with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Corporate

RISK MANAGEMENT POLICY

Policy Number:	CGP-08
Version:	3.2
Purpose:	To provide an overview of the Trust's risk management framework & supporting processes.
Consultation:	Audit & Assurance Committee, Executive, Risk Management Group (Directorate Risk Leads), Counter Fraud Service, JNCF.
Approved by:	Director of Corporate Governance and Trust Secretary, as delegated by CEO, Audit and Assurance Committee.
Date approved:	31 May 2023
Author:	Risk Manager
Date issued:	1st June 2023
Review date:	**January 2026**
Executive Lead:	Chief Executive Officer
Audience:	All staff
Dissemination:	Board, Risk Management Group and the Trust intranet
Impact assessments:	This policy has been equality impact assessed using the Trust's agreed process, and the assessment has not identified any significant adverse impact on people with one or more protected characteristic.

VERSION HISTORY

Version	Date	Reason for Change
1	October 2019	Policy developed for Gloucestershire Health and Care NHS Foundation Trust from 1st October 2019.
2	March 2021	Reflect movement of responsibility for risk to Head of Corporate Governance and Trust Secretary, the revised Risk Appetite Statement in line with new Strategic Objectives and ensure in line with Management of Policies and Procedural Documents Policy
3	March 2023	Routine review and update to reflect the current risk management framework and arrangements in place to support the policy. Removal of section on levels of assurance. Removal of references to NHS Improvement.
3.1	13 May 2025	Review date extended to January 2026 as agreed by the Audit & Assurance Committee meeting held on the 30 April 2025.
3.2	17 June 2025	Appendix 2 – Risk Appetite Statement including Themes and Descriptors updated as approved by the Trust Board 29 May 2025

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PART 1

STRATEGIC OVERVIEW – AIMS

Risk management is fundamental to ensuring the safe and effective functioning of the Trust as it is the process whereby the organisation systematically identifies and addresses the risks related to its activities, as well as to its strategic objectives. This is supported by a risk framework that is based upon a *3 Lines of Defence* model which is detailed within this policy. This is underpinned by an organisational risk appetite statement agreed by the Trust Board.

The aim of risk management is to drive down organisational risk through effective management. The purpose of this document is to provide a comprehensive overview of the Trust's risk management framework to enable staff to identify, manage and report on risk in a consistent and effective manner.

The document defines the duties and responsibilities of committees and individuals within the risk management framework.

STRATEGIC OVERVIEW – OUTCOME

Delivering services responsibly requires us to manage risk effectively. We need to make the right decisions and do the right things for our patients, stakeholders and staff.

We have a Risk Management Framework in place to steer the way we identify, prioritise, manage and mitigate the risks we face. It ensures we tackle risk in a consistent way, with robust internal controls, and that every colleague understands their personal and collective risk-related responsibilities. The Framework meets external (CQC) and internal governance (Board, Internal Audit) requirements and is owned by Chief Executive Officer supported by the Director of Corporate Governance.

RISK MANAGEMENT FRAMEWORK

The Trust is committed to having an organisational risk management framework, process and systems in place that will support a consistent and robust approach to risk management.

Specifically, this policy details the Trust's Risk Framework which has the following key components;

- 3 Lines of Defence
- Risk Appetite
- Risk Registers
- Risk Identification
- Risk Assessment
- Escalation
- Reporting Arrangements
- Systems – Datix & Tableau

PART 2

1.0 INTRODUCTION

Gloucestershire Health and Care NHS Foundation Trust (hereinafter referred to as "the Trust").

Risk management is fundamental to ensuring the safe and effective functioning of the Trust, as it is the process whereby the organisation systematically identifies and addresses the risks related to its activities, as well as to its strategic objectives.

The aim of risk management is to drive down organisational risk through effective management.

2.0 PURPOSE

The purpose of this document is to provide a comprehensive overview of the Trust's risk management framework.

This policy seeks to provide detailed guidance to all colleagues across the Trust regarding the operation of the organisation's risk control systems in order to ensure a consistent and holistic methodology for risk management.

3.0 SCOPE

This policy applies to all colleagues within the Trust, including permanent, part-time, locum, interim, bank and agency staff, volunteers, staff on honorary contracts and staff contractors.

4.0 DUTIES

4.1 Trust Board

The Trust Board maintains overall responsibility for the management of risk across the organisation. Its specific duties include:

- routinely reviewing and re-evaluating the risk appetite for the organisation;
- ensuring an effective system of internal control including risk management across the Trust;
- receiving the Board Assurance Framework, and advising on mitigations and actions as appropriate;
- receiving assurance reports from all Board subcommittees with regard to risks, internal controls and assurance.

4.2 Chief Executive

The Executive Lead for Risk is the Chief Executive Officer supported by the Director of Corporate Governance/Trust Secretary.

Duties include;

- to be responsible for risk management in the Trust;
- to ensure that the appropriate arrangements are in place to manage risk across the Trust;
- to ensure staff are aware of their specific responsibilities, and processes are in place to identify and respond to training needs of employees;
- ensure the Board is aware of the most significant risks for the organisation;

- integrate risk management and line management responsibilities.

The Director of Corporate Governance/Trust Secretary is the Chair of the Risk Management Group and has operational responsibility for ensuring the management of the Risk Management Policy and Board Assurance Framework on behalf of the Chief Executive.

4.3 Audit and Assurance Committee

The Committee has responsibility for the oversight of risk management across the Trust. This includes overseeing all risk management processes, including the Board Assurance Framework, the overarching Corporate Risk Register and other risks as determined by the risk stratification matrix to ensure their effectiveness.

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

In carrying out this work the Committee will utilise the work of Internal Audit, External Audit and other assurance functions. It will also seek reports and assurances from other committees, directors and managers as appropriate. This work of the Committee should provide assurance to the Board that risks are appropriately managed within the organisation.

4.4 Risk Management Group

This Group is chaired by the Director of Corporate Governance/Trust Secretary and reports quarterly to the Audit and Assurance Committee. The membership comprises the Directorate Risk Leads, Risk Manager and appropriate experts invited by the Chair as required.

The Group reviews all reported significant risks to ensure a consistent approach to risk scores, that risks are being effectively managed and are escalated as appropriate.

The Group also oversees and promotes the development of the risk management framework and supporting processes in response to management requirements and recommended good practice.

4.5 Trust Risk Manager

The Trust Risk Manager is responsible for the management and oversight of the Corporate Risk Register and ensuring appropriate co-ordination with the Board Assurance Framework.

Whilst not owning the risks on the Risk Register, the Trust's Risk Manager will provide support, advice, challenge and guidance on the management of their risks to include;

- the development, implementation and maintenance of risk management systems;
- developing and maintaining a risk register for the Trust to defined standards;
- ensuring the board reporting timetable is delivered;
- maintaining and developing effective working with Directorate Risk Leads;
- ensuring ownership of risks is at a level which has authority to assign resources to the management of the relevant risk;

- ensuring that risks are properly evaluated using the defined criteria and which are applied consistently;
- ensuring that all new significant risks are escalated in a timely manner to the Director of Corporate Governance/Trust Secretary and the appropriate executive;
- maintaining an overview of staff training in relation to risk management.

4.6 Senior Staff

Senior staff play a vital role in helping ensure that the risks are identified and reported in a timely manner. Their role includes:

- supporting staff who identify potential risks
- ensuring risk identification is discussed at local team meetings
- recording and updating risks on Datix
- liaising with their Directorate Risk Leads
- knowing how to access the Risk Management policy on the intranet
- knowing where to seek support

As senior staff play such a key role in embedding effective risk management arrangements, specific "*essential to role*" training is provided. (Care to Learn - Risk Management – Module 1).

4.7 All colleagues

All colleagues within the Trust, including permanent, part-time, locum, interim bank and agency staff, volunteers, staff on honorary contracts and staff contractors are responsible for ensuring that they:

- know how to use the intranet to access policies and obtain contact details to provide support or advice on risk management
- raise potential risks with their manager for consideration for addition to the Risk Register
- raise potential risks at team meetings and / or supervision
- initiate appropriate action, within their sphere of responsibility, to prevent or reduce the adverse effects of risk;
- participate in risk assessments as may be relevant to their individual post/specialty;
- take reasonable care of the health, safety and security of themselves and others.

4.8 Executive Risk Owners

Executive Directors are responsible for owning risks being managed in their areas of responsibility. This includes;

- monitoring of local systems of risk identification and control
- ensuring appropriate risk governance arrangements are in place for their Directorate
- recording and reviewing progress on Datix
- escalating risks where required
- tracking actions detailed within the Corporate Risk Register and Board Assurance Framework.

4.9 Directorate Risk Leads

This is a key role within the Trust's risk management framework in achieving a de-centralised approach to risk management.

A Directorate Risk Lead is a member of the Trust's workforce whose role and position gives them responsibility for the facilitation of the identification, management and mitigation of risks within their directorate and appropriate escalation of risk.

Directorate Risk Leads are expected to take an active lead in ensuring that risk management practices and systems are applied consistently within their directorate. They support the management of risks to reduce the risk score down to the target acceptable to the Trust where possible. They will:

- provide day to day contact on risk issues for their Directorate;
- support Leads for Risk in recoding risks on Datix and in meeting their responsibilities (see below);
- ensure that the Directorate Risk Register is adequately maintained and monitored with progress updates from the Leads for Risk;
- Provide ad-hoc risk reports from Datix for directorate meetings;
- ensure that new significant risks are escalated to the Trust Risk Manager in a timely manner;
- help develop good working practices through regular liaison with the Trust Risk Manager.

4.10 Leads for Risk

This is generally the named individual on Datix who has the day to day oversight responsibility for an individual risk. Their responsibilities are to;

- ensure the risk record on Datix is accurate
- update Datix with progress updates at least quarterly, reviewing;
- actions taken / planned
- challenges
- oversight arrangements
- when risk will be fully/partially mitigated
- risk scores correct
- target risk score/date correct

5.0 RISK FRAMEWORK

5.1 Three lines of defence (Figure 1 – see page 9)

In line with best practice and recommendation by internal audit, the Trust has adopted a *Three Lines of Defence* model. This is designed to provide a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

- Adopting this model will help ensure;
- risk management is embedded within the organisation;
- risks are monitored more effectively by their owners;
- actions are aligned with the risk;
- risks are escalated to board committees appropriately;
- risks are monitored consistently.

5.2 First Line of Defence – operational

This refers to the every-day business as usual activities of every department within the Trust.

As the first Line of Defence, operational managers own and manage risks. They are also responsible for implementing corrective actions to address process and control deficiencies.

Operational management is responsible for maintaining effective internal controls and for executing risk and control procedures on a day-to-day basis. Operational management identifies, assesses, controls, and mitigates risks, guiding the development and implementation of internal policies and procedures and ensuring that activities are consistent with goals and objectives.

Operational management naturally serves as the first line of defence because controls are designed into systems and processes under their guidance of operational management. There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, inadequate processes, and unexpected events.

This model has been refined to include the Risk Management Group that will report to the Executive Team (1st line of defence) to provide appropriate oversight of risks before reporting to the Board Committees (2nd line of Defence).

5.3 Second Line of Defence – oversight

The second line is created by the oversight function(s) made up of Board committees, compliance and risk management. These functions set and monitor policies, define work practices and oversee the business frontlines with regard to risk and compliance. A key feature of the second line of defence is the Trust's Committee structure.

5.4 Third Line of Defence – independent/external oversight

The third and final line of defence is that of auditors and external regulators. Both internal and external auditors regularly review both the operational and oversight functions to ensure that they are carrying out their tasks to the required level of competency.

Directors receive reports from audit, oversight and the business, and will act on any items of concern from any party; they will also ensure that the 'Three Lines of Defence' are operating effectively and according to best practice.

In addition, the Trust's Executive and Non-executive Directors will receive ad-hoc reports from NHS England (NHSEI) and Care Quality Commission that provide assurance around the well-being of patients and the organisation.

5.1 - FIGURE 1

<table>
<tr><th colspan="7">RISK MANAGEMENT FRAMEWORK - 3 LINES of DEFENCE</th></tr>
<tr><th colspan="4">1st LINE of DEFENCE</th><th></th><th colspan="2">2nd LINE of DEFENCE</th><th>3rd LINE of DEFENCE</th></tr>
<tr><th></th><th>RISK LEADS</th><th colspan="2">OVERSIGHT</th><th>MANAGEMENT GROUPS</th><th colspan="2">BOARD COMMITTEES</th><th>REGULATORY /EXTERNAL OVERSIGHT</th></tr>
<tr><td>Chief Executive Officer (CEO)</td><td rowspan="9">DIRECTORATE RISK LEADS</td><td rowspan="9">The Risk Management Group

The Group reviews all reported significant risks to ensure a consistent approach to risk scores, that risks are being effectively managed and are escalated as appropriate.</td><td rowspan="9">Executive Meeting</td><td>Audit & Assurance:
• Health & Safety & Security Management Group
• Risk Management Group
• Information Governance Group
• BEME Management Group</td><td></td><td rowspan="9">Audit & Assurance Committee (Incorporating functions of Risk & Governance)</td><td rowspan="9">TRUST BOARD</td><td rowspan="9">Internal Audit
External Audit
Care Quality Commission
Commissioners
NHS England</td></tr>
<tr><td>Director of Finance & Deputy CEO</td><td>Resources
• Digital Group
• Capital Management Group
• Business Intelligence Management Group
• Strategic Oversight Group
• Community Mental Health Transformation Programme</td><td>Resources Committee (Incorporating functions of Transformation, Innovation & Performance)</td></tr>
<tr><td>Director of Nursing, Therapies and Quality</td><td>Great Place to Work Committee
• Workforce Management Group
• Joint Negotiating and Consultative Forum
• Local Negotiating Committee
•ICS People Function</td><td>Great Place to Work Committee</td></tr>
<tr><td>Chief Operating Officer</td><td rowspan="2">Quality
• Quality Assurance Group</td><td rowspan="2">Quality Committee (Incorporating functions of Safety & Quality Improvement)</td></tr>
<tr><td>Director of Strategy & Partnerships</td></tr>
<tr><td>Director Human Resources and Organisational Development</td><td rowspan="2">MHLS
• Mental Health Operational Group,
• Mental Health Manager's Forum</td><td rowspan="2">Mental Health Legislation Scrutiny Committee</td></tr>
<tr><td>Medical Director</td></tr>
</table>

6.0 RISK APPETITE STATEMENT

It is recognised that a well-defined risk appetite should have the following characteristics:

- reflective of strategy, including organisational objectives, business plans and stakeholder expectations;
- reflective of all key aspects of the business;
- acknowledges a willingness and capacity to take on risk;
- is documented as a formal risk appetite statement;
- considers the skills, resources and technology required to manage and monitor risk exposures in the context of risk appetite;
- is inclusive of a tolerance for loss or negative events that can be reasonably quantified;
- is periodically reviewed and reconsidered with reference to evolving industry and market conditions;
- has been approved by the Board.

The Risk Appetite Statement for the Trust is reviewed annually by the Board and appears as **Appendix 2.**

7.0 RISK REGISTERS

The Trust needs a mechanism to understand its comprehensive risk profile. The risk register is a single document that is a central log of risks clinical and non-clinical that threatens success in achieving the Trust's aims and objectives.

It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. The Trust's Risk Manager will oversee management of the risk register through Datix.

8.0 RISK IDENTIFICATION

Risks are identified by the following methods:

- operational risks may be identified at any time by any member of staff. Such identification may result from any number of factors which may include the direct observation / identification of issues of concern within the workplace
- emergency escalation processes
- Board and its Committees
- internal risk assessments of routine working practice
- internal audits, both clinical and non-clinical, of routine working practices
- internal evaluations that may include quality visits, peer reviews etc
- external evaluations that may include Care Quality Commission inspections, Healthwatch reports etc;
- external guidance or alerts that are issued by the Department of Health & Social Care, NHS England and Improvement and successor bodies
- a trend in under-performance within a particular service

- a trend in incidents or concerns arising from Serious Incidents Requiring Investigation (SIRI)
- a trend in complaints or other related quality issues
- a concern regarding a legal claim or Coroner enquiry
- raised by colleagues at appropriate organisation forums [e.g. team meetings]
- fraud / Bribery /Corruption – response to the Trust's Counter Fraud, Bribery and Corruption policy.

The Trust encourages colleagues to raise risks through their Team Managers who are responsible for onward reporting of risks.

Procedures and systems are in place to help ensure that Team meeting agendas consider the risks raised and for the Team Manager to escalate to their senior manager and /or Directorate Risk Lead where appropriate.

Once a risk has been identified it should be reported using the risk module of the Datix system. Access to the risk module is generally restricted to senior staff and is controlled by the Datix Team.

9.0 RISK ASSESSMENT

In order that risks are consistently assessed a risk scoring matrix is used which was originally published by NHS National Patient Safety Agency (NPSA) and adopted by the Trust. The same matrix is incorporated into the Datix system to facilitate the risk scoring function.

The matrix requires a risk *consequence* [1-5] and *likelihood* score [1-5] to produce a total risk score with a range from 1 to 25.

Table 1 summarises the full risk scoring matrix which appears in **Appendix 1** together with instructions on its use.

TABLE 1

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	**15**	**20**	**25**
4 Major	4	8	12	**16**	**20**
3 Moderate	3	6	9	12	**15**
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Key:

1 – 3 LOW RISK	4-6 MODERATE RISK	8-12 HIGH RISK	15 and over Extreme

This approach does not automatically identify which areas of risk require

greatest attention. However, it will help inform discussion about which risks are most significant, and what action is required to address them. The risks that score the most points are likely to be those which most demand some form of control action, and those risks which are assessed as “High” or “Extreme” should be given particular attention.

Once a risk has been identified and assessed, it should be explored in greater detail so as to determine an appropriate course of action and/or mitigation.

10.0 CORPORATE RISKS

Corporate risks are those that an assessment calculates the risk score to be 12 or above. These risks are reported to the Executive and relevant Board Committees in line with their work plans.

If the new risk scores 12 (or higher) then this should be immediately escalated to the Directorate Risk Lead and Executive Director responsible for the risk.

10.1 Closure of Risks

A risk will be considered to be effectively closed (although not removed from the electronic risk management system so as to retain an audit trail, when it is considered that the target risk score has been achieved and is sustainable.

Risk closure is confirmed by the Risk Management Group.

11.0 BOARD ASSURANCE FRAMEWORK

Strategic risks will be articulated within the Trust’s Board Assurance Framework (BAF). Strategic risks are defined as those risks that, if realised, could fundamentally affect the way in which the Trust exists or operates, and that could have a detrimental effect upon the Trust’s achievement of its strategic objectives.

The BAF will also highlight all the prevailing operational risks, as these link to the strategic risks, so that the Trust Board has full oversight of the risk environment.

Strategic risks will be identified by Non-Executive and Executive Directors, and will be aligned to the Trust’s strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Any gaps will be identified and action plans put in place to strengthen controls.

The BAF will be fully reviewed by the Board as required by current work plans basis (a minimum of twice a year) and it will support the Chief Executive in completing the Annual Governance Statement at the end of each financial year. In addition, the BAF will be reviewed by Board Committees on a quarterly basis. The development and maintenance of the BAF is the responsibility of the

Director of Governance/Trust Secretary.

12.0 BAF AND RISK REGISTER

This section provides clarification regarding the relationship between the BAF and risk register.
The BAF and risk register are separate and distinct documents. As stated in this policy, strategic risks are identified by Non-Executive and Executive Directors, and aligned to the Trust's strategic objectives.

These risks are assessed and scored to reflect the threat to the achieving the Trust's strategic goals. This differs from risks on the risk register which are assessed and scored in the context of a directorate's operational objectives using the risk scoring toolkit (**Appendix 2**). The risk register is just one source of information that can inform the Executive when determining a strategic risk. These risks are assessed using the NHS recommended risk scoring tool (**Appendix 2**).

However, it is not the case that risks are routinely escalated / demoted between the risk register to the BAF based purely on a risk score.

In order to provide a joined-up view of the Trust's risk landscape the individual corporate risks on the risk register are linked to the BAF strategic risks providing a complete picture and support the assurance provided. Both the BAF and Risk Register are generally presented in tandem at Board Committee meetings thereby providing a comprehensive view of the Trust's risk profile.

13.0 REPORTING ARRANGEMENTS

13.1 Board Committees

Risk register and Board Assurance Framework reporting is in line with the Work Plans for the following Board committees;

Board committee	Risk Register	Board Assurance Framework
Executive Meeting	Quarterly	Quarterly
Board	Annual	6 Monthly
Board Committees	Quarterly	Quarterly

Only those risks with a risk score of 12 and above or outside their risk appetite are reviewed by Board Committees. Risks below this risk score will be reviewed by Directorate meetings.

13.2 Reporting Process

Based on the 3 *Lines of Defence* model a robust reporting sequence has been established with the following key components;

1st Line
• Individual risk review by executives facilitated by Risk Manager
• Risk Management Group
• Executive meeting
2nd Line
• Audit & Assurance Board committee
• Resources, Quality, GPTW and MHLS Committees

13.3 **Management Groups**

Management Groups will consider risks within their area of responsibility and provide the appropriate board committee with a summary assurance report;

Audit & Assurance
• Health & Safety & Security Management Group
• Risk Management Group
• Information Governance Group
• BEME Management Group
Resources
• Digital Group
• Capital Management Group
• Business Intelligence Management Group
• Strategic Oversight Group
• Community Mental Health Transformation Programme
Quality
• Quality Assurance Group
MHLS
• Mental Health Operational Group,
• Mental Health Manager's Forum

14.0 SYSTEMS

14.1 **DATIX**

Datix is web-based patient safety software for healthcare risk management applications. The system delivers safety, risk and governance elements through a variety of integrated software modules, enabling a comprehensive oversight of risk management activities within the Trust**.**

14.2. **Tableau Reports**

This management information system is owned by Business Intelligence Team and is used by the Trust to provide performance information to senior management.

This system draws information from Datix and provides risk reports for board committees. In addition, the system readily enables desk top risk reviews to be undertaken thereby encouraging wider use by colleagues.

15.0 DEFINITIONS

Terms used within this Risk Management Policy include the following:

15.1 **Risk is defined as;**
An event or series of events that could occur, generally as a result of a control failure caused by people, systems or external situation thereby impacting on the Trust's ability to meet its key objectives.

15.2 **An Issue is defined as;**
An issue is essentially a risk that has happened. In other words, risks are potential future problems and issues are current problems

15.3 **Risk Management;**
An active and continual process which aims to reduce or eliminate the possibility of harm, damage or loss to people, property and services including deviation from expected organisational performance or the achievement of objectives.

- **Risk management within the Trust will result in one of four possible responses:**

  → **avoidance (or termination):** some risks will only be manageable, or containable to an acceptable level, by termination of the associated activity;
  → **reduction (or treatment):** although it may not be possible or practical to eliminate some risks completely, the impact of such may be reduced to an acceptable level by suitable management;
  → **transfer**: some risks may be transferable to a third party (for example, via insurance where appropriate), however this course of action would need to be undertaken with clear and transparent agreement;
  → **retention (or acceptance):** the ability to mitigate some risks may be limited, or the cost of the necessary action may outweigh the potential benefit gained, and in such cases, the most appropriate response to the risk may be to tolerate or accept it;

- **strategic risks** are those risks that, if realised, could fundamentally affect the way in which the Trust exists or operates, and/or which may have a detrimental effect on the organisation's achievement of its strategic objectives. The realisation of strategic risks may lead to material failure, loss or lost opportunity (for example, loss of significant sums of money), failure to meet Care Quality Commission (CQC) or other mandatory requirements, death or serious injury of a service user or Trust colleague, and/or failure to meet significant strategic targets;
- **operational risks** are those risks that are associated with the day-to-day workings of the Trust that would increase the likelihood of a strategic risk

being realised. These may therefore originate within service delivery teams, or else they may be related to any of the Trust's support services including finance, HR, estates, IT, professional and clinical excellence, health and safety, governance, information governance etc;

- **risk appetite** is the level of risk that the Trust is prepared to accept, before action is deemed necessary to reduce it. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.
- **risk assessment** is a careful examination of what, in a colleague's work practice and area, could cause harm or compromise the ability of the Trust to achieve its objectives, so that staff can weigh up whether they have taken enough or suitable precautions or whether they should do more (NB care assessments of individual service users are carried out by clinical colleagues, and although based on similar principles, are not covered by this policy);
- **risk score** is the result of calculating the likelihood of the occurrence or re-occurrence of a risk, against the consequences of that risk's impact upon the Trust, as shown within the organisation's Risk Assessment Matrix tool which is included in **Appendix 2.** Whenever risks have been identified they should be scored (these scores are ordinal) to give a priority for action, particularly when limited resources may be available to manage risks.

16.0 PROCESS FOR MONITORING COMPLIANCE

The Audit and Assurance Committee will be responsible for the on-going monitoring and review of this Risk Management Policy.

The Risk Management Group supports this review and monitoring process.

17.0 TRAINING & SUPPORT

Appropriate training is an essential prerequisite of safe working. The Trust will assess the risk management training needs of all staff and develop, implement, monitor and training compliance ensures staff receive adequate training and professional education to enable them to carry out their duties safely.

Risk management training has been approved by the executive as being "essential to role" and a training module has been developed and is accessed via the *"Care to Learn*" training system.

Particular attention will be paid to the need for appropriate induction and training in risk assessment, risk management, health and safety, fire safety, managing violence, resuscitation, responding to complaints and professional updating. Guidance and Training is accessible on the Trust's Intranet.

18.0 ASSOCIATED DOCUMENTS

Counter Fraud, Bribery and Corruption policy.

19.0 APPENDICES

Appendix 1 – Risk Scoring Matrix and Toolkit
Appendix 2 – Risk Appetite Statement & Overarching Risk Appetite Profile

APPENDIX 1

RISK SCORING TOOLKIT

NHS National Patient Safety Agency

The risk scoring mechanism utilised by the Trust uses the descriptions provided by the NHS National Patient Safety Agency. These are shown below:

Description of consequence

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

	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	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Financial Impact	Below £0.25m	Below £0.75m	Below £2.0m	Below £4.0m	Above £4.0m

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

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

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

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk s**coring = consequence x likelihood (C x L)**

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

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

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

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

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

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

APPENDIX 2 - RISK APPETITE STATEMENT AND DESCRIPTORS

RISK APPETITE STATEMENT 2025/2026

The purpose of the Risk Appetite Statement is to inform all those responsible for identifying and managing risk at GHC of the context to use when assessing how a risk should be evaluated.

The risk appetite, set by the Board of Gloucestershire Health and Care NHS Foundation Trust is necessarily more open than in previous years. This reflects the unprecedented challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, the pace of societal and technological changes and the ongoing climate crisis. During this time of change we will continue to protect the Quality and Safety of Care and minimise risks that may have a detrimental effect on the Service User Experience and the experience of those supporting them (classified as a moderate risk appetite).

In relation to Organisational Culture, Meeting Population Needs, and Finance we will continue to have a moderate risk appetite, enabling us to explore opportunities whilst ensuring the breadth and importance of these areas is subject to sufficient oversight.

We acknowledge that service capacity continues to be a challenge across our healthcare system. Transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We will support our people to adapt and thrive during change. Investment decisions will reflect our ambition to provide outstanding physical and mental health care and learning disability services for the people of Gloucestershire, putting the person at the heart of our services focusing on *personalised care* from the perspective of '*what matters to you'* rather than '*what is the matter with you'*.

To achieve our aims of providing outstanding care, we have a high-risk appetite in our approach to Innovation, Transformation; Partnership and Collaborative Working and Workforce. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships. The digital agenda will underpin innovation and the transformation of services to become more efficient and effective. Whilst we are prepared to accept higher levels of risk to implement changes for longer term benefit, we have a moderate appetite in relation to Cyber Security and low in relation to Compliance and Regulation.

The Risk Appetite Statement provides the Board's appetite for risk taking and tolerances and is mapped against the Strategic Priorities. This clear understanding of the Board's tolerances and appetite for risk taking is necessary to steer and influence the development of appropriate risk mitigation controls.

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. Where this is the case, it is proposed that these decisions will be referred to the Board.

The Risk Appetite Statement was approved by the Board on 29 May 2025.

RISK APPETITE THEMES

Risk Theme	Risks within this Theme	Appetite Level	Tolerance	Reporting Impact
Quality and Safety of Care & Service User Experience	Quality and Standards	Moderate	10	11 and up
Innovation and Transformation (including AI)	Speed of Change	High	12	13 and up
Meeting Population Needs	Demand and Capacity Health Equity	Moderate	10	11 and up
Partnership and Collaboration	Relationships and Partnership Working	High	12	13 and up
Workforce	Colleague Recruitment & Retention & Development	High	12	13 and up
Finance	Funding for Transformation Strategic Commissioning Partnerships	Moderate	10	11 and up
Culture	Internal Culture Closed Culture	Moderate	10	11 and up
Compliance and Regulation		Low	6	7 and up
Cyber	Cyber	Moderate	10	11 and up

RISK APPETITE DESCRIPTORS

Appetite Level	Description	Upper Tolerance	Reporting
None (Averse)	Prepared to accept only the very lowest levels of risk, with the performance being ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.		1 and above
Low (Minimalist)	Willing to accept some low risks, while maintain an overall performance for safe delivery options despite the probability of these having mostly restricted potential for reward/return	6	7 and above
Moderate (Cautious)	Tending towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	10	11 and above
High (Open)	Willing to be innovative and prepared to consider all potential delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	12	13 and above
Significant (Seek)	Eager to seek original/innovative /pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return because of controls, forward scanning and robust systems	16	17 and above