South East Coast Ambulance Service NHS
NHS Foundation Trust

Risk Management Policy and Procedure

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1 Statement of Aims and Objectives

1.1. Risk management is everybody's business. Risk is inherent in all activities and at all levels of the Trust. Risk management is a statutory and regulatory requirement for the Trust. It is also an indispensable core component of good practice in all aspects of strategy, planning and operational management.

1.2. South East Coast Ambulance Service NHS Foundation Trust (henceforth, 'the Trust') is committed to identifying and managing all risks associated with its service delivery, support functions and the organisation as a whole. At an operational level good risk management is essential for the delivery of safe, efficient, and high-quality frontline services and effective, value-adding functions. At strategic level good risk management underpins the Trust's planning and development activities, both as an organisation and in collaboration with others as a system partner.

1.3. The Trust recognises that an effective risk management environment is a key factor in achieving provision of the highest quality care to patients whilst safeguarding assets and looking after our staff. The Trust recognises that failure to identify and address risk in a timely and effective manner could result in:

- Harm to patients, staff, volunteers, or others
- Failure to deliver the Trust's strategies, policies, plans and operational priorities
- Failure to achieve required levels of organisational resilience and business continuity, especially in response to and learning from major incidents or other significant events
- Loss or damage to the Trust's reputation or influence at national, regional or community level
- Loss or damage to the Trust's property, assets, systems, and data
- Financial and commercial losses
- Adverse publicity, complaints, and litigation
- Failure to meet statutory, policy or regulatory obligations

1.4. Actively recognising the risks associated with service delivery and support functions enables the Trust to plan and implement strategies to mitigate the likelihood and consequence of a risk materialising. However, managing risk is not just about avoiding adverse future events. Risk management good

practice also includes considered, well-controlled risk-taking in pursuit of opportunities to develop, improve and add value to the services and functions of the Trust.

1.5. Risk management is integral to the leadership, management, governance, and other corporate activities of the Trust. It is embedded into the routine business management of the organisation in order that it can effectively support and identify risks associated with service delivery, support functions, internal developments and change, and external factors.

1.6. Risk can be defined as: effect of uncertainty on objectives – IS0 31000 Risk Management 2018.

1.7. An effect is a deviation from the expected. It can be positive, negative or both, and can address, create, or result in opportunities and threats.

1.8. Objectives can have different aspects and categories and can be applied at different levels.

1.9. Risk is expressed in terms of risk sources, potential events, their consequences, and their likelihood.

2 Purpose / Scope

2.1. This policy and procedure set out the Trust's expectations and key processes regarding the identification and management of risks.

2.2. This policy and procedure apply to all activities associated with the Trust, including service delivery, support functions, internal business developments and change, wider system interactions and other external factors affecting any constituent part of the organisation and the Trust as a whole.

2.3. This policy and procedure apply to all categories of risk, including, but not limited to strategic, people, operational, information, technology, financial, legal, security, project/programme, property, governance, and reputational risks.

2.4. This policy and procedure apply to all directly employed staff, agency staff, contractors and volunteers engaged in work or other activities on behalf of the Trust.

2.5. Contained within Appendix A is a breakdown on key risk management responsibilities and accountabilities.

3 Risk management objectives:

3.1. The Trust seeks to adopt good practice in the identification, evaluation, and cost-effective control of risks to ensure that they are reduced to an acceptable level or are eliminated as far as is reasonably practicable.

3.2. The objectives of risk management across the Trust are to:

- Minimise the potential for harm to patients, staff, volunteers, and visitors, reducing this to levels that are as low as is reasonably practicable
- Protect everything of value to the Trust, such as high-quality patient care, staff and patient safety, reputation and influence, physical and intellectual assets, current and future income streams, information systems and data.
- Enable the Trust to anticipate, respond to, and remain resilient in changing strategic and operational circumstances
- Maximise opportunities for Trust development, innovation, and improvement of services and functions in a safe, considered, and controlled manner
- Ensure that the Trust achieves and sustains compliance with statutory, policy, regulatory and legal frameworks, and other similar requirements
- Inform the Trust's strategies, policies, and operational decisions by identifying risks and their likely impact, by developing actions and controls to manage these risks, and by capturing and applying learning from previous risk and control issues.
- Ensure that risk management and assurance activity is embedded into standard management practice across the Trust and is not regarded as separate or niche
- Ensure that risk management and assurance activity is seen as a live and dynamic process that is embedded in the work of governance bodies and managerial groups at all levels of the Trust
- Provide a standard set of policies, procedures, and processes to support consistent risk management practice across all functions and at all levels of the Trust

4 Risk Analysis:

4.1. The Trust uses a standard evaluation matrix to score and apply a rating to each identified risk. This matrix is based on the model developed for use by NHS bodies by the former National Patient Safety Agency. The model utilises a 5 x 5 matrix of consequence and likelihood scores to calculate an overall score for each risk.

4.2. The purpose of analysing and scoring a risk is to make a qualitative estimate of the level of exposure which will then help inform how the risk should be managed.

4.3. When analysing a risk, you will need to evaluate both the consequence and likelihood of the risk being realised, as this will determine the Trusts' risk exposure.

Step 1: Evaluate the consequence of a risk occurring. The consequence score has five descriptors:

Score	Consequence Descriptor	Consequence Description
1	Insignificant	*Please see Appendix B for Consequence Descriptors*
2	Minor	
3	Moderate	
4	Major	
5	Catastrophic	

Step 2: Analysing the likelihood (how often) a risk may occur. The table below gives the descriptors of the likelihood of a risk being realised:

Score	Likelihood Descriptor	Likelihood Probability
1	Rare	May only occur in exceptional circumstances
2	Unlikely	Unlikely to occur
3	Possible	Reasonable chance of occurring
4	Likely	Likely to occur
5	Almost Certain	More likely to occur

Step 3: To calculate the risk score, multiply the consequence score with the likelihood score:

CONSEQUENCE x LIKELIHOOD = RISK SCORE

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

5 Risk Evaluation

5.1. Once the risk analysis process has been completed, the risk score should now be compared with the level of risk criteria below which enables the Trust to measure the potential level of risk exposure and proceed to identify appropriate actions and controls.

Level of Risk
1 - 3 (Low)
4 - 6 (Moderate)
8 - 12 (High)
15 - 25 (Extreme)

5.2. Each risk will be assigned 3 risk scores: initial, current and target. The risk scoring process above will be carried out three times for each score using the guidance below.

5.3. Initial Risk Score -The initial risk score is when the risk is first identified, the risk analysis process for initial risk scores should be a measure of the consequence and likelihood before any controls/ mitigating actions are proposed. The initial risk score will not change for the lifetime of the risk.

5.4. Current Risk Score - The current risk score, the risk analysis process for current risks should be a measure of the consequence and likelihood once

controls and mitigating actions are in place, considering the effectiveness of the controls added.

5.5. Target Risk Score - The target risk score, the risk analysis process for the target risk should be a measure against the Trust Risk Appetite Statement.

6 Risk Treatment

6.1. Risk treatment is a process to modify risk and the selection and implementation of measures to treat the risk. This includes as its major element, risk control/ mitigation, but extends further to the appropriate selection of a risk treatment option, these are outlined in the table below.

Tolerate (Accept)	Can we accept the risk as it is i.e., without further controls? Would the cost of controlling the risk outweigh the benefits to be gained?
Treat (Reduce or remove)	Can we put controls in place to reduce the likelihood of the risk occurring or its consequence? It is recognised that the consequence cannot always be reduced, however should be considered. An example would be the use of airbags in cars which would likely reduce the extent of injury.
Terminate (Suspend the risk situation/ activity)	Can we avoid or withdraw from the activity causing risk? Can we do things differently?
Transfer (Responsibility)	Can we transfer or share, either totally or in part, by way of partnership, insurance, or contract?

7 Risk Appetite

7.1. Risk appetite provides a framework which enables the Trust to make informed management decisions. By defining both optimal and tolerable risk positions, the Trust has clearly set out both the target and acceptable position in the pursuit of its objectives. The Board has set out the Trust risk

appetite statement, which is kept updated on the Trusts' risk management intranet pages and Appendix C.

8 Risk Owners and Action Owners

8.1. In addition to the risk owner, each risk may have a designated action owner. Action owners are responsible for delivering the actions required to reduce the risk to the target level.

8.2. Each risk can have multiple actions. Each of these actions must have a designated action owner. Where a risk has multiple actions, it can have multiple action owners.

8.3. The risk owner and the action owner can be the same individual. They can also be different individuals and located in different services or directorates. It is permissible for the risk owner to develop the action plan associated with a risk and then to allocate or transfer some or all the actions to other individuals for them to manage through to completion. In such circumstances the risk owner remains the same, but these other individuals become the designated action owners.

8.4. The risk owner must always consult with the proposed action owner(s) prior to recording actions and allocating responsibility for their delivery. This is a matter of professional courtesy in line with the Trust's values and behaviours. It also ensures that the proposed action owner(s) formally accept ownership of the action(s) and take responsibility for delivery as set out in the action plan.

8.5. Upon leaving the organisation, an action owner must liaise with the risk owner to identify an appropriate successor action owner and enact the transfer of action ownership.

8.6. A designated risk owner can transfer overall ownership of a risk to another individual.

8.7. When transferring a risk, the current risk owner must always consult with the proposed new risk owner prior to transferring ownership of the risk. This is a matter of professional courtesy in line with the Trust's values and behaviours. It also ensures that the proposed new risk owner agrees to take ownership of the risk and be responsible for its management and action plan.

8.8. Upon leaving the organisation, the designated risk owner must identify an appropriate successor risk owner and transfer of risk ownership.

8.9. Closure of risks should be approved by aligned monitoring group as detailed in section 9 and only be closed when a risk no longer present.

Risks that have been managed to a tolerable level should remain active and be reviewed within the frequency set out in section 9.

12+

8-10

9 Risks are Escalated through the Organisation

4-6

1-3

risk immediately with your line manager/team leader and add to the risk register. This could be new risks or risks previously scored 1-10. The line manager/team leader must escalate the risk as soon as practicable to the Directorate's Executive Director.

(REVIEWED MONTHLY)

risk with your line manager/team leader and add to the risk register. This could be risks previously scored 1-6. This risk should be managed by the directorate and/or Group. Staff having regular update on how the risk continues to be managed. There is opportunity to review the risk rating.

(REVIEWED QUARTERLY)

Discuss the risk with your line manager/team leader and add to the risk register. This could be new risks or risks previously scored 1-3. This risk should be managed locally with staff having regular update on how the risk continues to be managed from their Line Manager. There is opportunity at each review to review the risk rating or to close the risk.

(REVIEWED EVERY FOUR MONTHS)

Staff and/or management groups e.g. safeguarding group can enter a risk on the risk register via Datix. This risk should be managed locally with staff having regular update on how the risk continues to be managed. There is opportunity at each review to review the risk rating or to close the risk.

(REVIEWED EVERY FOUR MONTHS)

9.1. Risks recorded on the Corporate Risk Register (12+) should be reviewed no later than **monthly** by the risk owner. RAG would report on monthly basis to both EMB and SMG.

9.2. Risks recorded on Directorate Registers (10-12) should be reviewed no later than **quarterly** by the risk owner. RAG would report on monthly basis to both EMB and SMG.

9.3. Risks recorded on Departmental and OU risk registers (1-6) should be reviewed no later than **4 monthly** by the risk owner.

9.4. Risk reviews should include an evaluation of the current risk score (using the risk evaluation matrix), review and confirmation of the target risk score, and a review of progress in completing the mitigation actions that should be recorded in progress notes section of the register entry.

9.5. Following a risk review the ‘current risk score’ should be recorded on the Trust’s risk management system, in addition to the ‘initial risk score’ and the ‘target risk score’. Taken together, the initial, current and target scores provide a view of progress towards reducing the risk to the target level.

9.6. Following a risk review and any change to the current risk sore there may be a need for the risk to escalated or deescalated to another risk register owner.

9.7. Risks that are submitted for escalation and de-escalation will be reviewed by the receiving Register Owner before acceptance onto their register.

9.8. Risk register reviews should be a standing agenda item for meetings of directorates, departments, and management groups.

9.9. The requirement to hold regular risk register reviews should be included in the terms of reference for such management groups. These risk register reviews should include the following standard elements:

- Review existing risks
- Review progress of mitigation actions
- Re-assess risk scores
- Consider emerging risks

9.10. The Risk team will plan and deliver an annual programme of local risk register ‘deep dive’ reviews.

9.11. Each directorate will have a nominated risk champion, who is their designated Directorate Risk Lead. The role of this Risk Lead is to maintain oversight of all risks for their directorate, be the representative for their directorate at Risk and Assurance Group (RAG) and provide updates to RAG on behalf of their service on existing and emerging risks. Appendix D presents a descriptor for the Directorate Risk Lead role.

The Risk and Incident Lead will meet with Directorate Risk Leads on a regular basis to review existing risks and discuss areas of emerging risk.

10 Project Risks

10.1. Project risks will be created and managed through the Trust project risk register and reviewed for updates/resolution within the frequency set out by the project group.

10.2. Project Risk owners will be agreed within the project group and must be a stakeholder within and a member of the project group.

10.3. Closure of project risks will be approved by the aligned project group. If the risk is an escalated risk, it will be discussed within the appropriate escalation group and closed.

10.4. Project risks agreed to transfer to the organisation at project closure must have agreement from the new owner and transferred to the appropriate risk Trust risk register prior to the project being closed.

10.5. Non-project specific risks identified during the project lifecycle should be added to the appropriate Trust Risk Register.

11 Risk Management Assurance Process

11.1. The Board Assurance Framework (BAF) is owned by the Trust Board. It represents ownership by the Trust Board of the key areas of risk to the achievement of the Trust's strategic objectives. The BAF sets out the main strategic risks to the organisation's objectives and the associated controls and mitigation actions. It presents an assessment of the strength of internal controls in place to reduce the likelihood and impact of key risks materialising, and it identifies the main sources of internal and external assurance regarding the effectiveness of those internal controls. BAF Risks will be contained on the Corporate Risk Register no matter what current risk score.

11.2. The Corporate risk register captures risks that could significantly impact on achieving the Trust's' strategic purpose and as such contains risk with a current risk score of 12+ and BAF risks only.

Risk Management Organisational Chart

11.3. Trust Board

The Trust Board is responsible for risk management throughout the Trust. It delegates some responsibility to the Executive Committee and the Audit, Risk and Assurance Committee and receives assurance from those committees on the effectiveness of the risk management strategy. To discharge its responsibilities, it will:

- Ratify the Trust's Risk Management Strategy every three years
- Review the 15+ Risks at least twice a year
- Review the Board Assurance Framework twice a year
- Delegate responsibility for taking assurance on the risk management processes to the Audit, Risk and Assurance Committee.

11.4. Audit and Risk Committee

The role of the Audit and Risk Committee is to oversee the implementation of the Risk Management Strategy and to take assurances that the processes supporting the Risk Management Strategy are effective in mitigating risk. It does not have operational responsibility for individual risks but will take assurances from the Executive Management Committee that risks are being managed. Its specific responsibilities are:

- To review the 12+ Risks at least twice a year

- To review the Board Assurance Framework at least twice a year.

The Audit, Risk and Assurance Committee will also receive assurances from the Board Committees to supplement the overall assessment of risk and the effectiveness of the risk management process within the Trust. Where the Audit and Risk Committee identifies significant gaps in the Trust's risk management strategy or processes for managing risk, the Chair of the Committee will make a verbal report to Trust Board and if deemed necessary to the Council of Governors.

11.5. **Board Committees**

There are three Board Committees with responsibility for seeking assurance relating to work within their remit. The Quality & Patients Safety Committee is particularly concerned with quality and safety matters and ensuring risk mitigation in these areas, whereas the Finance and Investment Committee is engaged in regular reviews of risk outcomes of financial performance and both short financial planning with actions to mitigate financial risks being identified. The Workforce and Wellbeing Committee Trust's receives assurance that system of internal controls relating to the workforce, encompassing resourcing, staff wellbeing and HR processes, are designed appropriately and operating effectively. Each of these committees has delegated oversight of those relevant strategic risks from the Board Assurance Framework which have been assigned to them by the Board. The committees will undertake the following roles in relation to the Board Assurance Framework.

- Seek assurance on a quarterly basis that the strategic risks under the Strategic Objective(s) aligned to the remit of the Committee are effectively managed and mitigated.

Executive Management Committee (EMB)

The Executive Committee has operational responsibility to ensure risks are being managed. It has specific responsibility to:

- Scrutinise and challenge the 12+ Risks monthly.

- Consider risks for escalation to the Board Assurance Framework and where identified recommend these for inclusion to the Board.

- Scrutinise and challenge the Board Assurance Framework at least twice a year.

- Receive assurance and escalations reports from the Senior Management Group on all aspects of risk management.

11.6. **Senior Management Group (SMG)**

SMG will review the Risk Register each month. SMG will review on behalf of EMB, all high and extreme risks ensuring that risks are manged in line with the Risk Management Policy, actions and mitigations are effective in controlling the risks and any gaps are addressed and escalated to EMB. SMG will also make decisions on new risks to be added to the Corporate Risk Register and those recommended for closure. SMG is not permitted to change risks scoring or close risks without direct engagement and involvement of the specific risk owners.

11.7. **Risk Assurance Group (RAG)**

On behalf of SMG, the Risk Assurance Group reviews and moderate the effectiveness of the risk management process ensuring that all risks that are scored 8 and above are reviewed and updated in terms of its contents; actions and risks scoring. The group is not permitted to alter risks on the Trust's risk register but will have discussions with the risk owners and make recommendations including the closure of risks to SMG.

11.8. **Management Group**

Management Groups are responsible for ensuring risk management is a standing agenda item at each meeting and members will discuss and report on each of the following criteria pertaining to each identified Open risk:

- Progress of action(s)
- Adequacy of controls (controls assurance) when identified
- Risk grading reviewed
- Reasons for Risk Lead failing to meet a review date
- Status review (Open or Proposed for Closure)

12 Education and training

12.1. Risk management training, guidance and advice is provided through the Risk Management team.

12.2. Risk management training is made available for staff as per the below table.

Staff/ Group	Type of Training	Type of Delivery	Frequency of Training
Risk register owners Risk owners Action owners Directorate Risk	1. Risk Management in SECAMB – Module (1)	E-Learning	Once – Prerequisite for access to DCIQ

coordinators Members of management and governance with risk function in TOR.	2. Datix Cloud Enterprise Risk Management (ERM) – system – Module 2 3. Discover E Learning platform and training records managed on ESR.		ERM
Board of Directors and Directorate Executives.	1. Risk Management and Assurance Training.	Face to Face/ Virtually	2 Yearly

13 Risk Reports

13.1. The following risk reports are distributed across the Trust to provide for scrutiny and or assurance:

Group/Committee	Report Type	Frequency	Owner of paper
Board	Assurance	As per annual board committee calendar of meetings	Company Secretary
Board Sub committees	Assurance report particular to committee's purview	As per annual board committee calendar of meetings	Risk and Incident Lead
EMB	Assurance report particular to Executive Board purview	Monthly	Risk and Incident Lead
SMG	Scrutiny report particular to Group's purview	Monthly	Risk and Incident Lead

14 Monitoring compliance

14.1. For the Trust to be assured that the processes described within this policy are working, monitoring arrangements are shown in the table below.

Auditable Standards	Methodology	Frequency	Monitoring Committee
All directorates should be represented at Risk and Assurance Group (RAG)	Review of attendance register by the Risk and Incident Lead	Annual	Risk and Assurance Group
	Review of RAG membership	Annual	Risk and Assurance Group
All recorded risks should remain in date	Review of Corporate Risk Register at RAG	Monthly	Risk and Assurance Group
	Risk review meetings: Directorate Risk Leads and Risk and Incident Lead	6-monthly	Risk and Assurance Group
Local risk registers undergo an annual 'deep dive' review	Programme of reviews planned and delivered by the Risk and Incident Lead. Sampling methodology to be agreed.	Annual	Risk and Assurance Group

15 Audit and Review (evaluating effectiveness)

15.1. All policies and procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy and procedure is approved and disseminated.

15.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

15.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

15.4. All changes made to this policy and procedure will go through the governance route for development and approval as set out in the Policy on Policies.

15.5. The Trust risk appetite statement will be reviewed annually by EMB.

16 References

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17 Financial Checkpoint

17.1. This document has been confirmed by Finance to have no unbudgeted financial implications.

Appendix A: Roles and Responsibilities

Trust Board – See 11.3

Chief Executive, as the Trust's Chief Accounting Officer

The Chief Executive has overall responsibility for ensuring that an effective system of risk management and assurance is in place and that the Trust meets its statutory and regulatory requirements in respect of good corporate governance. The Chief Executive is accountable to the Board for maintaining a sound system of internal control and is responsible for the Annual Governance Statement that sets out the Trust's risk management and assurance arrangements and how these support the achievement of the organisation's objectives. Whilst maintaining overall accountability, The Chief Executive has delegated relevant responsibilities and accountabilities as follows:

Executive Director of Nursing and Quality

The Executive Director of Nursing and Quality has designated responsibility for the direction, development, management, and implementation of the Trust's strategic framework for risk management and assurance. This Executive Director is the Trust's designated Senior Information Risk Officer (SIRO).

Risk and Assurance Group – See 11.8

The Executive Directors
The Executive Directors have responsibility for leading effective risk management within their respective Directorates and across the wider Trust.

Associate Directors
Associate Director is responsible for promoting and supporting of embedding of effective risk management processes within the Trust.

The Company Secretary
The Company Secretary is responsible for coordinating the Board Assurance Framework and ensuring the Board follows due process.

Senior Managers
All Senior Managers are responsible for managing the strategic development and implementation of integrated risk and governance within their directorate according to their role profile.

Risk and Incident Lead

The Risk and Incident Lead reports to Head of Patient Safety and is responsible for:

- The development of the Risk Management Procedural Documents, ensuring they are effectively coordinated, implemented, and monitored across the Trust.
- Maintaining the Trust Risk Register as an active document.
- Providing specialist advice and oversight to risk management peer review groups; recommending risk management treatment and oversight of risk registers
- Timely reporting to the Executive and Groups including the provision of data, analysis etc.
- Developing and implementing a suitable and sufficient risk management training provision across the Trust, ensuring role specific training is provided; and
- Monitoring the effectiveness of risk management across the trust (including compliance with policy).

All staff

All staff across the Trust have a responsibility to ensure they make themselves aware of and comply with the Risk Management Policy and Procedure. Staff are responsible for reporting identified potential risks within their area of work. Staff will be required to participate in activities which are commensurate with the Trust's Risk Management Policy and Procedure and statutory or legislative requirements

Appendix B – Risk Matrix – Consequence 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/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long- term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombud sman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage

Financial (including damage/loss/fraud/ bribery) – escalation to audit/board dependent on limits specified in SFI's	Negligible Organisational / personal financial (loss £<5k)	Minor Organisational / personal financial loss (£5k - £24k)	Significant Organisational / personal financial loss (£25k - £50k)	Major Organisational / personal financial loss (£50k - £1 million) Escalate to Director of Finance for further risk assessment	Severe Organisational / personal financial loss (>£1 million)
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix C – Trust Risk Appetite Statement

In all matters SECAmb aspires to be better today and even better tomorrow within the limits of practicality, efficiency, control, and financial resources. As part of that overall philosophy SECAmb intends to take risks appropriately and establish effective management mechanisms expected under the terms of the National Health Service Act 2006 and in accordance with the NHS Foundation Trust Code of Governance.

By carefully balancing our objectives against the risks we are prepared to take, we aim to conduct our business in a socially responsible and sustainable manner whilst delivering the best possible care to our communities. The Trust Board is committed to ensuring that all risks are identified, recorded, and managed effectively; bottom up and top down (operationally and strategically).

The Board recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. The Board also recognises the complexity of risk issues in decision-making and that each case requires the exercise of judgement. However, the Risk Appetite Statement can be used to inform decision-making in connection with risk and what limits may be deemed as outside their tolerance.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite, however these instances would usually be required to be referred to the Board.

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community, and strategic partners.

The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.

As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Similarly, the Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.

The Board has greatest appetite in seeking strategic transformation of healthcare across the South East Coast Ambulance Services current boundaries. As well as developing wider effective partnerships, alliances and commercial ventures where positive gains can be anticipated, it is providing they are done so within the regulatory environment in which we operate.

The Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk and the likelihood of it occurring.

The Trust are committed to protecting the environment by providing high quality health care services in an environmentally sustainable manner when viable.

In implementing the Trust's risk appetite, target risk scores must be determined for each risk based on the appetite described.

Escalation occurs to a higher group, committee, board or level of authority, because the risk profile is sufficiently close to the risk appetite limit that additional corrective action must be considered.

The Trust Board will review annually the levels of risk the Trust is comfortable to tolerate in the pursuit of its objectives and goals, but sooner if periods of increased uncertainty or adverse changes, both internally and externally are presented.

Appendix D – Directorate Risk Lead Descriptor

Directorate Risk Lead Responsibilities

Directorate Risk Leads will operate within their designated directorates, to promote and support effective risk management and encourage compliance with the Trust's Risk Management Policy and Procedure.

The following responsibilities of a Directorate Risk Lead represent guidance only and do not constitute a mandated element of the job description for any role or individual.

The Directorate Risk Lead will:

- Support risk register owners, risk owners and action owners in their directorate to identify and manage risks effectively and in accordance with the Risk Management Policy and Procedure.
- Ensure that risk registers within their directorate are maintained, updated, and reviewed in a timely and effective manner.
- Ensure that risks are identified and recorded in a timely and effective manner and in accordance with the Risk Management Policy and Procedure.
- Ensure that action plans are produced and recorded in a timely and effective manner.
- Monitor and review progress against action plans.
- Attend relevant directorate management groups, Trust committees, governance group and forums to discuss and present new/revised risks
- Attend the Risk and Assurance Group monthly to present new and revised high-level risks, and to discuss any areas of emerging risks.
- Act as a point of contact between the Risk and Incident Lead and their directorate.
- Develop a good level of competence in using the Trust's risk management system, and support staff in their directorate to use the system effectively.
- Support the Risk and Incident Lead to develop a Trust-wide professional network relating to risk management and related assurance activities.
- In general, act as a champion and positive role model for risk management

Appendix E - Risk Identification:

Some risks can be managed effectively by the person identifying them taking appropriate action themselves or within their immediate team. This is particularly true with types of health and safety risks, where identification and removal of the hazard will often be sufficient to manage the risk.

Health and Safety risks associated with activity and equipment identified hazards will be risk assessed as per the Trust's' Health and Safety Policy section 5.3.

Staff should initially consider what their main areas of work are and how these relate to their local objectives, and the objectives of the Trust. Identification using a systematic approach is critical because a potential risk not identified at this stage will be excluded from any further analysis.

All risks, whether under the control of the Trust or not, should be included at this stage. The aim is to generate an informed list of events that might occur. Key sources that will inform this exercise include (but are not limited to):

• Risk Assessment • Quality Impact Assessment • Incidents and Near Misses • Complaints and Concerns • Claims and Litigation • Central Alerting System • Triangulation of Information • Horizon Scanning • Inspections for Improvement • Central Alerts • Coronial Investigations	• Policy Development and Review • Internal and External Audit • Business Continuity Plans and Exercises • Regulatory Frameworks • Compliance Reporting • Management Reviews • Risk Workshops • Programme / Project Assurance • Debriefs

Appendix F - Articulating Risk Statements

Each risk entry on a Trust risk register requires a risk statement that outlines the risk itself (the event), the cause, and the effect to allow for effective risk treatment.

To avoid poor expressions of the risk, the risk description should encompass three key elements:

"Because of <cause>, <risk> *might occur, which would lead to* <effect>.*"*

Appendix G - Managing controls and gaps

Every control should be relevant to the risk that has been described, it should be clear that the control directly impacts on managing the risk and the strength of the control should be considered when deciding the influence this will have on the risk score.

Each control should have evidence in place to provide assurance that the control is effective and being monitored.

Despite having identified controls, where the service has established a risk exists, it is the uncontrolled issues that are articulated as gaps. Gaps are issues which are not controlled and directly affect our mitigation of the risk. Gaps require clear and proportionate actions to address them.

Appendix H - Action Planning

The risk owner is responsible for developing an action plan to mitigate the risk. The risk owner must ensure that the planned actions are proportionate to the gaps in control and are relevant to the mitigation of the risk.

Each identified gap in control associated with a risk should be addressed by at least one remedial action. The action should be specific to the gap identified, be time- limited, and have a designated owner who is responsible for delivering the action (or for ensuring its completion via delegation to others).

The Trust's risk management system includes functionality to record actions associated with risks. All actions to address gaps in controls, or otherwise to mitigate a risk, should be recorded in the Trust's risk management system.

An individual gap in controls might require multiple remedial actions. In such circumstances each action must be recorded separately to ensure that an audit trail of implementation progress is captured for each individual action.

Actions plans should include for each action a designated owner, a review date, and a completion date. Review and completion dates are important

because they enable the Trust to monitor progress over time towards reducing the risk.

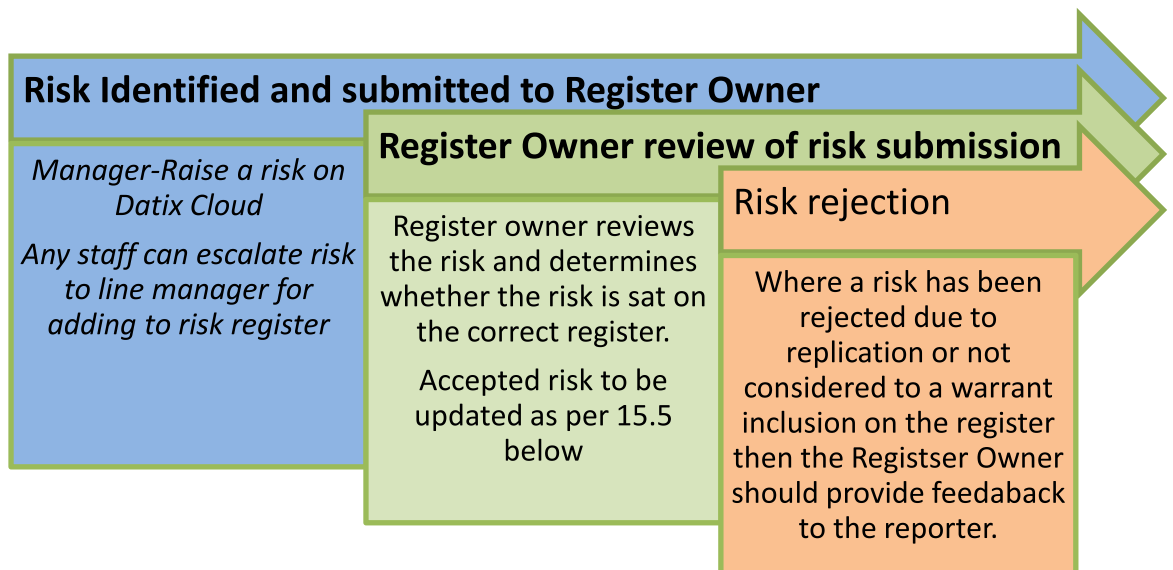
The Trust's risk management system will alert action owners by email to prompt them when their actions are due for review and / or completion

Appendix I - Risk Recording

All risks must be recorded in the Trust's risk management system. This applies to all categories and types of risk, including programme and project risks as well as operational business risks.

Diagram 1 below details the process for adding risks as both a manager and non-manager.

Diagram 1 – adding a risk



Proposed risks should be added to the risk register and submitted to the appropriate risk register owner for approval or rejection onto the register.

Risk register owners provide that necessary assurance that risk is correctly detailed and sat on the correct risk register and are indeed a risk.

Where a risk is accepted by the risk register owner, then the following should be recorded about each risk accepted onto the risk register:

- Risk title
- Risk description (the event, the cause, and the effect)
- Risk owner

- Risk type and sub-type
- Risk review date
- Initial risk score
- Current risk score
- Target risk score
- Controls and gaps in controls
- Actions, including action owners and action due dates
- Progress notes if applicable

Appendix J - Responding to System Auto-Prompts

The Trust's risk management system will automatically send a prompt to risk owners to inform them that a risk review is due.

The Trust's risk management system will automatically send a prompt to action owners to inform them that an action has reached its due date.

Risk owners and action owners should respond to system prompts in a timely manner.

It is not necessary to wait until a system auto-prompt is received before reviewing and updating the information recorded about a risk or an action. Progress about a risk or an action can be updated at any time. Owners of risks and actions should not wait to receive a notification if the recorded information can be updated earlier.

For any given risk, the overall risk review date and the individual action due dates may differ. This is entirely appropriate as there may be multiple actions to be completed over a period, each with a different completion date, to mitigate the risk and achieve the target risk score.

Appendix K - Completing Actions

The action owner is responsible for updating and closing actions as and when these are completed.

When an action has been completed the date of completion should be added to the information associated with that risk as recorded in the Trust's risk management system. This provides an audit trial to demonstrate the delivery of the action required to mitigate the risk.

When an action has been completed consideration should be given to the impact on the risk score and rating. If the completed action has a

significant impact on the likelihood or consequence of the risk occurring, the risk score and rating should be reviewed and potentially reduced.

A risk that remains open can have several completed actions recorded against it. However, when all the planned actions have been complete, the risk owner should consider whether further actions are required to manage the risk, or whether the risk can be closed.

Where the completion of all actions results in a risk being reduced to its target risk score, or being eliminated entirely, that risk can be closed.