk review process often reduce the likelihood to demonstrate progress in mitigating and managing the risk, it is worth noting that in some rare instances, where response controls have been put in place, (e.g. installation of sprinklers in high-rise buildings), the ***impact*** or ***consequence*** could also be reduced to align with progress. Risk owners should often seek to ensure and provide assurance on the effectiveness of controls and the management of risks through relevant management and governance meetings.

3.4. Criteria for escalating risks onto the Corporate Risk Register (CRR):

- The risk must be scored 15 or more and must be approved for escalation by the Service/Directorate/Divisional local clinical governance (LCGC)

meeting and/or management team and supported by the relevant senior management team and/or Exec Director.

- The risk must be appropriately assessed, and all fields completed prior to presentation for escalation.
- Once a risk has been approved for escalation by the LCGC and/or management team, the risk Manager should be notified so they could liaise with the Service and/or Directorate to ensure the risk is appropriately captured on the CRR template and included onto the agenda for the RMG. Please see appendix 2b for details of the Trust`s risk escalation flow chart.

3.5. Risk Escalation:

- Timely and dynamic escalation of risks is important for effectively risk management; hence this policy identifies two pathways through which risk could be escalated to the RMG: -
- **Via Governance route**: through appropriate governance meetings as described above.
- **Via management route:** This implies expedited escalation, hence, in the case where the local governance meeting isn`t due to be held for a few weeks or months. Once management at the local service/Directorate/ Divisional level have reviewed the risk and are satisfied that it has been appropriately described and scored, it should be presented to the Clinical Director (CD) (or the appropriate Senior Manager) for support and shared with the relevant Executive Director for signed-off and either: -
    a. Presented to the RMG for approval and/or
    b. Direct inclusion onto the CRR via Chair`s action, in the case where the RMG isn`t due to hold soon. This will ensure timely and dynamic escalation of risks; however, such a risk will need to be presented at the earliest RMG for review, scrutiny, noting, learning and minuting.
- If in doubt, services/Directorates/Divisions are encouraged to contact the Risk Manager for support and clarifications.

A manager from the Service/Directorate/Division escalating the risk and/or the CD supporting its escalation should be invited to attend the RMG to present the risk. However, if a risk isn`t approved at the RMG following escalation, the RMG will provide advice through the colleague who presented the risk and request that it be de-escalated and held in the relevant service for appropriate mitigation and management or for review, amendments, and re-escalation if that is deemed appropriate.

3.6. Board Assurance Framework (BAF)

- The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Trust and co-ordinating them to best effect, hence, it helps in driving strategic oversight.
- The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Trust`s strategic goals have

been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance.

- It thus provides a structure and process through which the Trust could focus on those principal risks which may undermine the achievement of its strategic goals as defined in the Level 1 priorities in its updated Strategy.
- Executive Directors and their ADs are responsible for ensuring that risks within their portfolio captured on the CRR and BAF are timely and regularly updated prior to presentation at the relevant Board Committees.

3.7. Linking the CRR to the BAF

- BSMHFT`s BAF and CRR are maintained distinctively separate, however, both assurance toolkits complement each other and are symbiotically linked; inform, shape and feed-off each other. Both documents are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks to the delivery of the Trust`s strategic priorities are appropriately mitigated and managed in line with best practice and this Risk Management Policy.

3.8. Collaborative and shared Risk Management

- BSMHFT recognises that there will be instances where the effective management of a risk will require inputs from other colleagues and stakeholders who may not necessarily be part of the service/Directorate in which the risk has been identified. For example, a service may identify a risk, which requires inputs from subject experts from say Informatics, Finance, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively mitigate and manage it. However, when involving colleagues in the collaborative management of risks, it is important to recognise that responsibility and accountability for ownership, mitigation and effective management of the risk lies with the local service where it has been identified.
- In such a situation, Services/Directorates should ensure that all key stakeholders who need contribute to the effective management of the risk are involved in the discussions on how best to reduce and manage it. It is worth recognising that in other instances, collaborative management of a risk many involve external stakeholders such as the Local Authority; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately mitigating and managing such risks.

3.9. Risk Management Training:

- BSMHFT recognises that developing staff capacity, capability and organisational resilience in risk management is critical for fostering engagement and embedding its culture of safety and effective risk management.
- The Risk Manager with the support of the relevant AD, Senior Professional Lead or Exec will design and deliver bespoke risk management training that will be available to all staff and managers as well as to contractors delivering services on behalf of BSMHFT. Staff will be regularly signposted to log onto the learning zone to book onto the Trust`s risk management training programme i.e The Fundamentals of Risk Management.

3.10 Risk Management Annual Improvement Plan:

- BSMHFT is committed to continuously learning and improving its risk management arrangements, hence, it has adopted a QI approach to improving its risk management landscape through the implementation of a risk management annual improvement plan.
- The plan will be monitored at the RMG on a quarterly basis and assurance provided to ET.

4. Responsibilities

Staff/ Groups	Responsibilities	Ref
All Staff	All staff should be aware of risk assessment findings and risk management measures, which could affect their practice and professional needs. They must inform their line managers of risks deemed to be unacceptable and/or outside of their ability to manage. In addition, all staff (permanent and temporary) must • Report incidents/accidents and near misses in a timely manner and in accordance with incident reporting policies via Eclipse. • Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business. • Comply with all Trust policies and procedures and any other instructions/guidelines to protect the health, safety, and welfare of anyone affected by the Trust's business. • All staff including Trade Unions colleagues, contractors and partners who provide services for and on behalf of BSMHFT are responsible for effectively mitigating and managing risks to the delivery of the Trust`s operational	

	and strategic objectives/priorities. In short, risk management is everyone`s responsibility.	
Executive Directors & Trust Board	The Chief Executive maintains overall accountability for risk management within the Trust and will however, delegate responsibility to nominated Executive Directors of the Trust Board. The Director of Finance (on behalf of the Chief Executive) is the Executive Director responsible for risk management and for co-ordinating the implementation and operationalisation of the Risk Management Policy across the Trust. The Executive Director of Finance shall ensure the provision of effective risk management including risk governance structures and robust systems which assure implementation of the Trust's risk and risk governance objectives through the proactive identification and prioritisation of key organisational and risks from service areas, through to Directorates and ultimately the Board. The Executive Director of Finance shall ensure the development of systems, control process and risk management arrangements that comply with internal and external risk governance and best practice requirements and ensure continuous improvement of the quality of risk information, particularly in the areas of key controls. The Executive Director of Finance shall be responsible for designing, developing, coordinating and reporting on the Corporate Risk Register to the Trust Clinical Governance Committee, Board and Board Committees as well as for the implementation of the Annual Risk Management Improvement Plan and the Annual RMG Self-assessment while ensuring there are effective risk management systems and processes in place. They are also responsible for ensuring that there is a bespoke risk management training programme in place to support developing staff capacity and capability and organisational resilience in risk management. The Executive Director of Finance has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). The Executive Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and for the effective management of risks within their portfolios.	

	The Executive Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning. The Executive Director of Strategy, People and Partnerships has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships.	
Clinical Directors	Clinical Directors are responsible for ensuring that there are robust systems and processes in their Directorates to support the effective identification, assessment, mitigation, monitoring and management of risks. They are responsible for ensuring that risk management and especially high-level operational risks in their directorates are periodically reviewed and scrutinised at their Directorate Clinical Governance Meetings. Clinical Directors will be responsible for timely reviewing and approving high operational risks scoring 15 and above from their directorates being put forward for escalation to the RMG prior to their presentation at the RMG.	
Head of Health and Safety and Regulatory Compliance/ Associate Director of Corporate Governance	The Head of Health and Safety and Regulatory Compliance will be responsible for ensuring all clinical and patient safety related risk are appropriately added onto the Trust risk management information system. They will be responsible for embedding a culture of risk awareness, risk maturity and risk compliance in the Nursing Directorate, Services and Directorates. They will liaise with the Risk Manager in ensuring Services and Directorates escalating risks to the RMG for consideration, approval and inclusion onto the corporate risk register are appropriately supported. The Associate Director of Corporate Governance has overall responsibility for the designing and regularly refreshing Risk Management Policy and through the Company Secretary for the management of the Board Assurance Framework. They shall also work closely with ADs, Non-Executive Directors, Executive Directorates and the Company Secretary in designing, regularly refreshing and implementing the BAF. The AD of Corporate Governance shall with the support of the Company Secretary be responsible for presenting the BAF twice a year at the TCGC, at least bi-monthly at the RMG, bi-monthly at Board Committees and at the Board.	

Associate Directors / Corporate Senior Professional Leads	All Associate Directors and Corporate Senior Professional Leads have delegated responsibility for the effective management of risks within their portfolios and for ensuring that significant risks to the achievement of their local operational objectives are escalated in line with this Policy. ADs and Corporate Senior Professional Leads are responsible on behalf of their Executive Directors, for BAF and CRR risks that are assigned to their portfolio, ensuring these are regularly reviewed and updated as well as all related actions appropriately implemented and evidenced.	
Senior Leaders and Managers (including Senior Directorate Teams).	• Implementing Trust policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility. • Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. • Overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register. • It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.	
Risk Manager	• They are responsible for ensuring the Trust has effective risk management arrangements in place, populating the Trust`s risk management policy, raising the profile, visibility and supporting Services and Directorates across the Trust to embed risk management into business as usual.	

	• Creating space for a risk aware-culture to flourish across the Trust and the provision of risk management-related assurance to the Board and its sub-committees. • Act as an adviser to the Trust on all aspects of risk management and lead on the development of a dynamic, comprehensive, proactive, agile, sustainable Trust-wide risk management infrastructure. • Support local services and Directorates in reviewing and keeping their local risk registers up-to-date and in pulling risk registers for local governance meetings if requested including servicing the RMG. • Designing and delivering the Trust`s risk management training. • Provide admin support to the RMG including, servicing, minuting and ensuring all reports and papers are collated and timely circulated.	
Trust Board	Responsible for: - • overall risk oversight, scrutiny, gaining assurance, setting the tone and culture that underpins the Trust`s risk management approach. • ratifying the Trust's Risk Management Policy including the Risk Appetite Statement. • reviewing the Board Assurance Framework and the Corporate Risk Register.	
Audit Committee	Responsible for: - • reviewing the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management. • making recommendations to the Board as appropriate regarding its risk management arrangements.	
Quality, Patient Experience and Safety Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect quality, safety, and patient experience risks and that there are effective controls, assurance and mitigation to manage these.	
Finance, Performanc e and Productivity Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect performance, sustainability, financial and governance risks and that there are effective controls, assurance, and mitigation to manage these.	

People Committee	Responsible for • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect workforce related risks and that there are effective controls, assurance, and mitigation to manage these.	
Caring Minds	Responsible for • reviewing related Board Assurance Framework and the Corporate Risk Register risks which could negatively impact on its operations, finances, and reputation. • It will seek assurance that there are robust risk management arrangements in place including risk mitigation plans, and regular monitoring of risks in the space of the Trust`s charity work.	
Risk Management Group (RMG)	Responsible for: - • seeking assurance on the effectiveness of the Trust's risk management systems. • developing and overseeing the implementation of the Risk Management Policy. • reviewing and approving risks escalated to it and ensuring that those rated 15 or above are properly recorded in the Corporate Risk Register. • Considering evidence and approving the closure of risks on the Corporate Risk Register. • Supporting the Board with the development and maintenance of the Risk Appetite Statement and the CRR. • Receive, review the BAF twice a year and offer advice and recommendations to the Board via relevant Board Committees.	
Planning & Delivery Sub-Committee (P&DSC)	Responsible for: - • Planning & Delivery Sub-Committee for providing scrutiny, assurance, governance and oversight, of all risks and impact assessments relating to change programmes and projects. • Planning & Delivery Sub-Committee for providing scrutiny, assurance, governance and oversight of performance and finance-related risks.	
Local management and assurance groups	Responsible for: - • maintaining risk registers relating to their area of responsibility.	

	• systematically reviewing relevant risks, seeking and providing assurance that they are being managed through their local governance arrangements. • escalating risks with a score of 15 or above through their Directorate meetings to the Risk Management Group.	

5. Development and consultation process

Consultation summary	
Date policy issued for consultation	July 2025
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Staff and reps from Services/ Directorates - Workshops	July/August 2025
Policy Development Management Group (PDMG – for noting)	August 2025
Local Governance Committees	August 2025
ET	--- August 2025
Risk Management Group	21st August 2025
Audit Committee	24th September 2025
Board	1st October 2025

6. Reference documents

Australian/New Zealand Standard AS/NZS 4360:

7. Bibliography

None

8. Glossary

None

9. Audit, assurance & monitoring implementation.

The policies, systems, framework and processes covered by the Risk Management Policy and Strategy and the Board Assurance Framework will be regularly, systematically and independently audited as required by the Audit Committee.

Monitoring implementation of this Risk Management Policy

- BSMHFT will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs – please see appendix 2a for details) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 10 risks randomly selected from each Directorate risk registers and 5-10 from the Corporate Risk Register in measuring the following KPIs as set out on the table below: -

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
1. Compliance	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.
2. Maturity	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.
3. Data Quality	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C`ttee, FPP, AC & Board.

10. Appendices

1 Equality Impact Assessment
2a. Definitions of KPIs for monitoring implementation of this Risk Management Policy
2b. Risk Management Flow Chart
3. Risk Scoring
4. Risk Thresholds/Risk Level Monitoring
5. Key definitions
6. Risk Appetite Framework

Appendix 1: Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Risk Management Policy		
Person Completing this proposal	David Tita	**Role or title**	AD Corporate Governance
Directorate	Finance	**Service Area**	Corporate Governance Team
Date Started	July 2025	**Date completed**	July 2025
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Quality, Sustainability, People and Clinical Services			
Who will benefit from the proposal?			
The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The Policy may directly affect service users as its effective implementation may have positive impacts the Trust`s safety culture and enhance the delivery of high-quality patient-centred safe care.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
N/A			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			

N/A				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
N/A				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimal Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	✓			It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their age.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			It is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of any disclosed disability. The Trust have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. This is dependent if the individual

				feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues. The current WDES is showing the Trust is ranked in the top 10% nationally in Recruitment and Reporting of harassment, bullying and abuse.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	✓			It is anticipated that gender will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. Currently gender is collated and there is a disparity around gender pay gap overall with an increase from 6.99% to 11.17%. The Trust has now set up a Women's Network and Men's Network who meet on a monthly basis.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	✓			It is anticipated that marriage or civil partnership will not have an impact in terms of discrimination as this policy ensures that the staff group who affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	✓			It is anticipated that pregnancy and maternity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide

				necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. This is dependent on staff feeling comfortable about being open about their or their partners pregnancy, including miscarriage. We also have started the Women's Network where these matters can be discussed and shared there.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	✓			The Trust is working towards a Anti Racist organisation and will be launching the Anti Racist Framework. It is anticipated that Race or Ethnicity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. We also have the Race Equity Network and Anti Racist Campaign to support those who are facing racial discrimination.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. The Trust will provide necessary support and reasonable adjustment for employees, and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their religion or belief.
Including humanists and non-believers				

Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. We currently have LGBTQ Staff Network who meet regularly where information is shared. It is anticipated that sexual orientation will not have a negative impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. The Trust has also launched the LGBTQ+ campaign to support staff and training.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	✓			Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment. The Trust is currently offering Trans Awareness training to support staff.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	✓			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010.

				This policy applies to all, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust

Affecting someone's right to Life, Dignity and Respect?
Caring for other people or protecting them from danger?
The detention of an individual inadvertently or placing someone in a humiliating situation or position?

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	~~Yes~~	No		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				✓

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action.
If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

Discussions took place with colleagues in the development of this policy.
EDI Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns.

How will any impact or planned actions be monitored and reviewed?

Via the Directorate CGCs, RMG, Board and Board Committees. Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
This is not relevant. The policy is applicable to all members of the Trust regardless of their personal protected characteristics.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Directorate or Service planning and monitored on a regular basis.

Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive impact in highlighting risks to equality and support specific approaches to close the gaps where these are identified.

Appendix 2a: Definitions of KPIs for monitoring implementation of this Risk Management Policy

- **Compliance:** This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components: -

  % of risks which are in date and/or out of date;

  Evidence that services escalating risks in line with this Risk Management Policy.

- **Maturity:** This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: -

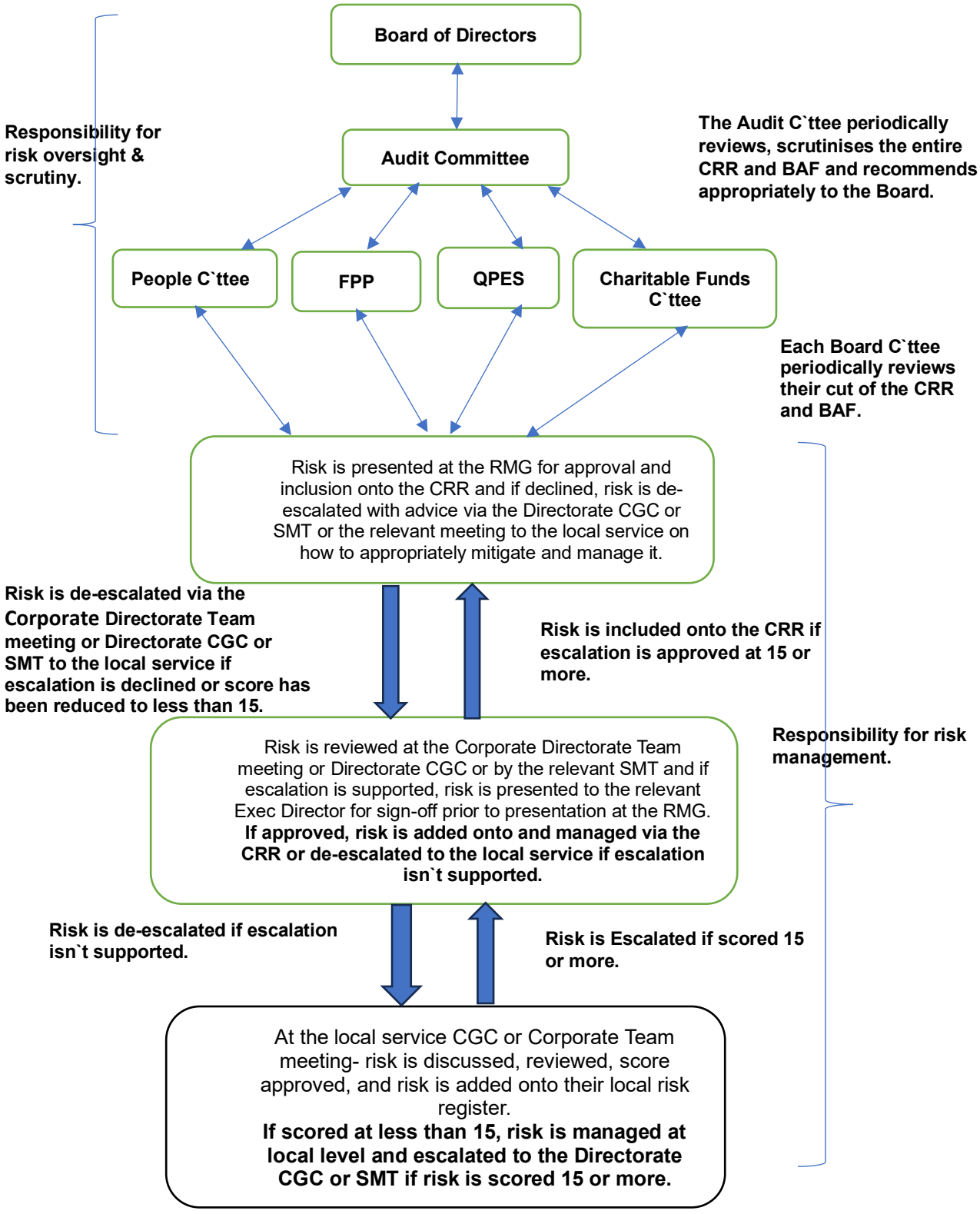
  % of risks appropriately completed.

- **Data Quality:** This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -

  % of risks which have been appropriately described.

Appendix 2b: Risk Management Flow Chart

BSMHFT Risk Management flow chart - Escalation and de-escalation of risks.



NB: Responsibility for mitigating and managing risks on the CRR lies with the local service which owns the risk as escalation doesn`t exonerate them from this responsibility.

RISK SCORING

The prioritisation and allocation of risk

To ensure that meaningful decisions on the prioritisation and treatment of risks can be made, the Trust will grade all risks using the same tool.

- **The 5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999) will be used to assign risk priority.**

  It is essential to have one system for prioritising and rating risks, and this will be used to prioritise risks on the Assurance Framework and Risk Registers, and for rating incidents, complaints, and claims. Risk analysis uses descriptive scales to describe the magnitude of potential consequences and the likelihood that those consequences occur.

Measures of likelihood – likelihood scores (non-financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur **at least annually.**	Expected to occur **at least monthly.**	Expected to occur **at least weekly.**	Expected to occur **at least daily.**

Measures of Likelihood – likelihood scores (financial risks):

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur in the current or next year	Unlikely to occur during the current or next year.	Could easily occur during the current or next year.	Will probably occur during the current or next year.	Definitely will occur during the current or next year.

Measures of Consequence – Domains, consequence and examples of score descriptors

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention. Requiring time off work <3days. Increase in length of hospital stay by 1-2days.	Moderate injury requiring professional intervention. Requiring time off work 4-14 days RIDDOR/agency reportable incident An event that impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work >14days. Increase in length of hospital stay by >15days.	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
				Mismanagement of patient care with long term effects.	
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal 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) 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 not resolved. Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if findings not acted on Inquest / Ombudsman inquiry Gross failure to meet national standards.
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day).	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>1day). Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objectives / service due to lack of staff. Unsafe staffing levels or competence.	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training / key training on an ongoing basis.
Statutory duty / Inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved.	Single breech in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breeches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable.	National media coverage with >3days service well below reasonable public expectation. MP

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		expectation not being met.		public expectation.	concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget. Schedule slippage.	<5-10% over project budget Schedule slippage	Non-compliance with national 10-25% over budget project. Schedule slippage. Key objectives not met.	Incident leading >25% over project budget Schedule slippage. Key objectives not met.
Finance – including claims	Non delivery/Loss of budget to value of £0-£50K	Non delivery/Loss of budget between £50K and £500K.	Non-delivery/Loss of budget between £500K and £2M.	Non delivery/Loss of budget between £2M and £4M.	Non-delivery/Loss of Budget of more than £4M.
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Measures of Consequence – Additional guidance and examples relating to risks impacting on the safety of patients, staff or public.

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling – no time off work required	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information / communication on transfer of care Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation, fracture, blow to the head Loss of limb Post-traumatic stress disorder	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis Incident leading to long-term mental health problem Rape / serious sexual assault

5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)

	Almost Certain	5 Yellow	10 Yellow	15 Red	20 Red	25 Red
	Likely	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	Possible	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	Unlikely	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	Rare	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

Appendix 4: Risk Thresholds/Risk Level Monitoring

RISK THRESHOLDS / RISK LEVEL MONITORING

Level of Risk	Risk Scores	Determination of Level, monitoring of Action Plans and acceptability of risk to the Trust	Monitoring Process
Red	All risks rated ≥15 (post moderation) Unacceptable level of risk exposure which requires immediate corrective action to be taken. Risk should be considered for escalation.	Unacceptable risk Approved by the RMG if escalated. Risk treatment plan approved by relevant Executive Director and RMG.	Oversight by Risk Management Group QPES, FPP and People Committee if risk has been escalated onto the CRR. QPES, FPP and People Committee to advise Board on ways of managing high risks that cannot be addressed within existing resources.
Amber	All risks rated 12. Unacceptable level of risk exposure which requires constant active monitoring, and measures to be put in place to reduce exposure	Unacceptable risk Risk scores approved by local Service and Directorate clinical governance Committees. Level determined by **Executive Director.** Risk treatment plan managed by senior managers. Progress updates via Directorate Leads.	Included on the Risk Register and reported to local Service and Directorate Clinical Governance Committee. Risk treatment plan monitored by Executive Director.
Yellow	All risks rated 4- 10	Level determined by the **Service Manager.** Risk treatment plan managed locally by named managers on behalf of the Director.	• Risk treatment plan monitored by Directors Management team.
Green	All risks rated 1 - 4		

Appendix 5: Key definitions

KEY DEFINITIONS

Risk Description		There are 3 main components will need to be considered when articulating the risk description (cause, event and effect):
		- There is a risk of…if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Rating	Inherent	This is the score of a risk without taking into consideration any controls which may be in place to mitigate it. This is also referred to as gross risk, initial risk, uncontrolled risk or absolute risk.
	Current	This is the score of the risk taking into consideration the controls and mitigation measures in place. This is also referred to as net risk, residual risk, current risk, or managed level of risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is `rare` which denotes it will probably never happen, with a 5 being `almost certain` which indicates that it will undoubtedly or possibly happen.
Risk Score		Risk score is derived by multiplying the Impact by Likelihood.
Risk Appetite	Definition	Is defined as the amount and level of risk that the Trust is willing to pursue or accept in order to achieve its priorities.
Controls or risk mitigations	Definition	These are measures/interventions implemented by the Trust to reduce either the likelihood of a risk and/or the impact were it to be realised. Controls could include strategies, policies, procedures, systems, SOPs, Checklists etc being implemented to reduce either the likelihood and/or impact of the risk were it to crystallise. A control is also a measure that maintains and/or modifies risk (ISO 31000:2018(en).
Three Lines of Defence Model	1st Line of Defence	The first Line of defence refers to the service or function that owns, mitigates and manages the risk on a day-to-day basis.
	2nd Line of Defence	This refers to other functions in the in the Trust which oversee compliance or risk management e.g. HR, Risk Management team etc.
	3rd Line of Defence	This refers to functions in the trust which provide objective and independent assurance and may include Internal Audits, External Audits etc.

Appendix 6: Risk Appetite Statement

RISK APPETITE FRAMEWORK (RAF)

Risk appetite provides a framework which enables an organisation to make informed management decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target and acceptable position in the pursuit of its strategic objectives. The benefits of adopting a risk appetite include:

- Supporting informed decision-making.
- Reducing uncertainty.
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement.
- Focusing on priority areas within an organisation.
- Informing spending review and resource prioritisation processes.

BSMHFT Risk Appetite Framework

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range	Board`s preferred risk appetite
Quality & Safety	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	Cautious	6 - 8	Cautious
Reputational	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Open	9-10	Open
People	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Open	9 – 10	Open
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	9 – 10	Open
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	6 – 8	Cautious

Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	**Open**	**9 - 10**	**Open**
Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**	**Open**
Data and Information Management	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	**Cautious**	**6 - 8**	**Cautious**
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	**Cautious**	**6 – 8**	**Cautious**
Digital Improvement	New technologies viewed as a key enabler of operational delivery. Maximisation of patient care and avoidance of harm. Agile principles are embraced.	**Eager**	**12**	**Eager**
Cyber Security	Consideration given to adoption of established /mature systems and good cyber security architecture and awareness of cyber security threats. Agile principles are considered.	**Cautious**	**9 - 10**	**Cautious**
Transformation/Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	**Open**	**9 – 10**	**Open**
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	**Minimal**	**2 - 4**	**Minimal**

Property	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	**Open**	**9 - 10**	**Open**
Environment	Requirement to adopt a range of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	**Cautious**	**12**	**Cautious**
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	**Open**	**9 – 10**	**Open**
Partnerships & Provider Collaboratives	Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking.	**Open**	**9 -10**	**Open**

N.B: BSMHFT`s Risk Appetite Framework is aligned to target risk scores!