

Corporate Risk Management and Escalation Framework

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Purpose of the Policy:	To provide a robust organisational risk management and escalation framework to ensure the safe, sufficient and effective management of all organisational risks.



Signed on behalf of the Trust:

Anna Hills, Chief Executive Officer

Version Control Page

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2.0	Jan 2009	ASP Head of Risk	Policy ratified by the Trust Board.
3.0	Feb 2011	Head of IG and Risk Manager	Policy updated to reflect new governance structure and key priorities.
4.0	Oct 2012	Director of Service Improvement and AD-Performance, Information and Audit	Policy updated to reflect new governance structure and risk appetite as agreed by the Board.
4.1	Nov 2013	Director of Service Improvement and AD-Performance, Information and Audit	Policy updated to reflect new appetite escalation.
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RISK MANAGEMENT AND ESCALATION FRAMEWORK

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RISK MANAGEMENT AND ESCALATION FRAMEWORK

1. PURPOSE

This document describes the organisational framework for managing, monitoring and escalating risks throughout the organisation, ensuring there is robust and appropriate identification, scrutiny and mitigation at all levels.

2. RISK MANAGEMENT OVERVIEW

- 2.1 By its very nature healthcare is a high-risk activity and effective management is often based on taking calculated risks. Risk management helps to ensure that judgements can be made from a measured range of fully identified options and from a sound knowledge of the risk causes, effects, and consequences.
- 2.2 Effective risk management is best achieved in an environment of openness and transparency in which it is recognised that whilst risk can never be eliminated, it can and must be managed.
- 2.3 The Trust Board has delegated the responsibility for the management of risk to key committees. These Committees are responsible for ensuring individual Directors undertake a full programme of risk management activities, maintain up-to-date risk registers and take action to control risks in line with risk management responsibilities. Each Committee has Terms of Reference which have been agreed by the Board.
- 2.4 Risk management is additionally monitored by external and internal agencies (e.g. CQC, NHS Improvement). Performance is monitored against national standards and is subject to self-assessment review and audit. Where performance in these assessments falls below acceptable levels, detailed action plans will be developed, and work programmes put in place to improve practice.
- 2.5 There are a number of indicators which support the implementation of the Trusts Risk Management Framework, for example; adverse incidents, complaints, claims and litigation. Quality and safety activity reports are presented to the Trust Board and Performance Risk Executive (PRE) on a monthly basis, and to the Quality Safety and Governance (QSG) Committee on a quarterly basis. The Serious Incident Group (SIG) meets on a weekly basis and oversees all adverse incidents. Health and safety, moving and handling, RIDDOR and ligature incident and activity reports are presented to the Risk Reduction Group (RRG) on a bi-monthly frequency, with exception reporting to the Quality Compliance Executive (QCE).
- 2.6 The process for managing incidents is provided in the Trust Incident Management including Serious Incidents and Near Misses Policy, available on the Trust website.
- 2.7 The Trust approach to investigating and learning from incidents focuses on what went wrong and not on who to blame. However, should staff have a concern or feel unable to report an incident via the incident reporting system, they should

follow the Freedom to Speak Up (Raising Concerns) Policy, available on the Trust website.

3. INTRODUCTION

The Risk Management Framework outlines the Trust values and strategic priorities against which the key risks are identified and monitored. The framework sets out key priorities for management of those risks and the performance measures by which the Trust will assess and assure itself on how successful it is in managing risks.

The Risk Management Framework should be read in conjunction with:

Risk Assessment Policy – a document setting out in detail the process for identifying, assessing, controlling, monitoring and reviewing risks.

Health and Safety Policy - describes the Trust's responsibility for ensuring the health, safety and welfare of its employees and others who may be affected by its activities. The Trust requires all employees to equally accept their responsibilities as part of the development of a true safety culture. The Trust aims to ensure the achievement of high standards in relation to the provision of its health and safety arrangements.

Safety Alert Procedure – a document which describes the framework used to receive, escalate and action all patient safety alerts received, alongwith individual responsibility.

Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity (BC) Strategy and Framework - sets out the Trust framework for declaring, responding, managing and recovering from major incident and emergency situations, which affect the provision of normal services.

Emergency Preparedness, Resilience and Response (EPRR) Incident Response Plan - sets out the Trust plan to cope with a major incident scenario and subsequent reporting requirements.

Emergency Preparedness, Resilience and Response (EPRR) Corporate Business Continuity (BC) Plan - describes key business areas and critical functions of the entire Trust which must be maintained in the event of a major incident, and details how the organisation will reduce, maintain and recover from a significant incident scenario.

Emergency Preparedness, Resilience and Response (EPRR) Directorate Business Continuity Plan – describes key business areas and critical functions specific to the Directorate and details how the Directorate will reduce, maintain, recover and provide support in the event of a major incident scenario. High service risks identified in the Directorate Business Continuity Plan are fed into the Corporate Business Continuity Plan.

Emergency Preparedness, Resilience and Response (EPRR) Operational Business Continuity Plans – Each service area must have in place a completed Business Impact Assessment (BIA) and Business Continuity Plan (BCP) which outlines the service profile, high risk functions, core resource requirements, key dependencies and contingency arrangements of the service. High service risks identified in these plans are fed into the Directorate Business Continuity Plan.

Incident Management Policy Including Serious Incidents and Near Misses - describes the Trusts approach to incident reporting with a commitment to reducing accidents, incidents, near misses and violence in the workplace. This policy relates to all incidents and near misses and clinical incidents, including unexpected deterioration in the health of a patient.

Freedom to Speak Up (Raising Concerns) Policy – this document encourages Trust staff to apologise to patients who are harmed as a result of healthcare treatment, to provide explanation and information, and to explain that an apology is not an admission of liability.

Information Governance Policy – provides guidance on the safe and effective storage, use and sharing of information.

4. DEFINITIONS

The definition of ***‘Risk’*** is:

The chance that something will happen that will have an impact on achievement of aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact of magnitude of the effect of the risk occurring).

‘Risk Management’ is defined as:

The culture, processes and structures that are implemented and directed towards the effective management of potential opportunities and adverse affects.

‘Risk Management Process’ is defined as:

The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.

‘Risk Appetite’ is described and defined as:

The resources available for managing risk are finite and so the aim is to achieve an optimum (and proportionate) response to risk, prioritised in accordance with an evaluation of the risks. The amount of risk that is judged to be tolerable and justifiable is the “risk appetite”. Risk appetite is ‘the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

‘Board Assurance Framework (BAF)’ is defined as:

A tool used to drive discussion around organisational risks which could potentially threaten the successful delivery of strategic objectives. The BAF is a

live document reflective of the highest-level strategic risks identified which are identified and assessed at Executive level and which have the greatest impact on and link to the achievement of the organisational strategic objectives.

‘Operational Risk Register (ORR)’ is defined as:

A live register of operational risks which apply to the organisation as a whole or risks which reside on directorate risk registers and have been scrutinised and escalated from the relevant accountable scrutiny Group/Committee.

‘Directorate Risks’ are identified as:

Risks that are applicable to the Directorate and threaten delivery of the Directorate and/or operational objectives.

‘Service Risks’ are defined as:

Risks that threaten operational delivery and are applicable to a particular service or team.

5. ASSURANCE FRAMEWORK

5.1 Trust Board

The Trust Board is committed to the development and implementation of Integrated Governance and for ensuring that the themes of governance, risk, quality and assurance are aligned.

The Board retain overall responsibility and authority for the risk management framework and review the risk detail outlined on the Board Assurance Framework (BAF) at each meeting, seeking assurances on mitigation and ongoing action.

5.2 Audit and Assurance Committee

The Audit and Assurance Committee meets on a quarterly basis and has a core role to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all Trust activities (both clinical and non-clinical) in support of achieving the Trust objectives.

Assurance on the effectiveness of the risk management framework and its implementation into practice is measured through the annual internal audit, which is reported into this committee and informs the statement of internal control.

5.3 Board Sub-Committees

- **People, Safety and Quality (PSQ) Committee**
- **Business and Performance (B&P) Committee**

The Board sub-committees are chaired by a Non-Executive. The Committees are responsible for providing the Trust Board with assurance that the organisation is able to meet all expected regulatory and statutory standards of care, expected safety and quality performance, strategic and operational risks, and that any

associated risks are managed to an acceptable level and within the set acceptance threshold.

Each committee meets on a bi-monthly basis and receives an activity report on the top operational risks held at strategic level, relevant to the core business area of each committee agenda. Each committee routinely selects specific risks for further scrutiny in order to assess that appropriate measures and controls are in place to mitigate or reduce the risk.

All risks recorded are assigned an 'owner' who will be responsible for recording progress made in mitigating the risk, and highlighting any emerging issues.

5.4 Executive Led Group/Committees

The Trust accountability structure outlines the key Executive Led Groups responsible for routinely reviewing, monitoring, scrutinising and escalating respective business risks.

Scrutiny Groups/Committees are identified as follows:

- Performance and Risk Executive (PRE)
- Trust Team Leadership (TLT) Meeting.

Each Group/Committee is chaired by the Chief Executive Officer and reviews respective business risks at each meeting to assure effective implementation of risk systems and mitigation are in place. Risks with a mitigated risk score of 12+ are reviewed and judgement taken as to whether escalation onto the Operational Risk Register (ORR) or Board Assurance Framework (BAF) is necessary.

5.5 Directorate Management Team (DMT) Meetings

Each Directorate holds a Management Team Meeting to review relevant operational risks, mitigating plans and agree whether any risk needs escalating up to Performance Risk Executive or Trust Leadership Team level.

DMTs are chaired by an Associate Director of Operations and meets monthly to provide assurance that effective implementation of risk systems and mitigation are in place.

5.6 Service Specific Team Meetings

Each team meets with their Service Manager on a monthly basis to ensure any learning and local risk activity is discussed and/or feedback to staff.

The Service/Ward/Team Manager will ensure that any issue unable to be managed locally or which requires broader discussion or decision making, will be escalated to the next level line management, who will ultimately escalate to the relevant Scrutiny Group/Committee (dependent on severity).

6. RESPONSIBILITIES

6.1 Trust Board

The Trust Board holds risk management at the core of its business. Board members are responsible for ensuring risk management initiatives are

appropriately implemented, communicated and carried out through the appropriate management committees.

6.2 Board Sub-Committees

The People, Safety and Quality Committee, Business and Performance Committee, and Audit and Assurance Committee are all sub-committees of the Board, chaired by a Non-Executive Director. Each committee is responsible for ensuring that any area of concern or risk are appropriately actioned and mitigated.

6.3 Executive Led Groups

The Patient Safety Executive, Clinical Effectiveness Executive and Workforce Executive Groups are chaired by Executive Directors and meet on a monthly basis. Each group is responsible for reviewing and approving risk management and patient safety policies and for receiving activity reports from the Risk Reduction Group by way of exception.

6.4 Risk Reduction and Emergency Preparedness Group

The Risk Reduction and Emergency Preparedness Group is chaired by the Associate Director of Estates and meets on a bi-monthly basis. The group is responsible for overseeing the risk management portfolio, which includes: health and safety, ligature reduction programme, safety alerts, medical devices, and emergency preparedness. Regular activity reports are presented by operational leads at each meeting, escalating to the Patient Safety Executive by way of exception reporting.

6.5 Chief Executive Officer

As accountable officer the Chief Executive has overall responsibility for ensuring the Trust has an effective risk management system in place and that the Trust meets all statutory requirements in respect of risk and governance. Responsibility for the delivery and effective risk management portfolio is devolved to the Director of Finance.

6.6 Director of Finance

Supported by the Head of Risk Services, the Director of Finance has overall responsibility for health and safety across the Trust and seeks assurance by operational leads via the Risk Reduction Group.

The Director of Finance is also the Executive Lead responsibility for financial, IT, performance and estates risks.

6.7 Director of Nursing, AHPs and Quality

The Director of Nursing, AHPs and Quality is the Executive Lead for patient safety, patient experience, clinical effectiveness, infection prevention and control, nursing, safeguarding and allied health professional practice.

6.8 Medical Director

The Medical Director is the Executive Lead responsible for any risks arising from medical professional practice.

6.9 Director of Operations and Stakeholder Partnerships

The Director of Operations is the Executive Lead responsible for the management of all operational risks arising from provision of services to patients.

6.10 Director of People and Business Development

The Director of People and Business Development is responsible for all risks related to people and business development.

6.11 Clinical Directors and Associate Directors

It is the responsibility of each Directorate Clinical Directors and Associate Directors, in conjunction with their management team, to:

- disseminate and implement this policy and procedure.
- develop and promote risk management principles within his / her areas of responsibility.
- ensure that robust systems are in place for the management of risk.
- ensure that their staff are aware of their responsibilities and duties.
- where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risks to the attention of their respective line manager for further advice and escalation as appropriate.
- ensure the risk register is routinely reviewed and updated to demonstrate that effective controls are in place to manage risks.
- ensure all operational risk are recorded.
- ensure scrutiny of operational risks at Directorate level.

6.12 Head of Risk Services

The Head of Risk Services reports to the Associate Director of Estates, and drives forward the risk management and EPRR portfolio, overseeing and supporting activity and compliance across the organisation. Assurance is provided to the Director of Finance on a monthly basis and subsequently shared at each Risk Reduction and Emergency Preparedness meeting. The Head of Risk Services is supported by the Health and Safety Team.

6.13 Heads of Service / Service Managers

It is the responsibility of each Service Manager to ensure local risk management and assessment activities are carried out and controls to manage identified risks are appropriate and robust.

6.14 All Staff

The key responsibilities of all staff are to:

- report incidents/accidents and near misses following the Trust's procedures.
- provide safe clinical and social care practice in assessment, diagnosis, treatment and other interventions.
- be aware that they have a duty under legislation to take reasonable care of their safety and the safety of all others who may be affected by the Trust's business.
- comply with all Trust rules, regulations and instructions to protect health and safety and welfare of anyone affected by Trust's business.
- be familiar with the risk management framework and associated health and safety procedures and comply with these.

- do not either intentionally or recklessly, interfere with or misuse any equipment provided for the protection of safety and health.
- be aware of emergency procedure e.g. resuscitation, evacuation and fire procedures appertaining to their particular Directorate locations.

This includes all agency and contract staff working within their area.

7. THE RISK MANAGEMENT PROCESS

Risk management is the responsibility of everyone in the organisation. The risk management process is a continual cycle and the Trust has adopted the Australia/New Zealand standard AS/NZS4360: 2002 as an integral component to the overarching risk management framework.

7.1 Risk Identification

If a significant risk is identified in either a clinical or non-clinical setting, which cannot be safely managed, it should **always** be brought to the attention of the Service/Team Manager who will work locally to help reduce the risk, or escalate the risk to the Head of Nursing and/or Associate Director.

Strategic Business risks are identified as part of the annual business planning process and Executive Directors oversee the action and controls in place to assure these risks are managed effectively.

All risks should be recorded within the Datix Risk Module and routinely reported on via the Datix system, and overseen by the relevant operational or scrutiny group for ongoing review.

The Datix Risk Module User Manual is available on the Trust Intranet.

7.2 Risk Assessment

The risk assessment process is described in more detail in the Trust Risk Assessment Policy, but in broad terms gives consideration to environmental, business, support service (such as IT), clinical and financial risks.

The risk assessment process will:

- Identify and document hazards of all kinds, which exist within the various functions of the Trust, and assess them for likelihood and impact.
- Initiate risk treatment solutions to eliminate risks, where it is reasonably practicable to do so, or reduce the effect of risks through contingency, prevention or transference, which cannot be eliminated.
- Monitor as far as is practicable the effectiveness of risk treatment solutions, improvements and developments.
- Identify trends and 'near misses'.
- Ensure effective communication and consultation internally and externally on management of identified risks.

The Trust has adopted the National Patient Safety Agency (NPSA) risk management scoring matrix, which should be used when scoring all risks.

The table below provides a numbered grading system for the assessment of risk, calculating the likelihood of risk occurrence, with the consequence of the risk, resulting in an overall risk score.

CONSEQUENCES	LIKELIHOOD				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Negligible – 1	1	2	3	4	5
Minor – 2	2	4	6	8	10
Moderate – 3	3	6	9	12	15
Major – 4	4	8	12	16	20
Catastrophic – 5	5	10	15	20	25

Dependent on individual risk scores, ongoing monitoring of recorded risks should be reviewed as follows:

CPFT Risk Management and Escalation Framework:

Risk Grade:	Low Risk	Moderate Risk	High Risk	Extreme Risk
Management Level:	Local Team / Ward Manager	Head of Service / Service Manager	Associate Director / Clinical Director	Executive Director
Review Group:	<i>All low risks:</i> - Local Team / Ward	<i>All moderate risks:</i> - Department / Directorate Management Team	<i>All high risks:</i> - Performance Risk Executive - Trust Leadership Team - Board Sub-Committee	<i>All extreme risks:</i> - Executive - Board - Board Sub-Committees
Review Frequency:	6 monthly	Quarterly	Monthly	Monthly

7.3 Risk Appetite – Tolerance Threshold

All senior managers are required to put agreed risk treatment plans in place and monitor risks which are within tolerance ranges. Any risks which cannot be controlled to an acceptable level, must be minimised as far as they are able, then develop a specific management plan that includes consideration of funding and escalate in accordance with the risk framework.

The Trust Board has decided to adopt differential levels of risk appetite depending upon the nature of the strategic risk for high level risks identified (BAF and ORR), which are assessed against the 5T framework.

Risk acceptability thresholds have been discussed and agreed by the Trust Board. These are summarised below:

The risk threshold for quality and safety risks has been set at 8+, however the Board has devolved responsibility for these risks to the Patient Safety Executive Group for oversight, reporting up to the People Safety and Quality Board Sub-Committee.

Ref	Business Link	Risk Tolerance Threshold
1	Quality and Safety	8+
2	Workforce	12+
3	Technology and Estate	15+
4	Financial Strategy: Profit and Loss	12+
5	Financial Strategy: Commercial	12+
6	Business and Reputation	12+

7.4 Monitoring and Review of Risks

It is necessary to monitor risks, the effectiveness of risk control, strategies and the management system that is set up to control implementation. Risks and the effectiveness of control measures are monitored by the person or group who assessed and controlled the risk to ensure changing circumstances do not alter risk priorities.

Ongoing review is essential to ensure that the management plan remains relevant. Factors that may affect the likelihood and consequences of an outcome may change, as may the factors that affect the suitability or cost of the various treatment options which may necessitate a regrading of the risk. It is therefore

necessary to regularly repeat the risk management cycle. Review is an integral part of the risk management treatment plan.

The Trust Board of Directors, Board Sub-Committees, Executive Led Groups and Directorate Management Groups are responsible for the monitoring, review and challenge of operational and strategic risks recorded to ensure effective controls and assurances are in place to manage all risks. Each committee has the authority to regrade any risk taking into account new information, gaps in assurance or other influencing factors or if there is an agreement that the risk requires regarding.

7.5 Risk Escalation

There are varying degrees of risk faced by Trust staff on a daily basis. Actions are routinely taken which reduce the risk, without referral to a more senior member of staff or committee. It is therefore the residual risk following any mitigation within the power of the local team which defines whether a risk is acceptable.

8. EDUCATION AND TRAINING

8.1 Trust Board Members

Trust Board members receive risk awareness training on an annual basis. It is the responsibility of the Trust Secretary to ensure all Board members receive this training, record attendance and to bring to the attention of the Chair, those members who have not participated. The Trust Chair will ensure that all Board members receive the expected level of risk management awareness.

8.2 Associate Directors/Heads of Service/Senior Managers

All Associate Directors, Heads of Service and Senior Managers undertake risk awareness training on a three year rolling basis as part of the 'working safely' core module, as described in the mandatory training needs analysis.

In addition, specific risk awareness sessions are provided in relation to the Datix Risk Module and Risk Register framework and wider risk assurance support via each monthly Directorate Management Team meeting.

8.3 All Staff

All staff will undertake risk awareness training on a three year rolling basis as part of the 'working safely' core module.

The Trust's Mandatory Training Needs Analysis (TNA) includes the timescales for frequency and identifies the level of mandatory training staff require in relation to managing risk. This can be viewed on <http://nww.training.cpft.nhs.uk/> or through hard copy by contacting the Learning and Development Team. All Trust employees must abide by the requirements of the Mandatory TNA.

9. MONITORING COMPLIANCE

Effectiveness of this strategy will follow a number of lines which include:

Area to be monitored/audited	Monitoring arrangements	Frequency
Monitoring training compliance	L&D Team and Trust Secretary for Board Risk Training.	Annually
Reporting of training compliance/non-compliance, and issues of concern	L&D Team report to the Risk Reduction Group	Bi-Monthly
Monitoring the risk framework	Board, Board Sub-Committees, Executive Led Groups	Monthly
Monitoring or risk audits, processes and findings	Head of Risk Services (via the Risk Reduction Group)	Bi-Monthly
Audit of data quality	Through scrutiny groups.	Ongoing

The Audit and Assurance Committee is responsible for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives.

This Committee will provide an annual report to the Trust Board on the effectiveness of its Risk Management Framework. Internal audit reports will also be used for assurance that effective management of risk is taking place.

10. LINKS TO OTHER DOCUMENTS

This strategy should be read in conjunction with:

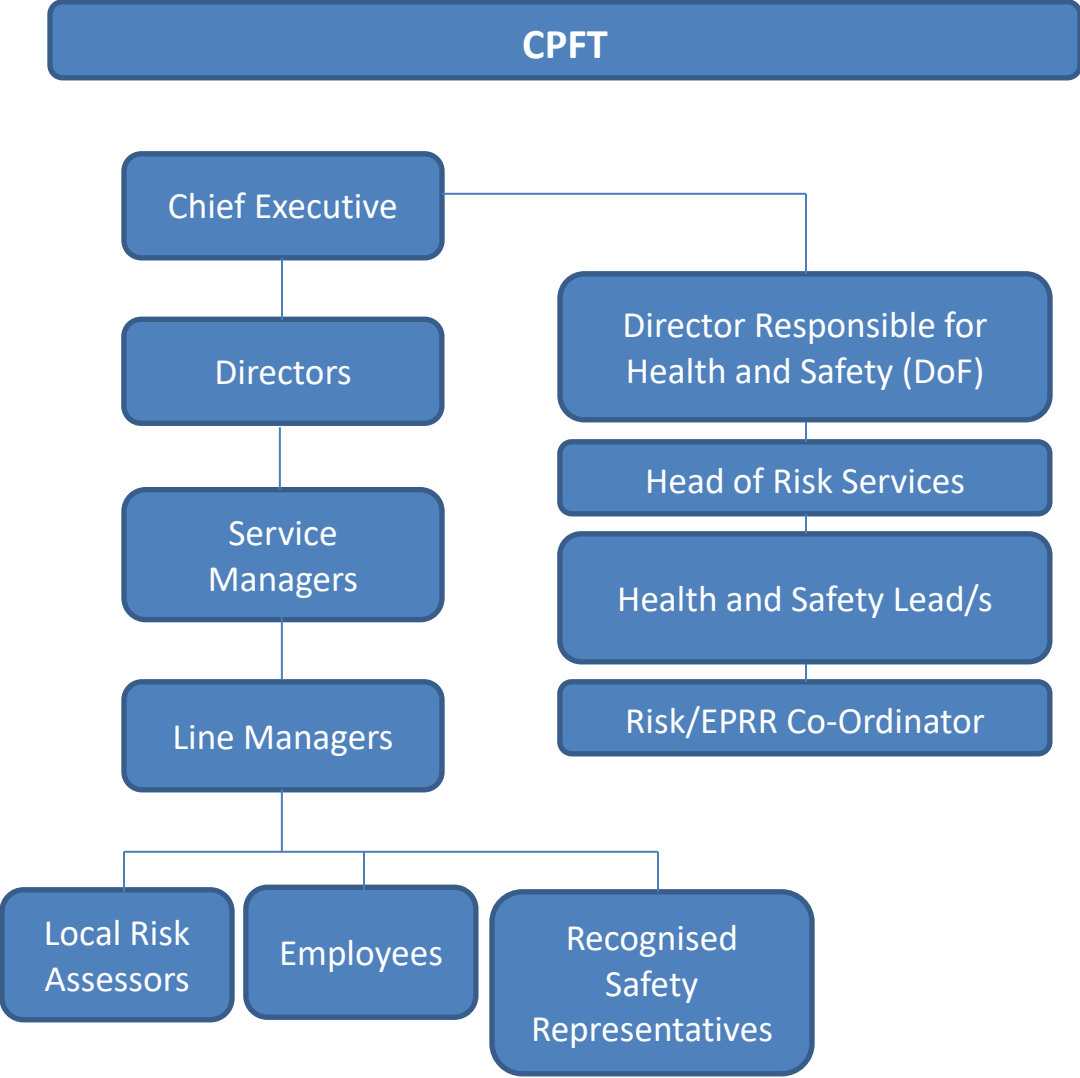
- People, Safety and Quality Terms of Reference
- Business and Performance Committee Terms of Reference
- Audit and Assurance Committee Terms of Reference
- Executive Led Groups Terms of Reference
- Health and Safety Policy
- Risk Assessment Policy
- EPRR and Business Continuity Framework and Strategy

11. REFERENCES

- **National Patient Safety Agency (NPSA) (Jan 2008)** *A Risk Matrix for Risk Managers*. NPSA.
- **DOH (2000)** *An Organisation with a Memory*, DOH London.
- **NHS England (2007)** *Risk Summit National Guidance*
- **AS/NZS ISO 31000:2009 (2009)** *Risk Management Principles and Guidelines*

APPENDIX 1 - Risk Team Structure Chart

Health and Safety Responsibilities in the Trust



APPENDIX 2 - Risk Escalation Process

