East London NHS Foundation Trust

Risk Management Framework

Version number:	4.9 (replacing the Risk Management Strategy)
Consultation Groups	Risk Management Leads
Approved by (Sponsor Group)	Audit Committee
Ratified by:	Quality Committee
Date ratified:	22nd April 2026
Name and Job Title of author:	Risk and InPhase Manager
Executive Director lead:	Chief Nurse
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Next Review date:	Extended to May 2026

Services	**Applicable to**
Trust wide	√
Mental Health and LD	
Community Health Services	
Primary Care	

Version Control Summary

Version	Date	Author	Status	Comment
V1	January 2019	Risk and Datix Manager	Final	Replacing existing Risk Management Strategy
V2	September 2019	Risk and Datix Manager	Final	ICO Comments added
V3	March 2022	Risk and Datix Manager	Final	Updated to ensure compliance with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology
V4	July 2022	Risk and Datix Manager	Final	Update to page 17, risk assessment section and extension agreed for 6 months
4.1	October 2023		Extended	Extension agreed by the Quality Committee 18 October
4.2	January 2024		Extended	Extension agreed by the Quality Committee Jan 2024
4.3	May 2024		Extended	Extension agreed by the Quality Committee May 2024
4.4	September 2024		Extended	Extension agreed by the Quality Committee Sept 2024
4.5	November 2024		Extended	Extension agreed by the Quality Committee November 2024
4.6	February 2025		Extended	Extension agreed by the Quality Committee February 2025
4.7	July 2025		Extended	To accommodate recommendations from the Risk Register Deep Dive Report.
4.8	November 2025		Extended	Extended for 3 months whilst awaiting result of risk management audit
4.9	April 2026		Extended	Extended whilst awaiting Trust risk appetite to be agreed by the Trust Board

Contents

1. Introduction

The East London NHS Foundation Trust (ELFT) Risk Management Framework and associated policies formalises risk management responsibilities and processes within a broad corporate framework and sets out how all stakeholders may be assured that risks are identified and managed effectively. This document covers the period from January 2019 to January 2022.

The management of risk underpins the achievement of the Trust's Objectives. The Trust believes that effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in the business planning process where a more competitive and successful edge and public accountability in delivering health services is required. Risk management is the responsibility of all staff from Ward to Board.

Risk management is a fundamental part of both the operational and strategic thinking of every part of service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks. Risk management processes involve the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals to reduce the incidence and impact of the risks they face.

The Trust considers risk management to be an essential element of the entire management process and not a separate entity.

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its aims. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors/regulators and relevant legislation. The Trust will have a low threshold for risks that impact on safety and a greater appetite to take considered risks in terms of their

impact on operational and reputational issues. The Trust has the greatest appetite to pursue quality improvement and innovation and will take opportunities where positive results can be anticipated.

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. As part of this, the Trust undertakes to ensure that adequate provision of resources, including financial, personnel, training and information technology is as far as reasonably practicable, made available.

The framework has been developed to ensure that the latest guidance, best practice and recommendations from independent reviews and assessments are taken into account in the systems and processes that are in place to manage risk and strengthen assurance arrangements. It strongly reflects NHS Improvements Well Led Framework, Code of Governance and Department of Health requirements and guidance.

2. Purpose of the Risk Management Framework

This document and associated supporting processes set out systems and arrangements to enable all staff to manage risk, and includes the Trust's risk appetite statement to articulate the levels and types of risk the Trust is prepared to accept in pursuance of its objectives. This informs planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks, supporting the organisation and its staff's pursuance of its goals and opportunities, as well as the process of managing its risks.

3. Scope of the Risk Management Framework

The Risk Management Framework applies to all employees of the Trust and requires an active lead from all staff and managers at all levels. The framework and associated risk management processes include the risk management approach within the Trust which involves risk assessments, risk registers, incident management, complaints, claims and safety alerts. The framework overarches both clinical and non-clinical risk management.
This framework is supported by a range of processes including

- Trust's Quality Agenda,
- Clinical Governance and Patient Safety strategies,
- Operational and Clinical Policies and procedures,
- Health and Safety policy and procedures,

for complying with NHS Improvement, Care Quality Commission and other regulatory requirements.

4. Promoting a Fair and Open Culture

All members of staff have an important role to play in identifying, assessing and managing risk. To support staff, the Trust provides a fair, open and consistent environment and does not seek to apportion blame. In turn, this will encourage a culture and willingness to be open and honest to report any situation where things have or could go wrong. Exceptional cases may arise where there is clear evidence of wilful or gross neglect contravening the Trust's Policies and Procedures and/or gross breaches of professional codes of conduct.

5. Risk Management Objectives

The Trust Board recognise that implementation of an effective risk management framework is key to the delivery of the Trust's strategy and the development of a positive learning environment and risk aware culture. In order to achieve this, the Trust will continue to develop a co-ordinated and systematic process for risk management where:

Risk management drives change

- Improving mechanisms to ensure leadership and accountability for the implementation of risk management, with Directors actively involved in the development of local risk management strategies and being responsible for ensuring change occurs as or when risks are identified
- Local governance groups have responsibility for reviewing local risks with the Directorate management team which monitor Risk Registers.
- Risk management will support decisions for the effective use of finite resources

Risk management is systematic

- To provide a consistent, standardised approach to risk assessment both clinical and non-clinical across the Trust. This trust wide approach will be supported though the Trust's Audit Committee's roles for overseeing risk management.

Risk management is focused

- Trust-wide risk management priorities will be identified through the Governance framework to ensure that risk management maintains a core function of operational and governance committees and to ensure that mandatory national requirements are met.
- A Trust-wide risk assessment activity plan will reflect these priorities.
- The Trust-wide priorities will be incorporated into local action plans.

Staff are trained in how to undertake risk assessment

- Ongoing training programmes will be provided to ensure that new staff are aware of the Trust's Risk Management Framework on induction, and that comprehensive risk management training is available for existing staff to enable them to identify and manage risk within their own working environment.
- Risk training is aligned to key actions agreed as part of the risk reduction process.
- Risk training needs will be subject to ongoing review.
- Risk registers are used to identify the most significant risks faced by the Trust, which will influence training programmes.

Risk management is part of the culture of the organisation

- Improving mechanisms to enable increased staff awareness of their responsibilities for risk management.
- Inclusion of risk assessment for all committee papers and in all clinical policies, encouraging the reporting of risks and sharing good practice across the Trust.
- Focuses attention on learning lessons from both internal and external sources in order to improve standards of safety and reduce risk.
- A risk appetite statement will be regularly reviewed by the Board and will form the basis for communications activity

Risk management will support the Trust meet its statutory and regulatory obligations

The framework will ensure that risk management arrangements meet the requirements of regulatory bodies that directly assess the overall adequacy of the Trust's risk management arrangements including:

- Health & Safety regulations.
- Care Quality Commission essential standards;
- The Health Act 2006 and the Health and Social Care Act 2012;
- NHS Improvement's Licence and Single Oversight Framework.

6. Definitions

Risk is defined as “the chance of something happening, or a hazard being realised, that will have an impact upon objectives’’. It is measured in terms of consequence and likelihood.

Risk Management is defined as the “systematic and consistent identification, analysis, assessment and control of risks”.

Risk appetite can be defined as ‘the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives. Organisations will have different risk appetites depending on their sector, culture and objectives. A range of appetites exist for different risks and these may change over time.

Mitigating actions are individual actions which reduce the likelihood of a risk materialising or reduce the potential impact of a risk.

Controls are committees, systems, policies or people which act to minimise or reduce either the impact (consequence) or likelihood (or both) of risks. Controls may be comprised of a number of individual actions, which need to be taken together to become effective. The Trust must ensure that there are controls in place which manage identified risks. The controls in place must be documented in the Risk Register. Controls must be mapped to each of the risks identified. One specific risk may be mitigated by a number of controls. Some of these controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk. Controls are assessed regularly to determine whether there are any gaps. This will ensure that the action being taking is enough to mitigate the risks identified and agree further action if required. Mitigating actions should be identified to address gaps in control if the level of risk is deemed as unacceptable.

Assurance is an integral part of the Trust’s governance and risk management arrangements. Assurance provides the Board with the confidence that the controls (systems, policies and people in place) are operating effectively.
Assurance can be identified from a number of sources; internally, external or independent sources or a combination of all three. The Trust must record in the risk registers, all sources of assurance used to evidence that the controls in place are effective. Assurances listed on the assurance framework should be specific and clearly mapped to controls. Actions should be identified to address gaps in assurance if the level of risk is deemed as unacceptable.
Independent assurance on the effectiveness of the controls detailed in the Board Assurance Framework will be obtained by bespoke audits, commissioned from the Trust's Internal Auditors. Assurance on the effectiveness of the controls detailed in the Corporate Risk Register will be obtained through a range of internal and external sources.

Risk Registers are a tool for documenting risks, controls and actions to manage each risk. The risk register is essential to the successful management of risk.

7. Categories of Risk

The Trust is exposed to range of risks which have the potential to damage or threaten the achievement of the Trust objectives.
The categories of risk faced by the Trust include:

- **Strategic risk** is associated with the Trust’s ability to maintain its longer-term viability and the delivery of developing national and local priorities.

- **Performance risk** the ability of the Trust to deliver high quality care for patients in accordance with the Trust's business plan and the standards set by NHS Improvement, the Care Quality Commission, and Commissioners.

- **Financial risk** is a potential weakness in financial control which could result in a failure to safeguard assets, impacting adversely on the Trust's financial viability and capability for providing services.

- **Reputation risk** may occur if the organisation receives negative publicity, which impacts on public and stakeholder confidence in the organisation.

- **Operational risk** threaten the day to day delivery of clinical care and services.

- **Clinical risks** are risks whose causes or effects are primarily related to the health and wellbeing of service users or the provision of care to them. A key risk is that of clinical risk assessment and management of individual service users which feeds into the Care Programme Approach (CPA) arrangements, the outcome of which is a tailored plan of care for the service user.

- **Health and Safety Risks** are risks which potentially affect the health or safety of any person as a result of environmental or corporate factors.

- **Organisational Risks** are defined as those risks which relate to the way in which the Trust is organised, managed and governed.

- **Information Security Risks** Any breach of confidentiality/deliberate or inadvertent disclosure of person identifiable /sensitive information to those outside the ''need to know'' requirements. Loss of data – loss, theft or destruction of records held by the Trust in whatever form (paper/electronic) including cyber-crime / security.

- **Third Party Risks** to public stakeholders are managed through a formal review process with the Clinical Commissioning Group through joint actions on specific issues such as emergency planning, and through scrutiny meetings with Local Authorities.

- **Event Risks** relate to happenings outside of the control of the Trust for example environmental disasters such as floods, acts of terrorism and major epidemics.

- **Fraud and bribery risks** will be managed in line with the Government Counter Fraud Profession (GCFP) fraud risk assessment methodology, but the Trust's risk scoring matrix will be used to assess risks. An appropriate fraud risk assessment template will be used. Fraud and bribery risks will be recorded on one central Fraud Risk Assessment maintained by the Counter Fraud Team'

8. Risk Management and Corporate Governance

The Trust is required to demonstrate that it is doing ''*its reasonable best to manage risk''.* In practice this means having systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risks within the Trust.
This is achieved by ensuring that risk management and corporate governance is an integrated process through which the organisation will identify, assess, analyse and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level.
This includes:

- Integrating risk management functions into all decision making processes
- Integrating all risk management functions including patient safety, safeguarding children adults, health & safety, complaints, and litigation

- Integrating risk management functions with service developments and clinical governance activity to unify frameworks and improve outcomes for service users
- Integrating systems of risk assessment to improve clarity and communication
- Implementing a consistent approach to training, management analysis and investigation of risks and incidents.
- Using a consistent approach to populating and review Risk Registers across the Trust
- Integrating processes and decisions about risks into future business and strategic plans
- Implementing robust governance and assurance arrangements enabling the Trust to make a public declaration of compliance with risk management standards as part of the Annual Governance Statement.

9. Roles, responsibilities and accountability

This section outlines roles, responsibilities and accountability for risk management on a number of different levels:

- Governance and Risk Management Committees
- Executive Leadership
- Directorate risk responsibilities
- Specialist and Professional Support Functions

Organisational Accountability
The Board, Governance and Risk Management Committees

The Trust Board are corporately responsible for ratifying and adhering to the Risk Management Framework and for providing entrepreneurial leadership of the organisation within a framework of prudent and effective controls that provide assurance that risks are effectively identified and managed.

Audit Committee provides an independent objective opinion to the Board on whether the Trust has adequate and effective internal financial control systems in place. It receives reports and where any issues or concerns are raised, the committee reviews action plans in place to address the issues in a timely manner.

The Audit Committee is the lead committee for risk management, including oversight of the Board Assurance Framework. This is achieved by receiving reports and presentations from lead directors, and receiving reports from the Trust's internal Auditors, on the effectiveness of the Board Assurance Framework and the systems in place to enable the Chief Executive to sign off the Annual Governance Statement, and the Board to self-certify to NHS Improvement.

The Audit Committee is responsible for integrating, overseeing and directing the risk management agenda and consolidating assurances for the Trust Board that all significant risks are adequately managed.

The Audit Committee appoint independent internal auditors who will develop and deliver an annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management are in place and effective. An annual Head of Internal Audit Opinion will be presented to the Audit Committee.

The Audit Committee Chair identifies any issues that affect the work of the Quality Assurance Committee and receives the minutes of the Quality Assurance Committee. The Committee also receives minutes and an exception report from the Quality Committee.

Appointments & Remuneration Committee is statutorily responsible for identifying and appointing candidates to fill the Executive Director positions on the Board and for determining their remuneration and other conditions of service. The Committee's work includes a focus on reviewing, monitoring and scrutiny of the strategic aspects of workforce (including staff experience) risks that threaten the achievement of the Trust's objectives.

Quality Assurance Committee work focuses on reviewing, monitoring and scrutiny of all aspects of the Trust's quality governance risks, across the Trust's activities, which threaten the achievement of the Trust's Objectives.
The Quality Assurance and Audit Committees share minutes and have direct links, the Chair of the Quality Assurance Committee is a member of the Audit Committee. Internal Audit, the Director of Finance and the Director of Corporate Affairs also attend both committee meetings.

Quality Committee is responsible to the Quality Assurance Committee for developing and monitoring a Quality Strategy and integrating the processes of clinical governance and risk management.

Health, Safety and Security Committee is responsible to the Quality Committee for developing and co-ordinating the implementation of risk control plans in relation to the health and safety and welfare of staff, patients and members of the public in accordance with legislation. It is responsible for ensuring that health and safety decisions are adequately consulted upon with accredited representatives.

Directorate Governance groups provide leadership, driving the local governance agenda that includes reviewing and monitoring:

- local arrangements for risk management
- aggregated risk data
- directorate and local risk registers

They are also responsible for undertaking regular 'horizon scanning' to identify risks by looking forward to as part of the development of the Directorate and Trust Risk Registers, and to ensure effective escalation of serious risk to the relevant Executive lead.

Additional specialist committees provide assurances to the Quality Committee that clinical and non-clinical risks are being managed effectively and bring to the attention of the Committee any significant risks**.**

Safeguarding Children Committee is responsible to the Quality Committee for providing strategic direction for the Trust in relation to safeguarding children and promoting their welfare, in the context of its duties under the Children Act 1989 and Children Act 2004 and associated guidance such as *Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children* (HM Government 2006) and to provide the Trust Board with assurance that adequate controls are in place to identify and manage risk and to integrate activities relating to safeguarding children across the whole Trust healthcare governance framework.

Medicines Safety Group is responsible for reviewing and monitoring medication incidents and ensuring appropriate actions have been taken.

Infection Control Committee is responsible for developing implementing and monitoring the Trusts strategy for infection prevention and control including the development of the annual programme for infection control in line with Trust strategy for infection prevention and control.

Serious Incident Committee is responsible for providing assurance to the Quality Committee and Trust Board for the management and investigation and learning following Serious Incidents (SIs).

Information Governance Steering Group is responsible for compliance with national information standards and risks

Finance, Business and Investment Committee: is responsible for assessing risk in relation to major service developments, cash investments and financial planning and performance.

The identified committees have responsibility for overseeing the implementation of risk management arrangements, in addition there are monitoring and control decisions taken by other committees and by operational and executive directors that will ensure that all risk issues are appropriately managed.
The Board of Directors, the standing committees and sub committees will receive routine reports which detail the management of risk and resources to an agreed reporting schedule throughout each year. Examples include: financial reports, quality reports and performance reports.

The Board will also receive reports received in respect of external inspection and assessment, such as those from the Health & Safety Executive, NHS Improvement and Care Quality Commission.

Executive Leadership

The **Chief Executive** has overall responsibility for maintaining a sound system of internal control that support the achievement of the Board's policies, aim and objectives, whilst safeguarding funds and assets. This includes:

- Ensuring that the appropriate arrangements are in place to manage risks within the organisation
- Ensuring the integration of risk management and line management responsibilities
- Ensuring that the Board is aware of the most significant risks to the organisation
- Responsibility for risks relating to the external environment and partnerships
- Signing the Annual Governance Statement (AGS) in the annual report and accounts on behalf of the Board.

The **Director of Performance and Planning** supports the Chief Executive in the role as the Accounting Officer of the organisation and has responsibility for risk in relation to corporate and integrated governance, compliance and annual planning. The post holder supports the Chief Nurse and Chief Medical Officer to discharge their executive director responsibilities.

The Director of Performance and Planning is the lead Director for corporate governance in the Trust. This portfolio also includes delegated responsibility for information governance and ensuring compliance with relevant legislation and standards, as well as the Mental Health Act and legal affairs. The implementation and development of the risk management arrangements is an integral part of the assurance agenda to ensure that risk management structures are effective.

Day-to-day responsibility for risk management is discharged through the designated accountability of other executive directors:

The **Chief Nurse** is the executive lead for aspects of clinical governance, including patient involvement, quality and safeguarding and has line management responsibility for the Governance and Risk Department. This portfolio also includes delegated responsibility for**,** business continuity and emergency planning and ensuring compliance with relevant Health and Safety legislation and standards.

The **Chief Medical Officer** is the executive lead for quality, and is responsible for the professional standards of medical staff within the Trust, including the appraisal system for doctors, as well as leading on Healthcare Acquired Infections, patient safety, clinical risk and serious incidents.

The **Chief Finance Officer** has delegated responsibility for risks associated with the management, development implementation of systems of financial risk management and corporate governance including systems of internal control and assurance.

The **Chief Operating Officer** has delegated responsibility for risk associated with operational management, including organisational change, for emergency planning and business continuity. This portfolio includes delegated responsibility ensuring compliance with relevant Health and Safety legislation and standards.

Director of Commercial Development has responsibility for the performance framework and risks relating to commercial and business development.

Chief Quality Officer has delegated responsibility for leading the organisations quality system which includes the Trust's Quality Improvement Programme.

Director of Human Resources has delegated responsibility for risk associated with the delivery of effective Human Resources including workforce planning, staff welfare, recruitment and retention.

Director of Estates and Facilities has the overall responsibility for the management of environmental risks, including fire, assets and equipment.

Chief Information Officer has delegated responsibility for the risks associated with management, development and the implementation of systems of IT, the management of IT infrastructure and system security and IT business continuity.

Caldicott Guardian is responsible for ensuring the Trust satisfies the highest practical standards for handling patient identifiable information. The champion for confidentiality issues at Board/management team level, and acts as both the 'conscience' and enabler for appropriate information sharing. The Caldicott Guardian is central to the confidentiality and Data Protection assurance function ensuring that the confidentiality risks are appropriately reflected in Trust strategies, policies and working procedures for staff. In addition overseeing all arrangements protocols and procedures where confidential information may be shared with external bodies.

Non-Executive Directors of the Trust: the Trust Chair and Non-Executive Directors exercise non-executive responsibility for the promotion of Risk Management through participation in the Trust Board and its Committees. They are responsible for scrutinising systems of governance and have a particular role in this Trust for chairing the Audit Committee, the Quality Assurance Committee, the Appointments and Remuneration Committee and the Finance, Business and Investment Committee.

Operational responsibility

All Directors including Service Directors/Directorate Managers /Clinical Directors are responsible to the Executive Director and the Chief Executive for overall risk management within their designated areas. This includes ensuring that the work of departments and services within their executive remits including:

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities. These processes should be both reactive e.g. as a result of an adverse event, or proactive e.g. risks associated with the achievement of directorate plan objectives.
- Implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility.
- Maintaining the Directorate Risk Register identifying overarching risks both clinical and non-clinical, which may cause harm to individuals, the environment, impact on activity, loss of reputation, jeopardise the strategic objectives. This responsibility may be delegated to an agreed Directorate governance co-ordinator/ manager.
- Escalating high risks and/or where the level of risk warrants reporting to an external body, and highlight to the appropriate Executive Director, in order to agree decisions about subsequent management of the risk.

- Ensuring that all local policies, procedures and guidelines follow the approach to risk managed describes in this strategy, and when indicated undertake local risk assessments in line with those policies and procedures
- Ensuring that staff whom they manage receives information and training to enable them to work safely and to comply with the Trust's internal control systems. These responsibilities extend to any one affected by the Trust's operations including patients (for both mental health and community health services), sub-contractors, members of the public, visitors etc.

Specialist Roles & Responsibilities for Risk Management

There is a number of staff who have specialist responsibilities in relation to risk management including:

Associate Director of Risk and Governance leads the Trust's Risk and Governance Department which includes complaints and incident management, health, safety and security, emergency planning and business continuity. The role reports to, and supports, the Chief Nurse.

The Associate Director of Information Governance is the Data Protection Officer and responsible for managing data protection issues throughout the Trust. A Data Protection Officer is a legal requirement under Article 37 of the General Data Protection Regulation. The Data Protection Officer monitors internal compliance with data protection matters, provides advice and information on data protection obligations, acts as a contact point for data subjects and the Information Commissioner's Office. The Data Protection Officer is independent and has direct communication with the Board

Associate Director for Safeguarding Children is responsible for promoting a co-ordinated approach to implementing relevant national guidelines and standards in respect to safeguarding children.

Associate Director Domestic abuse and Safeguarding Adults is responsible for promoting and implementing relevant national guidelines and standards in respect of safeguarding adults.

Lead Nurse for Infection Control and Physical Health is accountable to the Trust Lead for infection prevention and control (Medical Director) for providing advice to all grades of staff on the prevention and management of infection control risks.

Associate Director for Legal Affairs is responsible for co-ordinating claims and inquests

Associate Director for Mental Health Law is responsible for compliance with the mental health act legislation.

Senior Information Risk Owner (SIRO) is responsible for information risks.

Data Protection Officer (DPO) is responsible for data protect and confidentiality

Health Safety and Security Manager is responsible for policy development and implementation and providing professional advice in respect of health, safety and security management to reduce risk in line with national policy and relevant legislation, and creating an environment of continuous quality improvement and development. The Health Safety and Security Manager is also the name local security management specialist.

Line Managers/Heads of Department/Matrons are responsible for the implementation of risk management policies including:

- Ensuring the local risk registers are in place, regularly updated and effectively utilised

- Ensuring that all incidents are properly documented including incident investigations and that corrective action is taken and learning is shared.

- Ensuring that risk assessments are undertaken either proactively or as a result of an incident

- Ensuring that Staff have access to and receive appropriate training in identifying and managing risk

All Employees including bank, agency staff and contractors have personal responsibility to contribute to the effective management of risk by:

- Complying with policies, protocols and procedures
- Attending training as required
- Reporting incidents/accidents and near misses and assisting in the identification of risks in their day – to day work
- Being aware of emergency procedures e.g. fire evacuation precautions and resuscitation relating to their particular directorate .departmental locations
- Be aware of existing risks assessments related to their area of work and relevant procedures or control measures to be adopted to reduce identified risks
- Recognise their duty under legislation to take reasonable care for their own safety and the safety of all others that may be affected by their actions or inaction
- Comply with all Trust rules, regulations and instructions to protect the health, safety and welfare of anyone affected by the Trust's business
- Neither intentionally, nor recklessly, interferes with or misuse or fail to use when required, any equipment provided for the protection of safety and health, and with the requirements of the appropriate professional body

10. Responsible Risk Taking

The Trust acknowledges that the delivery of healthcare can never be risk free and that taking decisions about risk and opportunity is a part of everyday clinical and non-clinical practice and management. It also recognises that staff are often faced with difficult dilemmas for which there is no single or simple solution, and there are situations where staff, service users and carers need to take opportunities which may carry a risk of an adverse outcome, and that not every decision or action taken has a successful or expected outcome. The Trust Board supports the right and need for these decisions to be made.
Reducing risk in all situations can be best achieved by adherence to the tenets of good professional practice, and though the responsible use of frameworks for safer practice and services, for staff and users, through adherence to sensible, transparent and practical policy, procedure and protocol, and to legislative requirements.

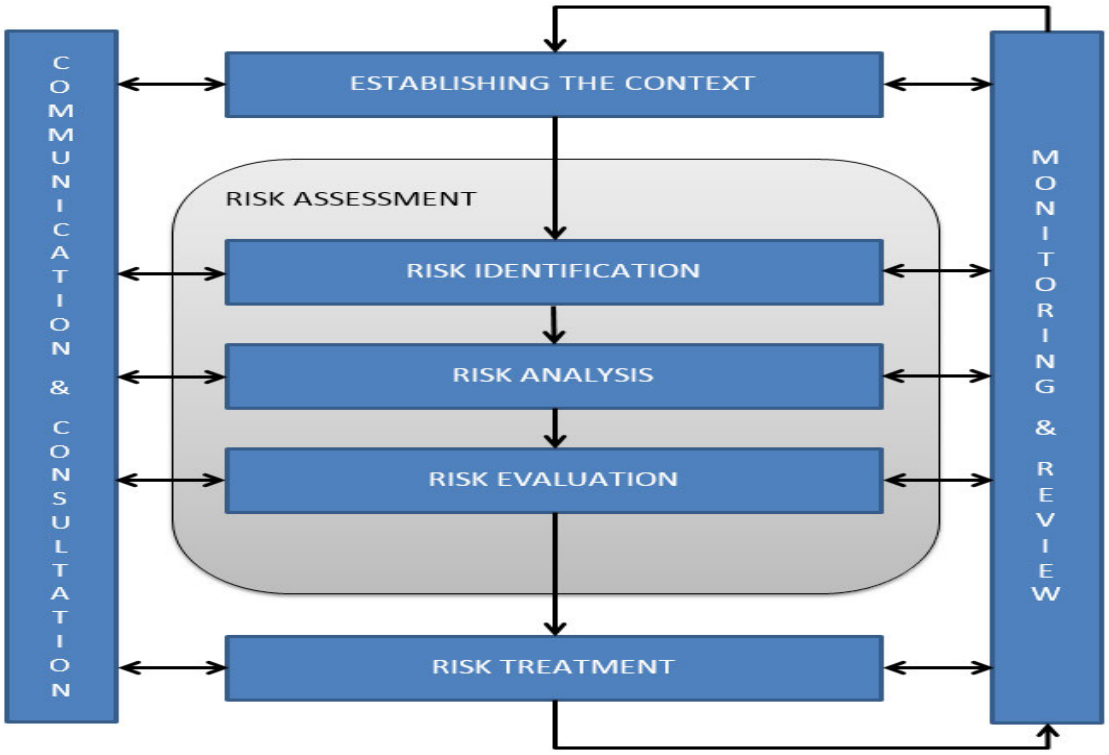
11. Risk Appetite and Statement

Is defined as "*the amount of risk than an organisation is prepared to accept, tolerate, or be exposed to at any point in time*" (HM Treasury Orange Book). The aim of the Trust's risk appetite statement is to articulate the levels and types of risk the Trust is prepared to accept in pursuance of its objectives. This then informs planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks

"The Trust recognises that its long-term sustainability depends on the delivery of its strategic objectives and, its relationships with service users and families, the public and strategic partners. Patient and staff safety is paramount however such risks have to be tolerated within specific boundaries. Risks which impact on regulatory compliance and reputation will not be accepted and will be managed through robust risk

management mechanisms. The Trust recognises the challenging business environment in which it operates and will tolerate increased risk to achieve innovation and excellence."

12. The Risk Management Process



ISO 31000 Process Diagram

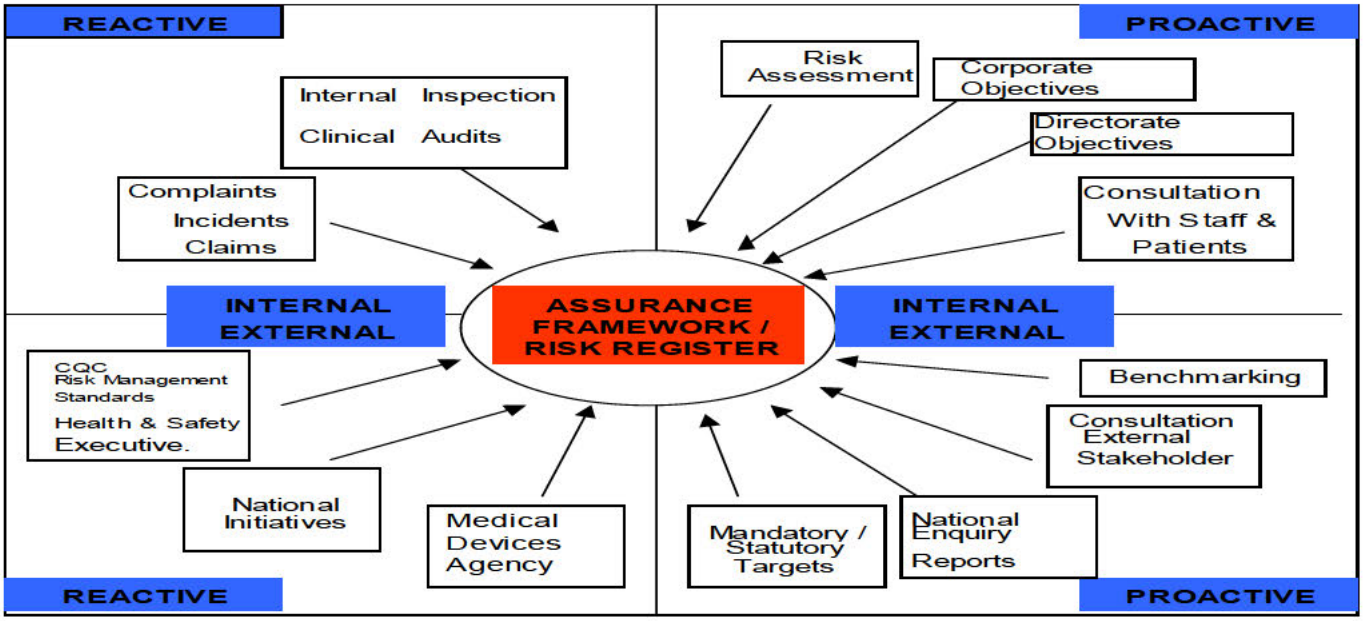
In practice this is achieved through the following processes:

Identification and management of risk

Sources of information used are Reactive (something that has happened) and Proactive (something that might happen) to identify risks and gaps in assurance. e.g. complaints, incident reports; claims; audit; risk assessments; patient surveys; waiting list trends; staff recruitment/retention trends; and performance information should be used as information to identify risks and potential risks to the Trust.

Trends between incidents, claims, complaints and outcomes from clinical audit to be identified and risk assessed. Potential threats to the organisation will only be considered to be risks if they can have a negative impact on achievements of the organisations objectives.

The chart below identifies the various sources of information which will be used to identify risk.

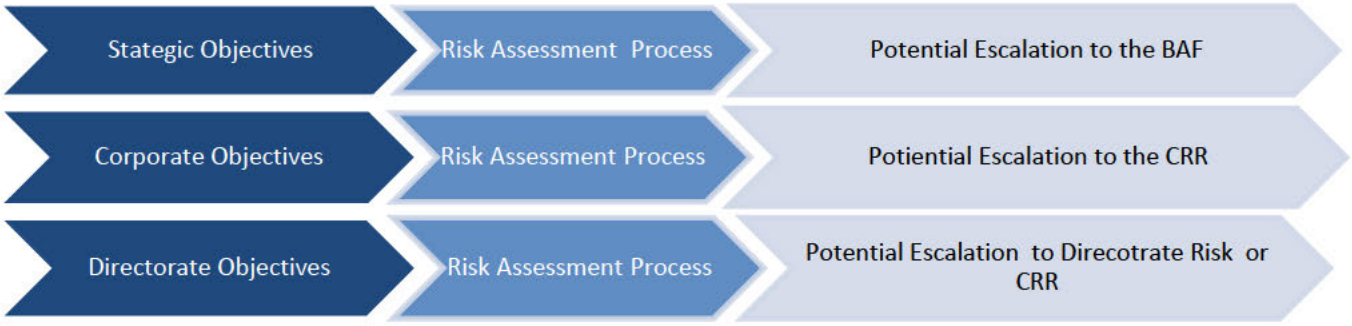


Risk Assessment

The Trust will identify, assess, prioritise and record risks through a variety of systems both internal and external. The review of risks and current control measures will enable risks to be prioritised to enable the Trust to determine the degree of risk that the Trust will accept.

Local teams are responsible for assessing clinical, environmental, financial and performance related risks against the area for which they are responsible. Where risks are identified, an action plan must be implemented and monitored through local governance arrangements. Where risks cannot be managed or responded to locally, the risk should be escalated through the management line to the Directorate management team meeting/ governance groups, and consideration should be given as to whether they should be added to the Risk Register. The Trust provides a training programme to support this approach

The Trust will proactively identify risks each year through reviewing our strategic, corporate and directorate objectives. Strategic, corporate and directorate objectives will be systematically risk assessed and outcomes recorded on the appropriate risk register.



In addition the Trust risk manager will be notified of causes of concern and potential risks identified at Board and delegated committees which require a risk assessment. The action will be noted in the meeting minutes; the Committee Chair will be responsible for notifying the Trust risk manager.

Topic based risk assessments will also be carried out in specific areas such as Health & Safety, Safeguarding, Control of infection, finance and fraud and bribery using specialized risk assessment templates and criteria. Specific policies and procedures for many high-risk areas also detail how effective risk assessment can be carried out.

The generic risk assessment template is attached at **Appendix 2.** The risk scores are based on the Trust risk matrix (a standard 5x5 matrix) **Appendix 1**. Risk assessments can be undertaken and recorded directly to the service / directorate risk register which clearly reflects the criteria of the risk assessment template.

Risk Registers

Local/ Team / Service risk registers / Specialist Risk Registers

Each service is required to develop a local risk register. These registers will include identified risks related to operational issues that are identified through both proactive risk assessments (i.e. environmental risk assessments) and reactively through incident reporting and other clinical governance activity. These will feed up to the directorate risk register through local team meetings and supervision or specialist committees.

Directorate Risk Registers

Individual Directorates are required to develop a Risk Register. These registers will include identified risks related to both strategic and local objectives including patient safety and quality, key performance targets, as well as departmental/ local risks of high rating or above. Actions required to mitigate risks should be identified within both the directorate risk register and the directorate service plan.

Directorate risk registers should be formally updated on a quarterly basis and reported to the Directorate Management Team meeting. The meeting will consider whether all relevant risks have been identified, adding additional risks as necessary, validate current risk ratings and review progress of actions and action plans focusing on red risks. Red rated risks will be reported to the Service Delivery Board via the Corporate Risk Register.

Directorate Risk Registers will be submitted to the Director of Performance and Planning on a quarterly basis as part of the performance review process for scrutiny, review of progress against actions and escalation of major issues.

Corporate Risk Register (CRR)

The Corporate Risk Register is a live document which identifies risks.

- To achieving the Corporate Objectives.
- Red rated risks escalated from Directorate risk registers (following review and moderation via Directorate Management Teams)
- Red rated risks from corporate functions.

The Service Development Board will receive the CRR bi-monthly.

In addition risks identified for potential escalation to the CRR will reviewed by the Chief Nurse, Director of Performance and Planning and Trust Risk Manager for scrutiny and moderation to ensure a consistent approach on a monthly basis.

The template for all risk registers is set out in Appendix 3

The Board Assurance Framework (BAF)

The BAF is a statutory requirement and incorporates a register of the Extreme risks faced by the Trust in meeting its principal and strategic objectives. It provides the Trust with a comprehensive method of describing the organisation's objectives, identifying the key risks to their achievement and the gaps in assurances on which the Board relies.

The BAF is developed by identifying the principal risks that may threaten the achievement of the Trust's strategic objectives and is revised annually as part of the development of the Trust's Annual Plan. The Executive Director of Performance and Planning with the Executive Management Team will identify and analyse key risks for each strategic objective. As part of the this process the Trust Board will review risks set out in the previous year's BAF for carry forward or de-escalation from the BAF.

The BAF will include the following information:

- details of the key controls in place to mitigate identified risks
- assurances that those controls operate effectively
- gaps in controls and/or assurances
- key performance indicators/outcome measures
- Mitigating actions.
- The risk (risk score) based on the Trust's risk matrix.

The draft BAF is submitted to the Audit Committee for approval and is reviewed at each meeting. The BAF risks will be presented to the Trust Board on as part of the performance report on a quarterly basis and in the intervening months the Board will receive an exception report on all red rated risks. The BAF is also received by the Executive Team.

In addition, other Board sub-committees will review risks relevant to their terms of reference and monitoring is undertaken by the Audit committee. The key risks and actions to mitigate the risks, target date for achievement of actions and a summary statement, drive and shape the Trust Board agenda.

It is a requirement for all risks to be explicitly identified, and graded as part of any business case presented to the Finance Business and Investment Committee (FBIC), the Service Delivery Board and in the papers seeking support for decisions which go before the Trust Board

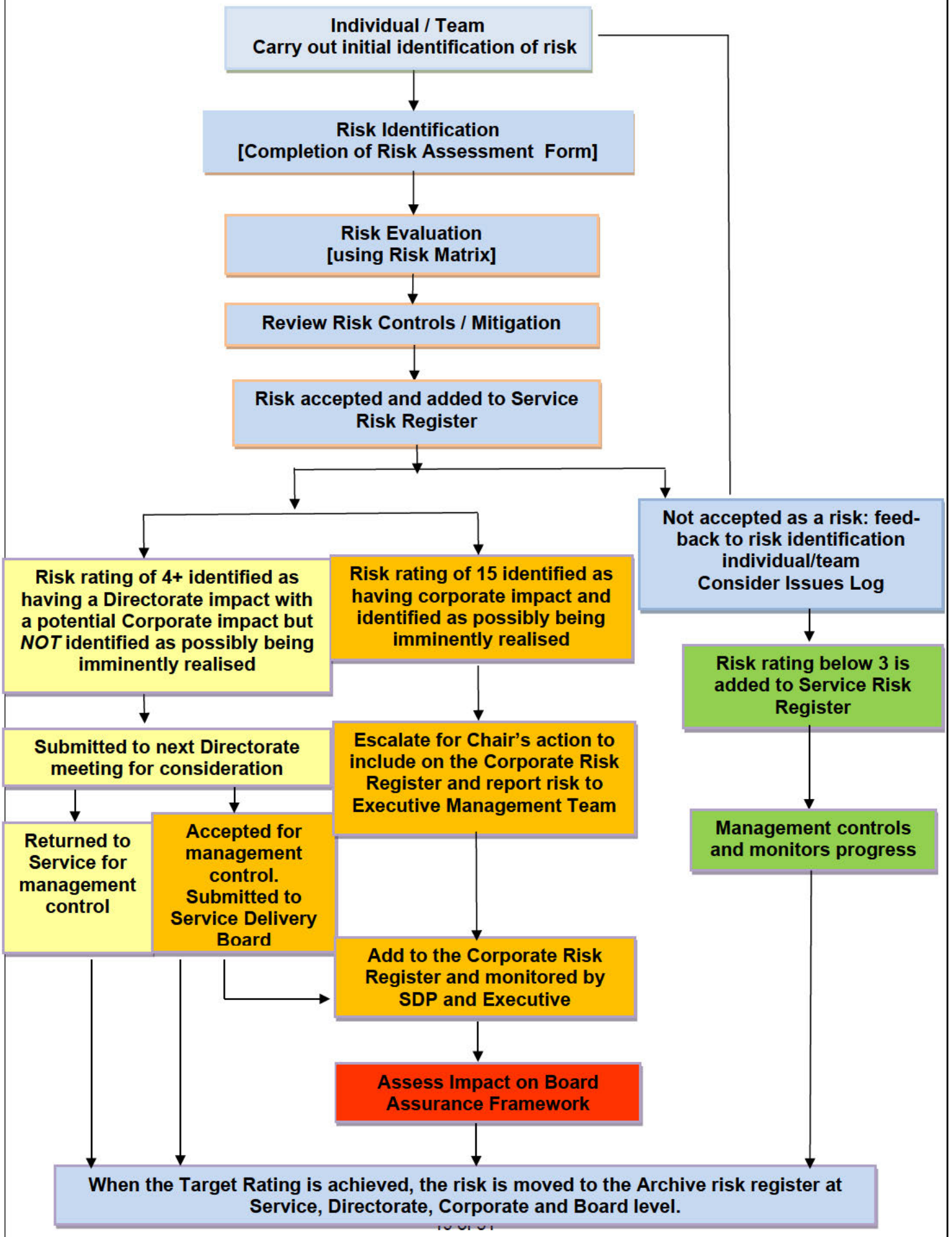
If at any time, performance reporting and risk management processes indicate that the Trust will not meet a current essential standard or target, and then the Trust Board will notify NHS Improvement via the exception reporting procedure.

The BAF template is set out at Appendix 4.

Business continuity

There may be occasions where the failure of an individual service, or the occurrence of an individual incident, leads to widespread disruption of our services and/or those provided by to the local health economy. Such incidents may disrupt the ability of the Trust to provide key services and potentially impact on the ability of the Trust to meet its objectives. To limit the impact and risk of any disruption, the Trust continues to develop robust contingency planning arrangements as part of our strategy. These arrangements will need to be embedded within all directorates, in conjunction with relevant associated organisations.

Risk Identification, Assessment & Reporting Process



13. Learning lessons from Risk Management

The Risk Management Framework will be used as a platform to drive organisational learning and feedback on the lessons learned through risk management and feedback on the lessons learned from the identification and management of risk.

The Trust operates a system to support risk management activities it is used to store data on incident reporting and management, complaints, claims and risks.

In addition, the Trust reports all patient safety incidents to the National Reporting and Learning System (NRLS), and uses the reports produced by the NRLS, for both benchmarking and learning.
Organisational learning and feedback will also be supported and informed by:

- Data provided by the risk management system for different functions and areas of the Trust.
- Regular meetings with Directorate managers will also be maintained in order to provide an opportunity to explore issues arising from local Risk Registers and to support appropriate action within the directorates.
- Regular Governance reports to the Quality Committee
- Regular reports to the Trust Board, for information and dissemination as appropriate
- Tailored reports for different groups within the Healthcare Governance framework, Directorate governance groups, for dissemination as appropriate
- The ad- hoc production of reports as required or requested
- Placement of reports on the Trust Intranet, for access by all staff
- Seminars to discuss issues raised by incidents known to be of Trust – wide concerns

14. Training

The Trust has conducted a Training Needs Analysis (TNA) to consider training requirements. The TNA is updated periodically by the Trust and approved by the Quality Committee. Full details of the training schedule, details of delivery of the training, booking arrangements and following up of staff who do not attend are to be found in the Trust Learning and Development Policy and associated Training Matrix.

15. Audit

Internal audit will carry out an annual audit of the Trust's risk management systems. The report and the accompanying action plan will be submitted to the Audit Committee within 6 weeks of completion of the audit. The Audit Committee will monitor completion of the action plan.

16. Monitoring the Implementation and Effectiveness of the Risk Management Framework

The implementation objectives are to:

- Raise awareness and develop a culture where all risks are identified, understood and managed;
- Ensure an appropriate system and organisational structure is in place for identification and control of key risks;
- Provide assurance that key processes are in place to provide reliable information and to make appropriate decisions; and
- Embed risk assessment and risk management into all our activities, including day to day and future ongoing management of the Trust.

The Framework will be supported by a detailed implementation plan and progress reports on a bi-annually to the Audit Committee.

The framework will be available, both internally and externally stakeholders, via a range of communication avenues including:

- Trust Intranet and internet
- Cascade through communications bulletins , Directors/Governance Groups
- Governance and Risk related training programmes

The effectiveness of the Risk Management Framework will be monitored through the following key performance indicators set out below.

INDICATOR	COMPLIANCE RATE	MEASUREMENT	REVIEW /AUDIT PERIOD	MONITORING COMMITTEE
Directorate Risk Registers reviewed in the last quarter by DMT.	100%	Risk Register	Quarterly	Assurance Committee
The Board Assurance Framework is submitted to, and discussed at the Audit Committee at each meeting	100%	Audit Committee minutes	Quarterly	Audit Committee
The Board Assurance Framework is amended appropriately by Lead Directors.	100%	Audit Committee minutes	Quarterly	Audit Committee
Risk management Policies are reviewed in accordance with review timescales	100%	Policy database	Annually	Quality Committee
Compliance with CQC essential standards	100%	Trust Board reports	As required	Assurance Committee
Internal Audit opinion on the effectiveness of risk management arrangements to inform the AGS	Acceptable level of Assurance	Audit Committee reports	Annually	Audit Committee

The Risk Management Framework will be reviewed every three years or as required to incorporate best practice or new mandatory requirements.

References

ISO31000
Care Quality Commission Essential Standards of Quality & Safety
Health and Social Care Act 2012
NHS Foundation Trusts Code of Governance 2006
NHS Improvement Single Oversight Framework 2016
Corporate Manslaughter Act 2008
NHSI Well Led Framework

17. Glossary

Acceptable Risk: The maximum score associated with a specific risk that the Trust is willing to tolerate.

Accident: An unintended event or series of events that result in death, injury, loss or environmental damage.

Adverse Event: An undesired outcome that may or may not be the result of error.

Board Assurance Framework: A register of significant risks mapped to the principal objectives and monitored by the Trust Board

Consequence: Outcome or impact of an event.

Control: An existing process, policy, device, practice, barrier or other action or device that acts to minimise negative risk and enhance positive opportunities.

Corporate Risk Register: A scored list of clinical, organisational, financial and strategic risks to the organisation, identified by the Executive Directors, by sub-committees of the Board or by processes of assurance. Controls and assurances in relation to these risks are also set out in the Corporate RR.

Hazard: A source of potential harm.

Incident: An incident is any occurrence which gives rise to, (or, in the case of a near miss narrowly avoids giving rise to), unexpected or unwanted effects involving the safety or wellbeing of any person on Trust premises or employed by the Trust. It also refers to the loss of or damage to property, records or equipment that is on Trust premises or belongs to the Trust. The term therefore includes accidents, clinical incidents, security and confidentiality breaches, violence, and any other category of event, which does or could result in harm. It also includes failures of medical or other equipment

Likelihood: Used as a general description of probability or frequency.

Residual Risk: Risk remaining after implementation of risk treatment.

Risk: The likelihood that an adverse outcome will arise from a given situation.

Risk Acceptance: An informed decision to accept the identified consequences and likelihood of a particular risk.

Risk Analysis: A systematic process to understand the nature of, and deduce the level of, risk.

Risk Assessment: The overall process of risk identification, risk analysis and risk evaluation.

Risk Avoidance: A decision not to become involved in, or to withdraw from, a risk situation.

Risk Evaluation: Process of comparing the level of risk against risk criteria.

Risk Exposure: The level of risk that an organisation or process or project is exposed to.

Risk Identification: This is the process of determining what, where, when, why and how something could happen.

Risk Management: The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects.

Risk Management Process: The systematic application of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.

Risk Reduction: Actions taken to lessen the likelihood, negative consequences or both associated with risk.

Risk Treatment: Process of selection and implementation of measures to modify risk (avoiding, modifying, sharing and retaining).

Service User: A person who is using services provided by the Trust.

Stakeholders: Those people and organisations who may affect, be affected by, or perceive themselves to be affected by a decision, activity or risk.

The Trust: East London NHS Foundation Trust

Appendix 1 Risk Grading Matrix

Instructions for use:

1. Define the risk(s) explicitly in terms of effect of the risk on achieving an objective
2. Use the descriptors below to determine the consequence score (s) for the potential outcome of the risk occurring).
3. Use the descriptors to determine the likelihood score(s) for the adverse outcome occurring.
4. Calculate the risk score the risk **multiplying** the consequence by the likelihood = risk score.
5. Identify the level at which the risk will be managed in the organisation, based on the risk matrix and escalation detailed below
6. Include the risk in the risk register at the appropriate level.

RISK SCORE MATRIX DEFINITIONS

Table 1 Severity/Consequence scores

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Severity/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
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	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Poor staff attendance for mandatory/key training	Very low staff morale No staff attending mandatory/ key training	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

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 **(i.e. 1 in 100 years)** <1%	Do not expect it to happen/recur but it is possible it may do so (i.e. 1 in 10 years) <10%	Might happen or recur occasionally (i.e. 1 in 1 year) < 20%	Will probably happen/recur but it is not a persisting issue (i.e. 1 in 1 month) <40%	Will undoubtedly happen/recur, possibly frequently (i.e. 1 in 4 days) <75%

Risk Grading Matrix					
Likelihood/ Frequency ↓	**Consequence/Impact →**				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	Moderate 5	High 10	Extreme 15	Extreme 20	Extreme 25
Likely 4	Moderate 4	Moderate 8	High 12	Extreme 16	Extreme 20
Possible 3	Low 3	Moderate 6	High 9	High 12	Extreme 15
Unlikely 2	Low 2	Moderate 4	Moderate 6	Moderate 8	High 10
Rare 1	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Appendix 2 Risk Assessment Template

GENERIC RISK ASSESSMENT

GUIDE TO COMPLETING THE FORM

Current Position

Risk Description

- Identify the nature of a hazard/risk
- Identify and specify those at risk, i.e. staff members, service users, visitors/contractors/members of the public
- Identify the possible outcome of an incident, i.e. level of injury, loss of life, impact on service delivery

Current Controls

- Detail the existing controls / practices / procedures in place to reduce the identified risk i.e. training, policy or procedures

Current Risk Rating

- Quantify the risk (1 – 5) to both the Consequence (C) and Likelihood (L) columns, using the Risk scoring Matrix. Multiply the two scores together to give the overall Risk Rating (RR). e.g. (C) **3** x (L) **2** = (RR) **6**

Going forward

Further Action Required

- Add any additional controls/measures/processes /actions that are required to reduce the risk. Actions should reduce to the risk to an acceptable level.

Target Date for Completing Further Action/Review Date Following Further Action Implementation

- Insert date for completing actions identified in the Further Action Required section and a suitable date for reviewing the action following completion of the Further Action.

Responsible Person

- Insert the name of the person responsible for the identified action

Target Risk Rating

- Taking into account the new control measures add a numeric score to the Likelihood column as in the Current Risk Rating section. The consequence score will normally be unaffected and remain the same as in the Current Risk Rating Section. Multiply the two scores together to give the target risk scoring.

NEXT STEPS

1. Share your completed risk assessment with your Manager / Service Director / Director for approval.

2. Upon completion and approval of the form it must be logged in the originating department.

3. Share, action, discuss and review at local team meeting as necessary

4. Retain and update risk assessment once approved by Director. It is your responsibility to review the assessment annually as a minimum. However, in the event of any changes that affect the identified risk, the risk assessment should be reviewed and updated as required and the details added to the Review section at the bottom of the form.

5. All high risks should by escalated to the appropriate manager at the earliest opportunity

GRADING

Acceptable Risk
Minor risk (Green): Risks scored between 1 and 3 will be considered 'acceptable risk'. On or below this level a risk is acceptable however existing controls should be monitored locally within Directorates and local Governance groups and adjusted regularly. No further action or additional controls are required.

Unacceptable risk
Moderate and High (Yellow and Amber): Risks scored between 4 to12 will be considered 'moderate or high. Immediate action must be taken to manage the risk and entered on the Service Risk Register and considered for escalation to the Directorate Risk Register via local team meetings and supervision. Control measures should be put in place, which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required. Resources may have to be allocated to reduce the risk.

Extreme Risks (Red); Risks scored between15 to 25 escalated to Directorate Risk Registers will be considered for escalation to the Corporate Risk Register or BAF. Notification takes place through submission of the Directorate Risk Registers to the SDB. Control measures should be put in place, which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required. Significant resources may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be undertaken.

RISK ASSESSMENT TITLE:			
NAME & TITLE OF PERSON COMPLETING ASSESSMENT:		**DIRECTORATE:**	
WARD/ UNIT/TEAM:		**ASSESSMENT APPROVED BY :**	
SERVICE:		**SERVICE DIRECTOR APPROVAL:**	
DATE OF ASSESSMENT:		**If relevant, name of person being assessed:**	

CURRENT POSITION					**GOING FORWARD**						
RISK DESCRIPTION • *Identify the task hazard / risk* • *Identify who may be affected* • *What is the possible outcome / impact?*	**CURRENT CONTROLS** *What current controls are in place to mitigate the risk?*	**CURRENT RISK RATING** (*Consequence x Likelihood*)			**FURTHER ACTION REQUIRED** • *What additional controls / measures can be introduced?* • *What actions will be taken to further mitigate the risk?*	**TARGET DATE FOR COMPLETING FURTHER ACTION**	**REVIEW DATE FOLLOWING FURTHER ACTION IMPLEMENTATION**	**RESPONSIBLE PERSON**	**TARGET RISK RATING** (Consequence x Likelihood) *Note: Consequence score remains as in the Current Risk Rating column*		
		C	**L**	**RR**					**C**	**L**	**RR**

Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	
Review Date		**Assessment Approved by: (Name and post held)**		**Date:**	

Appendix 3 Risk Register Template

Objective	Risk Ref	Risk Description	Initial Risk Score			Controls	Assurance	Current Risk Score			Gaps in Control / Gaps in Assurance	Mitigating Actions			Target Risk Score			Status
			C	L	RR			C	L	RR		Action	Lead	Due Date	C	L	RR	

Appendix 4 BAF template

BAF Risk no.		**Source**		**Associated BAF Risks**	
Strategic Outcome					
Risk Description					
Executive lead		**Lead Committee**			
Change since last review					

Risk Score					
Consequence x Likelihood	**Initial Score**	**Controls (CTL)**	**Current Score**	**Assurance (Assure)**	**Target Score**

Actions (to address gaps in Controls and/or Assurance which enables risk reduction to Target score)					
No.	**GAP**	**Action**	**Due date**	**Responsible Person**	**Progress/ Status**

Executive Commentary