

Risk Management Policy

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Risk Management Policy

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Checklist for Review and Approval

1 Staff Summary & Introduction

- 1.1 This document is the policy for the management of risk at Leeds Teaching Hospitals NHS Trust (LTHT). Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby ensuring the delivery of objectives.
- 1.2 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities and threats. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.
- 1.3 The Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.
- 1.4 The Trust's governance framework will be supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development.

Key Points for Staff

- 1.5 Risk is the effect of uncertainty on the delivery of objectives. For example, we have an objective to keep patients and staff safe, risk is therefore anything that could stop us from keeping people safe in our care. The primary purpose of risk management is to:
 - Reduce harm for patients, staff, visitors and contractors
 - Protect everything of value to the Trust, including clinical outcomes, staff safety, the estate, reputation, market share
 - Support and facilitate continuous improvements at Leeds Teaching Hospitals NHS Trust.

When identifying risk, we anticipate what could stop us from achieving our goals. To help identify risk we look at our historical themes and trends, previous events, current challenges, and needs of people who use our services now and in the future. Staff are required to be open, honest, think ahead and take an active part in identifying risk.

Risk analysis involves estimating the consequence (the impact the risk has on the Trust and people in our care) and likelihood (the probability of that impact happening). The scores are multiplied to give an overall risk rating. The risk

rating is used to determine risk management priorities and monitor acceptable levels of risk. Staff are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.

Risk is treated proactively using prevention controls. Prevention controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, training or IT systems. Staff are required to understand and implement controls designed to manage risk at the Trust.

Risk Appetite provides a framework which enables the Trust to make informed planning and management decisions. By defining Risk Appetite, the Trust will be able to clearly set the optimal position in pursuit of its strategy and vision. The benefits of adopting a Risk Appetite include:

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

Since budgetary constraints may prevent achievement of Risk Appetite (at least in the short-term), the defining of a Risk Tolerance enables the Trust to clearly set an acceptable position in pursuit of its strategy and vision.

Risk Appetite: the level of risk with which the Trust aims to operate.

Risk Tolerance: the level of risk with which the Trust is willing to operate.

Organisational learning is reflected in the Trust's ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim). Controls are monitored and continuously improved as part of an open and learning culture.

Risk management is everyone's responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.

An overview of the LTHT Risk Management Process is described in section 4 and Appendices A-C.

2 Purpose and Effect

- 2.1 The overall purpose of the risk management policy at the Trust is to:
- **Reduce the level of exposure to harm for patients, staff or visitors** by proactively identifying and managing personal risk to a level as low as reasonably practicable.
 - **Promote success and protect everything of value** to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
 - **Continuously improve** by proactively adapting and remaining resilient to changing circumstances or events.
- 2.2 Risk management is everyone's responsibility. This policy applies to all employees (including students), contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities on pages 13-15.

Risk Culture – The Leeds Way

- 2.3 Effective employee engagement is vital to our success and aspiration to become one of the safest and most effective NHS organisations in the country. The Leeds Way is “the way we do things around here” and is the result of the widespread adoption of a set of values and behaviours that guide our work.
- 2.4 By wholeheartedly embracing the values and behaviours embedded in the Leeds Way in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

3 Key Definitions

Risk management should operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2021) will improve consistency and avoid confusion.

Board Assurance Framework	A document which records the threats to the strategic objectives and goals of the Trust.	Operational Risk	The risk of loss or gain, resulting from inadequate or failed internal processes, people and systems or from external events
Control	Measure to mitigate or fully address the cause of the risk	Risk	Effect of uncertainty on objectives
Corporate Risk Register	The document which records the most significant operational risks faced by the Trust	Risk acceptance	Informed decision to take a particular risk
Current risk score	Current risk. The risk score remaining <u>after</u> risk treatment	Risk analysis	Process to comprehend the nature of risk and to determine the level of risk
Exposure	Extent to which the organisation is subject to an event	Risk appetite	Amount and type of risk the organisation is prepared to seek, accept or tolerate
Further Mitigating Actions	Actions required to address gaps in control	Risk assessment	Overall process of risk identification, risk analysis and risk evaluation
Gaps in Control	Missing controls or weaknesses in identified controls	Risk tolerance	The range of risk score the Trust will accept within the risk appetite category
Hazard	Anything that has potential for harm	Risk avoidance	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	Risk management	Co-ordinated activities to direct and control the organisation with regard to risk
Initial risk score	The risk score prior to any mitigating action	Risk owner	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Level of Risk	Magnitude of a risk expressed in terms of the combination of consequences and their likelihood	Risk Register	A record of information about identified risks maintained by CSU's and corporate functions.
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	Target risk score	The score at which the risk becomes acceptable

Risk Categories and Risk Appetite Statement

The Trust has developed a separate document that sets out the revised risk categories and risk appetite statements aligned to each category, within the risk management framework, which was approved by the Trust Board in March 2021 and revised in May 2026 and is available on the Trust's risk management webpage.

4 Risk Management Process / Process Flow Charts

Risk Management Process

Step 1: Determine Objectives

- 4.1** Risk is defined as the effect of uncertainty on the objective. It is essential, therefore, to be clear about objectives for each service and to express these in specific, measurable, achievable ways with timescales for delivery. Priorities will be determined by the Board of Directors and expressed through Clinical Service Units (CSU's), Corporate functions, service and personal objectives.

Step 2: Identify Risk

- 4.2** Risk will be identified by anticipating what is stopping, or could stop, the Trust from achieving stated objectives and strategic priorities. Risk identification involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static but is particularly aligned to the annual planning process. Staff may draw on a systematic proactive consideration of reasonably foreseeable failures alongside incident trends, complaints, claims histories, patient/staff surveys, observations, formal notices, audits or national reports to identify risk. In order to do this the Board of Directors and CSUs should identify what is uncertain, consider how it may be caused and what impact it may have on the objective.

Step 3: Assess Risk

- 4.3** The magnitude of the risk will be assessed by multiplying the consequence of impact by the likelihood of the risk occurring. Staff are required to be realistic in the quantification of severity and likelihood and use, where appropriate, relative

frequency to consider probability. The risk scoring matrix and guidance is provided in appendices B and C.

Step 4: Respond to the Risk

4.4 There are a number of different options for responding to a risk. These options are referred to as risk treatment. The main options most likely to be used include:

- **Modify** - this approach involves specific controls designed to change the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:
- **Accept** - this approach is used when no further mitigating action is planned, and the risk exposure is considered tolerable and acceptable. This would mean that the risk score had been lowered to its target level. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid** - this approach usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this approach involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement.*
- **Seek** - this approach is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*

Controls are used to address risk and comprise:

Prevention/Treatment - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks.

When considering how to reduce the risk, there's a certain order that should be followed. This is called the hierarchy of controls.

Elimination is the most effective hierarchy of risk control. If it is possible to physically remove a hazard, it must be done.

Substitution is the second most effective control. It proposes to replace the hazard with a safer alternative.

Engineering controls involve replacing equipment and processes or changing the work environment to separate or isolate workers from exposure to the hazard.

Administrative controls involve identifying and implementing safe work procedures so workers can perform their job duties safely. The findings of the risk assessment will form the basis of these safe work procedures.

Personal protective equipment and clothing Using personal protective equipment (PPE) is another important control to protect workers. For example, in certain workplaces such as laboratories, the use of PPE such as protective eyewear and gloves will help to reduce the exposure risk.

Step 5: Report Risk

4.5 Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥15 – Board of Directors
- ≥10 – CSU and Risk Management Committee
- ≥8 – Specialty/CSU Governance meeting/ward/departmental management

The **Board of Directors** will receive summary reports at each formal meeting to inform them of all material risk, the nature of controls and action plans. The risk profile shall be part of the Chief Executive's report and cover the risk source, description of the risk, the residual risk, main controls, date of review and risk owner. The Board of Directors will determine the Trust's appetite and tolerance for risks in relation to the threats to the achievement of the organisations strategic objectives which form the Trust's Board Assurance Framework.

The **Risk Management Committee** will receive reports to inform them of the distribution of risk across the Trust, details of all significant risks, material changes to the significant risk profile and progress with action plans. Reports will cover the risk source, description of the risk, the residual risk, main controls, date of review and risk owner. Information related to progress against controls and actions will be included in the Risk Management Committee minutes. The Risk Management Committee will also determine the Trust's appetite for risk in relation to operational clinical and non-clinical risks.

The Risk Management Committee will review significant risks with CSUs and corporate teams as set out in the Terms of Reference.

The Risk Management Committee will produce an Annual Report providing assurance on the management of strategic threats (Board Assurance Framework) significant operational risks (Corporate Risk Register) and other operational risks (CSU and Corporate Department Risk Registers), which will support the Trust Board in the completion of its Annual Governance Statement.

Clinical Service Units and Corporate Functions will have access to DatixWeb that enables them to generate specific reports in order to review patient safety incidents to identify risks within their wards, departments and specialties, and check that controls are in place and actions are being implemented.

CSU's will discuss risks at their governance meetings in accordance with their scheduled review dates. CSU's will minute the discussion and agreement in accordance with the Trust's agreed style.

The Executive Team will be informed by the relevant Executive Director (or Director of Quality) of any new significant risk arising at the first meeting opportunity.

The Audit Committee will scrutinise assurances on the risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

Urgent Escalation - in the event of a significant risk arising from meetings of the above, the risk will be assessed, reviewed by the relevant Clinical Director, Head of Nursing, CSU General Manager and Executive Director and reported to the Chief Executive (or deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting and through the Risk Management Committee to the Trust Board.

Step 6: Review Risk

4.6 CSU's and Corporate Functions review risk at a frequency proportional to the residual risk. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥ 15 – at least monthly.
- ≥ 10 – at least bi-monthly.
- ≥ 8 – at least quarterly.
- ≥ 6 – at least annually.

The Risk Management Committee reviews a number of corporate risks (≥ 15) at each monthly meeting, in line with the annual work programme. These formal reports are provided by the Lead Executive Director and a record and update provided on all further mitigating actions where the completion date has been reached.

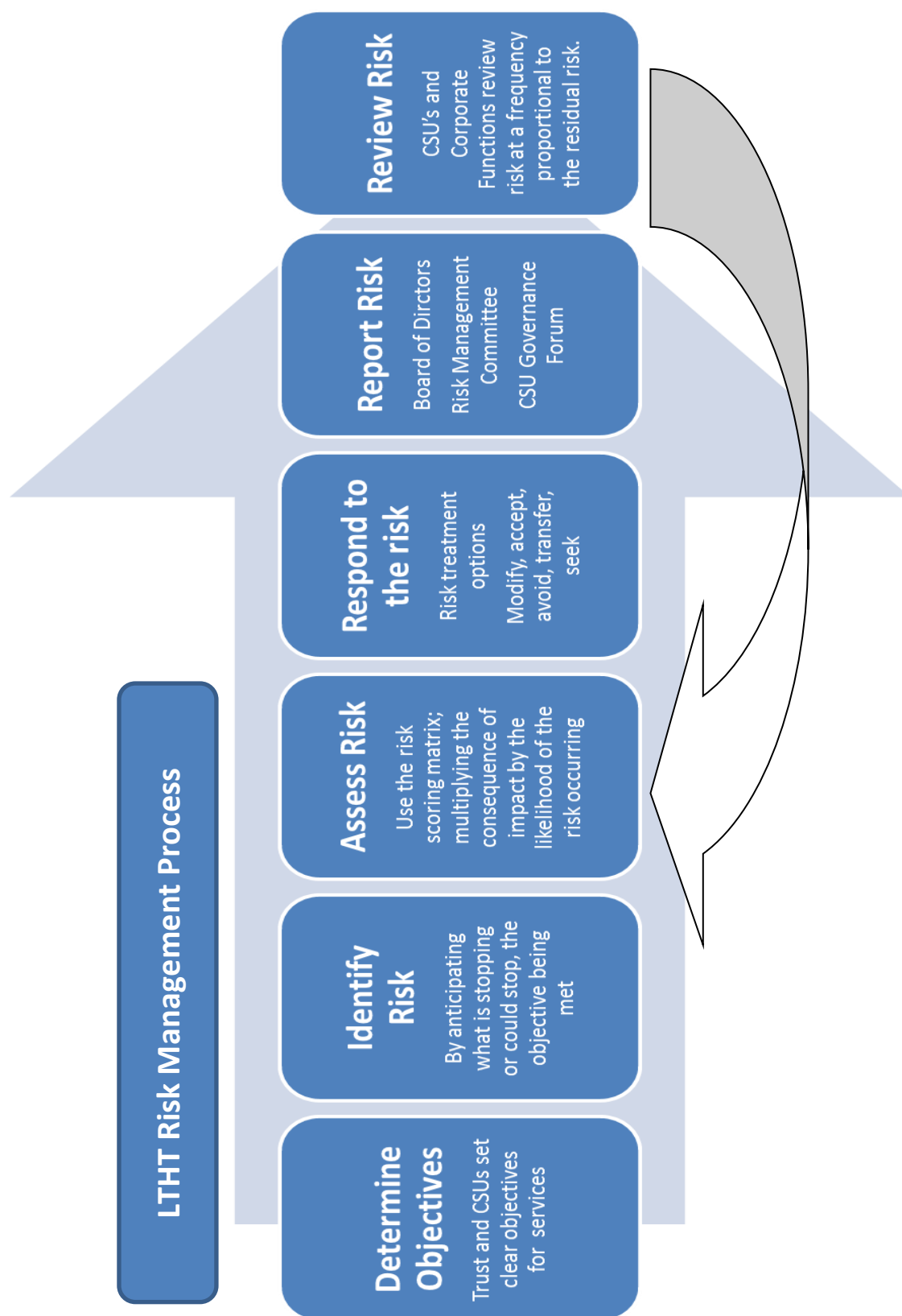
4.7 The relationship between Risk Management, Quality Assurance Committee, Finance and Performance Committee and the Audit Committee

- (i) To ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Risk Management Committee, Quality Assurance Committee, Finance and Performance Committee and Audit Committee is based on inclusiveness, clarity of purpose and constructive challenge. The Risk Management Committee will oversee the management of all significant risks and will provide the Audit Committee with assurance on the effective operation of internal controls.
- (ii) The Quality Assurance Committee will review assurances on the operation of clinical/quality governance. In addition, the Quality Assurance Committee may commission reviews of significant clinical risks in order to receive assurance on behalf of the Board.
- (iii) The Finance and Performance Committee will review assurances on finance and operational performance against the agreed national standards and NHS Standard Contract. In addition, the Finance and Performance Committee may commission reviews of significant finance and operational risks in order to receive assurance on behalf of the Board.
- (iv) The Audit Committee will oversee and satisfy itself that the system of internal control is effective. It will receive, but not be limited to, reports and assurance from the Chairs of the Risk Management, Quality Assurance and

Finance and Performance Committees in addition to independent assurances from the Internal Audit function.

- (v) The People and Culture Committee will review assurances on the risks related to staffing, staff welfare and those risks that relate to employees and culture. In addition, the People and culture Committee may commission reviews of significant risks in order to received assurance on behalf of the board.
- (vi) The Perinatal Improvement Assurance Committee will review assurances on the risks related to maternity services and perinatal care. In addition, the Perinatal Improvement Assurance Committee may commission reviews of significant risks in order to received assurance on behalf of the board.

4.8 LTHT Risk Management Process Chart



5 Key staff and committees/ groups

Roles and Responsibilities

In order to achieve the aims of the risk management policy the following roles, accountabilities and responsibilities apply:

Specific Duties & Responsibilities

- 5.1 **Chief Executive** has overall accountability to the Board for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board's appetite for taking risk. This responsibility has been delegated to the Chief Operating Officer.
- 5.2 **Chief Operating Officer** shall chair the Risk Management Committee (RMC), a committee of the board of directors, and ensure the provision of specialist advice from local subject matter experts, or externally if required.
- 5.3 **Chief Medical Officer** - on behalf of the Chief Executive the Chief Medical Officer is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. The Chief Medical Officer is responsible for risk management policy development, establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these, and monitoring the management of risk across CSU's. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure, the Chief Medical Officer will escalate the matter to the relevant Executive Director for their immediate attention and action.
- 5.4 **All Executive, Clinical and other Directors** have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They will intervene to ensure teams within their sphere of control follow the risk management process. In addition, executive directors, clinical and all other directors will also be responsible, where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.
- 5.5 **Director of Corporate Affairs** will maintain the Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation to ensure the Board and members adhere to their statutory duties. The Director of corporate affairs will provide oversight to the reporting of information flows between the Board of Directors and its committees to assist in risk triangulation and prioritisation. The Director of corporate affairs will work closely with the Director of Transformation

in the production of the Board Assurance Framework, which will be presented in full twice-yearly to the Board for review, and in the co-ordination and effective running of the Risk Management Committee. In addition, The Director of corporate affairs will:

- collate annual declarations by the executive team and their direct reports, analyse any significant gaps in control declared and reflect all material issues when drafting the Board's Annual Governance Statement
- support the Chair of Audit Committee to ensure the Audit Committee receives assurance on the effectiveness of risk management and risks identified within the Corporate Risk Register, and to ensure this is used to inform subsequent Internal Audit priorities and rolling programme of work.

5.6 **Director of Quality** - has responsibility for the risk management process. They will report to the Chief Medical Officer for the development of the risk management policy, administration of risk management systems, oversight of risk exposures facing the business and the provision of risk management training and support to CSUs. They will be responsible for the maintenance and reporting of the Corporate Risk Register and carry out sufficient checks within and across CSUs to monitor the management of risk alongside the Board's appetite for taking risk. They will be responsible for the effectiveness of DatixWeb, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system provider, to ensure its effectiveness, validity, data quality and data completeness. The Director of Quality will take the lead in triangulating lessons for learning ensuring defects, alerts or changes in practice are conveyed to front line teams promptly. The Director of Quality is supported in the execution of this role by the Associate Medical Directors (Risk), Head of Quality Governance and the Trust Risk Manager.

5.7 **Trust Risk Manager** – reports to the Director of Quality and has day-to-day responsibility for supporting, training and providing advice to staff in the management of risk. They will oversee the effective utilisation of risk management processes across the Trust, in addition to Coroner's inquest and claims handling. They will analyse and distil risk exposures populated on DatixWeb, ensuring a clear and up-to-date picture of risk is available for the Director of Quality at all times. The Trust Risk Manager will act as central reference point for risk management issues, providing advice and challenge to ensure risks are kept under prudent control. They will assume day-to-day administrative responsibility of DatixWeb and ensure the effective provision of risk management reports.

General Duties and Responsibilities

Main Duties	Board of Directors	Executive Director	CSU Triumvirate
Strategy & Policy	- Determine the Trust's vision, mission and values - Set corporate strategy - Provide leadership	- Develop and oversee the implementation of strategic plans - Develop and communicate corporate objectives - Proactively anticipate risk - Provide leadership and guidance to employees, business partners and stakeholders	- Develop and Implement Clinical Strategy - Alignment of CSU objectives to Trust strategy
Organise	- Establish an effective risk management system - Establish and keep under review the Board's appetite for taking risk - Focus on material risk and proactive anticipation of future risk	- Develop & apply Risk Management Process - Accept and allocate ownership for risk - Share ownership for cross-enterprise risk	- Apply Risk Management Process - Accept and allocate ownership for risk - Proactively anticipate risk - Provide leadership and guidance
Plan & Control	- Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks - Decide whether or not a risk can be accepted - Simultaneously drive the business forward whilst making decisions which keep risk under prudent control	- Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success - Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations - Allocate, structure and prioritise resources within and across CSU's so that risk is managed in accordance with the Board's risk appetite.	- Design and apply controls to manage risk in line with the Board's appetite for taking risk - Prepare risk management mitigation plans - Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events - Manage resources to optimum effect - Develop policies, guidelines, procedures and standards to govern the management of risk locally
Monitor	Keep under review material risk exposures that are not accepted by the Board at each formal meeting	Challenge, support, supervise and hold colleagues to account for performance and continuous improvement	Monitor the operation of controls and address identified gaps in control
Internal Audit	- Determine Audit priorities using a risk-based approach - Take account of reports from the Audit Committee	- Determine Audit Priorities using a risk-based approach - Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues - Account for control of risk to the Audit Committee where required	- Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues - Account for control of risk to the Audit Committee where required - Undertake appropriate inspection/checks of controls for safety critical procedures
Review	- Effectively hold those responsible for managing risk to account for performance and continuous improvement. - Take decisions	Report to the Board all material risks and significant gaps in control	- Report to the Board all material risks and significant gaps in control - Escalate risk in accordance with this Policy - Ensure all risks are reviewed correctly

6 Equality and Diversity Impact

This Policy has been assessed for its impact upon equality. The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

Due to the policy being overarching in serving the purpose of setting out the Corporate risk and governance arrangements, all policies and binding procedural documents that explicitly and collectively ensure the effective control of specific risks will be expected to have undergone their own equality analysis as a fundamental part of making sure the health, safety and welfare of all patients, staff, visitors and others in contact with the Trust are not adversely affected by the activities of the Trust. Any equality implications raised as part of the equality analysis process or throughout the life of a specific policy or binding procedural document that cannot be rectified will be expected to advance through the corporate governance arrangements set out in the Risk Management Policy until such a point that they are addressed.

7 Consultation and review process

This document has been reviewed by members of the Executive Team and the Trust Risk Management Committee prior to approval.

8 Standards/ Key Performance Indicators

The following indicators shall form the Key Performance Indicators by which the effectiveness of the Risk Management Process shall be evaluated:-

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board
- A number of significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Risk Management Committee
- The risk profiles (for risks ≥ 10) for all CSUs are reviewed by the Risk Management Committee at least annually as part of a rolling programme of reviews
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and $\geq 80\%$ of risks are within review date.

Compliance with the above will be monitored by the Risk Manager, reviewed by the Director of Quality and an annual report submitted to the Risk Management Committee to inform the Annual Governance Statement.

9 Monitoring Compliance and Effectiveness

This section, using the template below, must include details of how compliance and effectiveness of implementation of the policy will be monitored. This will include monitoring for any adverse impact on different groups. This should include the role of the Policy Lead and overseeing governance group in reviewing assurance.

Where an audit is required in order to measure compliance or effectiveness, the audit should be considered for inclusion in the Trust Annual Clinical Audit Programme.

Policy element to be monitored	Standards/ Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
All verified significant risks are reported to the Board of Directors at each formal meeting of the Board	Significant Risk Report produced to every Board meeting	Review Board Minutes	Trust Risk Manager	Annual	Trust Risk Manager	Risk Management Committee
A number of significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Risk Management Committee	Each Corporate Risk reviewed at least twice every year	Monitor Committee Forward Work Plan and agendas	Trust Risk Manager	Annual	Trust Risk Manager	Risk Management Committee

The risk profiles (for risks ≥ 10) for all CSU's are reviewed by the Risk Management Committee at least annually as part of a rolling programme of reviews	Each CSU risk register reviewed at least once every year	Monitor Committee Forward Work Plan and agendas	Trust Risk Manager	Annual	Trust Risk Manager	Risk Management Committee
Local risk registers are in place, maintained and available for inspection at ward/departmental level	All CSUs and specialties to maintain a risk register	Audit of Datix risk register module system	Trust Risk Manager	Annual	CSU Triumvirate Team	Risk Management Committee
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and $\geq 80\%$ of risks are within review date	All relevant fields to be completed	Audit of Datix risk register module	Trust Risk Manager	Annual	CSU Triumvirate Team	Risk Management Committee

10 Plan for Communication and Dissemination of Policy

Title of document:	Risk Management Policy
Approving Group/Committee	Risk Management Committee Executive Directors Group
Date Approved:	June 2026

Target Audience Eg staff groups or stakeholders	Objective	Action	Person Responsible	Target date
All Staff	Ensure awareness of Risk Management Policy	Include within Executive briefings, such as Operational Update.	Director of Quality	With 1 month of Committee approval
All Staff	Ensure awareness of Risk Management Policy	Include within the following:- • Trust and local induction • Mandatory Training • Other development opportunities	Director of Quality	Continual
Head of Health and Safety	Trust Risk Manager	Publish policy - Trust intranet and Risk Management pages	Trust Risk Manager	With 1 month of Committee approval
Head of Health and Safety	Head of Health and Safety	Include Policy awareness with the Controls Assurance Programme	Head of Health and Safety	

11 References / Associated Documentation

- BSI (2008) Risk Management - Code of Practice. BS 31100:2021. London. British Standard International

APPENDIX A: RISK MANAGEMENT TOOLS

Risks may be identified proactively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:-

a) New Risk Proposal Form

A CSU/Corporate Function based New Risk Proposal Form is available for ward/departmental managers to assist them in evaluating risk at ward or departmental levels. This template may be used as an input document prior to approval and recording on the Risk Register. The template can be obtained from the Trust intranet or from the Risk Management Department.

b) Electronic Risk Register

The Risk Register is maintained by CSUs and corporate departments on DatixWeb, which provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels.

c) Risk Management Training

This document recognises that training will be required to effectively manage risks in line with the process set out above. Details of all trust training programmes are set out in the Training Needs Analysis.

- i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive updates and briefings on the risk management process. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.
- ii) All staff will receive an Introduction to the Risk Management Process briefing as part of the Corporate Induction programme.
- iii) Additional training materials are available on the Risk Management Intranet pages.
- iv) Staff designated to regularly undertake incident investigations will have the opportunity to undertake investigation skills training.

APPENDIX B: CALCULATING CURRENT RISK SCORE

Each risk can be measured by multiplying the consequence of harm and the likelihood of that harm occurring. This calculation will produce a **Risk Score** which can be applied as an **Initial Score** (before any Controls or Gaps in Control) a **Current Score** (after Controls and Gaps in Controls) and **Target Score** (where the Trust would be comfortable that the risk cannot be mitigated further). The Trust uses a standard 5 x 5 scoring matrix set out below:

CONSEQUENCE INDEX		LIKELIHOOD INDEX		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control ≥1 in 10 chance
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more CSU's; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 100 chance
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more CSU's; Service closure	3	Possible	Limited effective control ≥ 1 in 1,000 chance
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control ≥ 1 in 10,000 chance
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control >1 in 100,000 chance (or less)

Consequence

Consequence is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of consequence looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment and using relative frequency where this is appropriate.**

Differing Risk Scenarios

In most cases the highest degree of consequence (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register.**

APPENDIX C: RISK GRADING

SCORE	Incident / Risk Grade	Action Priority	Risk Registers Communicated to and overseen by
15 - 25	Catastrophic	SIGNIFICANT	Board of Directors
10-12	Major	HIGH	Clinical Director Risk Management Committee
8 - 9	Moderate	MEDIUM	Service Manager
4-6	Minor	LOW	Ward/Departmental Management
1-3	None	VERY LOW	Ward/Departmental Management

The Trust distinguishes between the severity scoring for incidents versus the scoring of prospective risks on the risk register e.g. an incident leading to a single fatality would give a severity score of 5 whereas a prospective risk of a single fatality would score 4. This is reflected in the severity indices in the Risk Scoring Matrices of the Risk Management Policy and the Incident Policy.

5X5 MATRIX

X	LIKELIHOOD					
CONSEQUENCE		1	2	3	4	5
	1	1	2	3	4	5
	2	2	2	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Checklist for the Review and Approval of Policy

LEEDS TEACHING HOSPITALS NHS TRUST

Approving Body Checklist for the Review and Approval of Trust Policy or Procedure

To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/Unsure	Comments
1.	Format and Content		
	Is it in the correct format?	YES	
	Is the staff summary clear and adequate?	YES	
	Are the intended outcomes clearly described? (the Policy/Procedure Effect)	YES	
	Is there a Definitions section giving an explanation of key terms used.	YES	
	Has the policy's impact on Equality and Diversity been fully considered?	YES	
2.	Consultation and Review		
	Has there been appropriate consultation with stakeholders and users?	YES	Risk Management Committee
	Has an appropriate governance group reviewed and supported the document prior to submission for formal approval?	YES	Risk Management Committee
	For HR Policies only, has the TCNC approved the document?	No	Not required
	If it is a clinical policy/procedure has it been reviewed by the Clinical Guidelines Group?	No	Not required
	Has it been reviewed by the counter fraud team?		
3.	Dissemination and Implementation		
	Is there a communications plan to identify how it will be communicated and implemented? The Communications Team can help you with advice.	YES	
4.	Process to Monitor Compliance and Effectiveness		
	Is there a monitoring table setting out measurable standards or KPIs together with clear monitoring and reporting mechanisms (to ensure there is assurance of implementation)	YES	
5.	Review Date		
	Is the review date in 2 years? If not is there a justified reason?	YES	

If the document needs urgent approval before all of the above are satisfactorily addressed, please bring this to the attention of the appropriate committee so conditional approval can be given.

Endorsement from appropriate group(s)

(This will vary depending on content and nature of policy)

For example, a policy relating to radiation should be considered by the radiation safety committee.

A staff policy should be reviewed by TCNC.

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Group		Date	
Group		Date	