Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being held on 28 January 2025

Subject	Framework for Risk Management (Risk Management Policy) for approval
Supporting TEG Member	Sandi Carman, Assistant Chief Executive
Author	Judith Green, Head of Corporate Governance
Status	To Approve

PURPOSE OF THE REPORT

To present an update of the Framework for Risk Management to the Board of Directors for approval.

KEY POINTS

The Framework for Risk Management is a Trust policy reserved for Board approval in line with the Reservation of Powers to the Board of Directors and Scheme of Delegation.

The policy has been updated to reflect iterative changes to the Trust's risk management arrangements as part of continuous improvement work.

Updates to the policy are marked as track changes and encompass:

- Changes to thresholds for risk escalation in line with newly adopted risk tolerance scores which align with the Board's revised Risk Appetite Statement;
- Clarification of risk oversight responsibilities by Board Committees and Executive Committees;
- Changes to nomenclature relating to the Trust's management arrangements;
- Cross referencing to other risk management activities, ie Clinical Risk Management System; and
- Appending the updated Board Risk Appetite Statement.

Consultation on the updating of the policy has taken place with the Risk Management Executive Group and Audit Committee and it is being recommended for approval by the Trust Executive Group.

IMPLICATIONS

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board of Directors is asked to **APPROVE** the updated Framework for Risk Management.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Risk Management Executive Committee	16/01/2025	Y
Audit Committee	21/01/2025	Y
Trust Executive Group	22/01/2025	Y
Board of Directors	28/01/2025	

Framework for Risk Management (Risk Management Policy)

1. Introduction

1.1 Sheffield Teaching Hospitals NHS Foundation Trust (the Trust) acknowledges that risk is inherent in the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances.

~~1.1~~1.2 Risks will emerge and impact on the Trust from working in partnership with external stakeholders to deliver System objectives. In some cases risks will transfer to the Trust and therefore will need to be assessed in line with this framework.

~~1.2~~1.3 The identification of ~~these~~ risks, together with proactive management and mitigation, is essential to delivering high quality care.

~~1.3~~1.4 This Board-approved framework and its associated procedural documents underpin a strategic risk management approach which is centred on the following principles:

- Effective and dynamic risk management is an integral part of effective clinical and corporate governance.
- Systematic identification, evaluation and control of risks, irrespective of whether risks are clinical or non-clinical, ensure an integrated approach to the overall management of risk.
- Defined and embedded risk management systems and processes promote accountability and encourage all staff to be actively involved in recognising and reducing risk.
- An organisational culture which fosters openness and willingness to report risks, incidents and near misses supports organisation-wide learning.
- Risks should be managed in line with the Trust's Risk Appetite (Appendix A).

2. Purpose

2.1 The purpose of the Framework is to provide the overarching principles and detail the structures and standards required for the management of risk across the Trust.

2.2 Its key objective is to support managers and staff in the management of risk to ensure that the Trust is able to effectively deliver its objectives.

2.3 It clarifies accountability arrangements for the management of risk within the Trust from 'Ward / Department to Board'.

2.4 The Framework outlines clear reporting arrangements and describes how risks are reported through the Trust's governance structure and how the effectiveness of risk management is monitored.

3. Scope and exceptions

3.1 This policy applies to:

Setting	Trust-wide
Individuals	All staff including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.
Speciality	Trust-wide

3.2 A separate Trust Controlled Document (Clinical Risk Management System) sets out the structures and processes in place in relation to Clinical Risk Management (CRM) – the risks arising directly from health IT system implementation, use and decommissioning. This describes how CRM aligns to this framework.

4. Assessing and managing risk

4.1 Risks are adverse events that may happen, which if realised, could stop the Trust achieving its objectives or negatively impact upon its success. There are three types of risk that the Trust expects to be identified and managed; they are related to objectives at a strategic, project / programme and operational level.

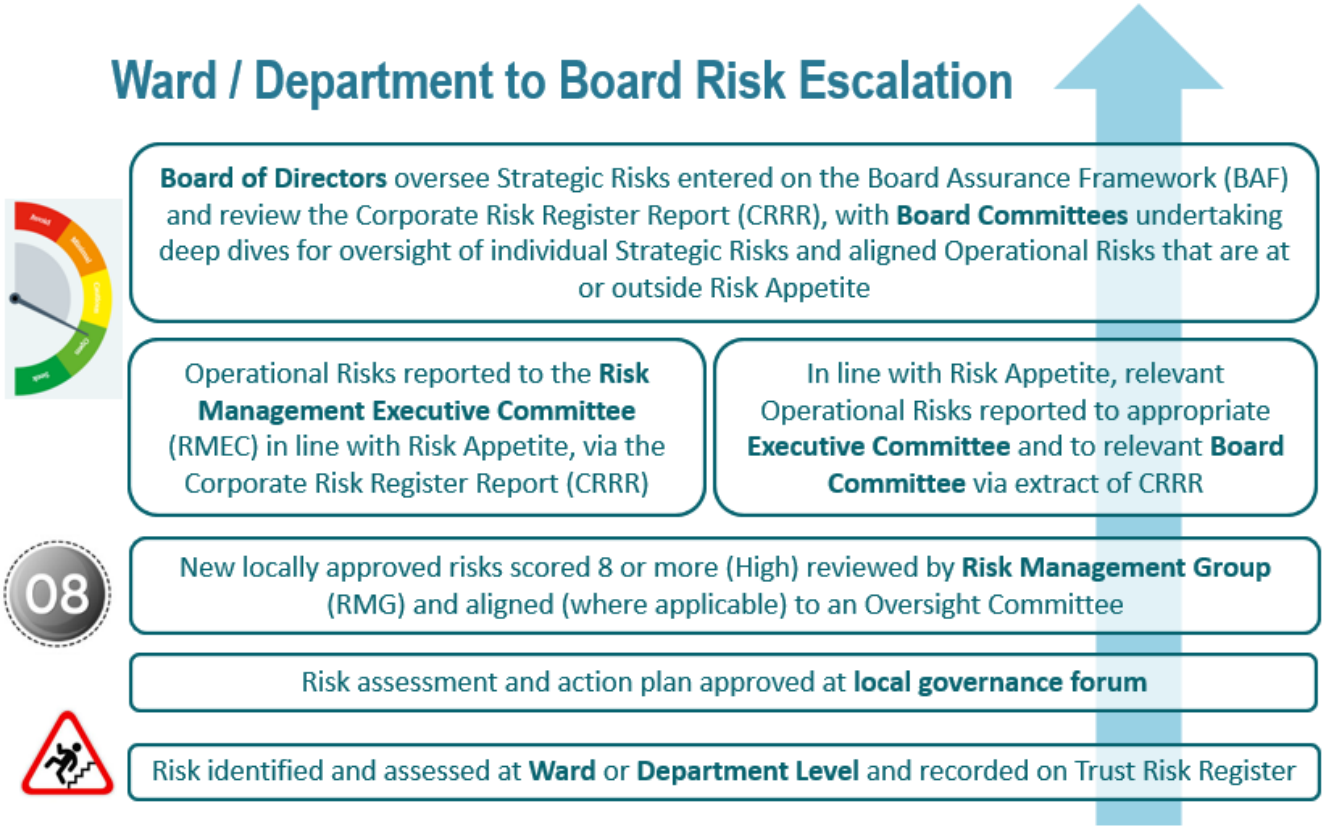
4.2 Regardless of the nature of risk, the Trust adopts a structured approach to risk management whereby risks are identified, assessed and controlled and, where necessary, reported through the governance mechanisms of the Trust. Staff should work to identify not only current risks but also complete horizon scanning to be aware of risks that are likely to emerge in the future.

4.3 The risk management process is described in detail in the associated procedural document - Guidance for assessing and managing operational risks.

5. Risk reporting

5.1 An integral part of effective risk management is ensuring that risks are reported and escalated within the Trust to ensure that appropriate action and prioritisation of resources can take place.

5.2 The table below describes these arrangements.



5.3 Operational Risks are monitored through the Trust's local and corporate governance structure with ~~new~~ locally approved risks reported in line with the following risk score thresholds:

- All new risks with a current risk score of 8 or above (High) will be reviewed for validation by the Risk Management Group where consideration will also be given to cross-cutting issues and the implications for risk aggregation. Risks will be aligned to an Oversight Committee, where appropriate.
- ~~New r~~Risks with a current risk score that is at or exceeds agreed risk tolerance as defined by the Board's Risk Appetite ~~of 15 or above (Extreme)~~ will be reported to Risk Management Executive Committee (RMEC) via a Corporate Risk Register Report and will be included within supporting materials to inform deep dive reviews of individual Strategic Risks.

5.4 The data recorded on ~~Datix®~~the Trust Risk Register will be used to facilitate risk reporting and provide assurance regarding the effective implementation of this Framework through risk management key performance indicator reporting to the Risk Management Executive Committee.

6. Board Assurance Framework (BAF)

6.1 The Board Assurance Framework (BAF) is a mechanism for proactively assessing risk and control at Strategic~~the very highest~~ level and seeks to provide assurance to the Board of Directors that there is effective management of key risks to the delivery of the Trust's strategic objectives (Strategic Risks).

6.2 Structured around a set of Strategic Risks identified by the Board of Directors and informed by the Corporate Risk Register Report, the BAF reports the controls in place to mitigate and manage the risks, and the assurances available to indicate that the controls are effective and ~~identified~~ any additional actions required.

7. Roles and responsibilities

7.1 To underpin delivery of this Framework, clear responsibility and accountability arrangements need to be embedded within the organisational structure of the Trust.

7.2 Responsibilities of key committees / groups and staff are outlined below:

Role	Responsibility
Trust Board of Directors	The Trust Board of Directors has overall responsibility for ensuring that effective internal controls are in place, and for reviewing the effectiveness of these controls. The Chief Executive as Accounting Officer is required to produce an Annual Governance Statement that confirms to the Board of Directors the adequacy of controls in place to manage risk. The Board approves the implementation of the risk management framework and oversees its effectiveness through the described monitoring and review processes. The Board of Directors sets and regularly reviews the Risk Appetite Statement ~~each year~~. Through the Board Assurance Framework (BAF), the Board assures itself that the Trust identifies and effectively manages any risks that could impact on the achievement of its Strategic Objectives. Board Committees provide additional oversight of strategic and ~~high-level~~operational risk within their remit in line with agreed reporting and escalation thresholds informed by Risk Appetite / Risk Tolerance scores.

Audit Committee	With delegated authority from the Board of Directors, the Audit Committee has overall responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and corporate).
Quality Committee / Finance and Performance Committee / People Committee / Research and Innovation Committee / Digital Committee ~~/ Board Nomination and Remuneration Committee~~	The committee structure of the Board of Directors provides assurance on, and challenge to, the Trust's risk management process. It is the key structure in ensuring quality, safety and management of risk, and provides the mechanism for managing and monitoring risk throughout the Trust and assurance reporting to the Board of Directors. Oversight of the management of risks within the scope of a Committee's terms of reference is undertaken through: – Receipt of meeting assurance reports – BAF deep dives and consideration of relevant entries on the Corporate Risk Register Report – Referral of matters from the Audit Committee
Trust Executive Group (TEG)	The Trust Executive Group (TEG) is responsible for the implementation of risk management and its assurance mechanisms. Individual Executive Directors provide leadership on the management of key areas of risk.
Risk Management Executive Committee (RMEC)	This Committee, comprising full TEG membership, is responsible for ensuring the Trust has robust processes and policies in place for the effective oversight and management of risks that challenge the delivery of the Trust objectives and for monitoring extreme and high risks to ensure that actions are in place and delivering risk reduction. The Committee reports to the Audit Committee through submission of a Meeting Assurance Report.
Safety and Risk Forum	This provides a networking and information sharing forum for Directorate Risk and Governance Leads on matters relating to safety and risk.
Risk Management Group (RMG)	This group is responsible for reviewing new locally approved operational risks to validate the risk score and to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating actions. All new operational risks with a current risk score of 8 or above, approved locally will be reported to RMG.

	The Group supports compliance with, and development of, the Trust's operational risk management systems and processes through the receipt of reports monitoring performance relating to risk management. The group produces a summary report for discussion by the Risk Management Executive Committee.
Directorate Management Teams – Clinical and Corporate	Members of Directorate Management Teams (through their local governance group, as relevant) have day to day accountability for the management of risks relating to their directorate. They are responsible for: • Ensuring that local risk management systems and processes are in place and functioning effectively. • Approving all risk assessments prior to validation by RMG and ensuring that RMG feedback is addressed in a timely manner. • Reviewing all risks and action plans in a timely manner in line with agreed standards.
~~Specialist Risk Groups~~Executive Committees / Oversight Groups	~~In addition to the above, there are a number of specialist Trust-wide groups (e.g. Infection Prevention and Control Committee, Radiation Safety Steering Group, Information Governance Committee etc.) that~~All Executive Committees have specific risk management responsibilities outlined in their terms of reference and should as a minimum include review of all operational risks at or above risk tolerance score on their workplan. Additionally, a number of subject matter forums are supported to hold oversight responsibilities for risk, in line with the scope of their terms of reference.
Chief Executive	The Chief Executive, as the Accounting Officer, is accountable for the Trust's risk management framework and ensuring that it operates effectively.
Assistant Chief Executive	The Assistant Chief Executive has delegated responsibility for the Board Assurance Framework and putting in place appropriate guidance and policy to manage risk. The Assistant Chief Executive also advises the Board of Directors in relation to the decision-making regarding the ~~Trust's~~ Risk Appetite Statement.
Executive Directors	Executive Directors have delegated responsibility from the Chief Executive for managing risk in accordance with their portfolios.
~~Patient and Healthcare~~Quality Governance	The ~~Patient and Healthcare~~Quality Governance Department is responsible for the operation of risk management in accordance with the framework outlined within this document.

Department	The Department works closely with the Chief Executive's Office in the maintenance of the Board Assurance Framework (BAF), ensuring a clear relationship between Strategic Risks identified by the Board of Directors and those recorded in the Trust Risk Register.
Risk / Governance Leads	All clinical and corporate areas, programme and project teams must have a nominated risk lead. The risk lead will be responsible for co-ordinating risk management processes in their directorate by: • consulting with teams to identify and assess risks and determine mitigating actions; • maintaining arrangement for oversight of all local risks and ensuring that these are recorded on the Trust Risk Register ~~Datix®~~ and undergo regular review and quality assurance; • promoting the risk management framework, procedures / best practice and communicating changes as necessary; • sharing information and knowledge on risks within their area through membership of relevant groups and committees; and • being the key contact for the ~~Patient and Healthcare~~Quality Governance Department on the management of risk and compliance with this Framework.
Clinical Directors, Operational Directors, Nurse Directors / Corporate Directors	Are responsible for ensuring effective systems for risk management are in place within their directorates and ensuring that their staff are aware of the Framework for Risk Management ~~Framework~~. Will be identified as the risk owner for each risk within the Trust Risk Register.

8. Monitoring

Standard, process or issue to be monitored	Monitoring method	Monitored by	Reported to	Frequency
Implementation of the Framework for Risk Management	Internal Auditor's report on the effectiveness of the system of internal control.	Chief Executive's Office	Audit Committee	Annually

9. Definitions

Term	Description
Assurance	is the means by which the Trust (Board of Directors, TEG, Directorate / Department Leadership Team) knows that the controls designed to manage / mitigate risks are effective and being properly implemented.
Board Assurance Framework (BAF)	supports the mechanism for proactively assessing risk and control at ~~the very highest~~strategic level and seeks to provide assurance that there is effective management of key risks to the delivery of the Trust's strategic objectives.
Corporate Risk Register Report	an extract of the Trust Risk Register detailing ~~Extreme R~~risks currently scored at or exceeding an agreed tolerance score informed by the Board's Risk Appetite Statement.~~(Risks with a score of 15 or more).~~
Control (Risk Control)	is defined as the mitigating ~~action~~ system / process intended to reduce the likelihood or impact (consequence) of the risk occurring. An effective control will always reduce the probability of the risk occurring.
Clinical Risk Management (CRM) / Clinical Risk Management System (CRMS)	a set of structures and processes put in place to ensure and assure that patient safety is deeply embedded in the development, implementation, and use of health IT systems by a healthcare organisation.
Internal controls	are Trust policies, procedures, practices, behaviours or organisational structures to manage risks and achieve objectives.
Governance	is the systems and processes by which the Trust leads, directs and controls its functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.
Operational Risks	relate to the day-to-day activity of the Trust and include anything that could impact on the achievement of objectives at an operational level. These will include a broad spectrum of risks including clinical risks, financial risks (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risks, ~~reputational risks~~ and/or risk of loss or damage to assets or system failures etc.
Project / Programme Risks	relate to a project / programme's objectives and are generally expressed in terms of anything that may impact on cost, time

	or quality. Such ~~Project~~ Risks are managed in the same manner as other risks within the Trust. A project / programme risk log will be maintained, reporting schedules and escalation thresholds to appropriate stakeholders will be defined, and the route of assurance is made clear. These details will be included in relevant project / programme documentation. Any risk of non-delivery of the project / programme should be entered onto ~~Datix~~ the Trust Risk Register as an operational risk.
Risk	is the threat or possibility that an action or event will adversely affect the Trust's ability to achieve its aims and objectives. It is measured in terms of likelihood and consequence and comprises of a combination of three elements: • Cause – What might trigger the event to occur • Event – An unplanned / unintended variation from an objective • Effect – How the Trust could be impacted should the event occur
Risk Appetite / Tolerance	is a narrative statement that clarifies the type and amount of risk that the Board of Directors is prepared to take to meet its strategic objectives. This has been translated into a tolerable risk score for each domain of risk. These risk scores provide the threshold for reporting operational risks for Board level oversight. The Risk Appetite Statement will be reviewed and refreshed ~~and updated every year~~ regularly. The current Board Risk Appetite Statement is found at Appendix A.
Risk Assessment	is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk Lead	is the member of staff responsible at Directorate level for the ~~day to day~~day-to-day administration of risk management procedures. The Risk Lead supports the Risk Manager in the management and review of an individual risk.
Risk Manager	all risks will have an identified Risk Manager who is responsible for the management of the individual risk. This includes undertaking scheduled review of the agreed action plan with appropriate update of the risk on the Trust Risk Register~~Datix®~~.

Risk Owner	a Clinical Director, Operational Director, Nurse Director or Director of a Corporate function accountable for each risk within the Trust Risk Register.
Risk Profile	is an aggregated report of Risks at Directorate level produced on a monthly basis across clinical and corporate areas.
Risk Register	is a formal log of all identified Trust risks relating to a set of objectives, including their history and status. The Trust uses an electronic ~~repository, Datix®~~ Risk Management System, for electronically recording and dynamically managing and reporting risks that have been appropriately assessed.
Strategic Risks	are risks relating to delivery of the strategic objectives of the Trust, these are identified by ~~TEG~~ the Board and recorded and reported to the Board of Directors on the Board Assurance Framework (BAF). Strategic Risks are managed at executive level.
Strategic Risk Owner	The executive lead for an individual Strategic Risk with responsibility for co-ordinating the update of relevant BAF content and leading on the Strategic Risk deep dive.

10. References / standards and statutory legal requirements

CQC Registration Regulations ~~2009 (Part4)~~
~~NHS Improvement / NHS England Single Oversight Framework~~
Health and Safety at Work Act 1974
Management of Health and Safety at Work Regulations 1999

11. Associated Trust and external documents

Guidance for assessing and managing risk
Risk Assessment Template
Guidance – Completing Health and Safety Risk Assessments
Guidance – Violence and Aggression Risk Assessments
Information Risk Management Policy
Business Continuity (Internal Incident) Plan
Management of Health and Safety at Work Policy
Freedom to Speak up Policy and Procedure
~~A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)~~

12. Appendices

Appendix A - Risk Appetite Statement

13. Document control

Ref	396
Version	~~2.2~~3
Status	For approval
TEG sponsor	Sandi Carman, Assistant Chief Executive
Controlled Document Lead / Author*	Judith Green, Head of Corporate Governance ~~Manager~~
Approval body	Trust Executive Group
Date approved	~~8 June 2022~~tbc
Approved for adoption by	Board of Directors
Date approved for adoption	~~28 June 2022~~tbc
Issue date	~~10 January 2024~~ tbc
Review date	~~1 July 2025~~tbc

14. Version history

Version	Date issued	Brief summary of changes	Author
1.1	July 2020	Rewrite to supersede Risk Management Policy (Ref 52)	Corporate Governance Manager
1.2	16/03/2021	Minor changes to replace links to associated documentation	Corporate Governance Manager
2.0	29/06/2022	Restructure to align to refresh of risk management arrangements inc. changes in nomenclature	Corporate Governance Manager
2.1	24/04/2023	Minor amendment - 2022/23 Risk Appetite Statement added	Corporate Governance Manager
2.2	10/01/2024	Amendments to reflect changes in Committee / group names and agreed ToR.	Head of Corporate Governance
3	Tbc	Updated to reflect revised approach to risk oversight following agreement of new Risk Appetite / Tolerance scores.	Head of Corporate Governance

15. Consultation and review

Groups / persons consulted	Date
~~Head of Patient and Healthcare Governance,~~Risk Management Executive Committee	~~1 June 2022~~16 January 2025
~~Occupational Safety Manager~~Audit Committee	~~1 June 2022~~21 January 2025
~~Assistant Chief Executive~~	~~31 May 2022~~

16. Intended recipients

Essential reading for	Board of Directors (Executive and Non-Executive Directors), TEG members, Clinical Directors, Nurse Directors, Operations Directors, Service Managers, Heads of Department, Governance and Risk Leads working in clinical and corporate areas
Information for	All staff

17. Rapid equality impact assessment

What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.

Delete ✓ × as appropriate

	Positive Impact#	Negative Impact#	Neutral Impact#	Advances equality of opportunity	Eliminates unlawful discrimination	Fosters good relations between people
Race (including nationality)	✓	×	×	✓	✓	✓
Religion/belief and non-belief	✓	×	×	✓	✓	✓
Disability	✓	×	×	✓	✓	✓
Sex	✓	×	×	✓	✓	✓
Gender Reassignment	✓	×	×	✓	✓	✓
Sexual Orientation	✓	×	×	✓	✓	✓
Age	✓	×	×	✓	✓	✓
Pregnancy and Maternity	✓	×	×	✓	✓	✓

Marriage / Civil Partnership	✓	×	×	✓	✓	✓
Human Rights (FREDA principles)	✓	×	×	✓	✓	✓
Carers	✓	×	×	✓	✓	✓
Other groups E.g. Travellers, vulnerable adults/children, homeless, care leavers, asylum seekers or refugees	✓	×	×	✓	✓	✓

[#]**Extent of impact**
Positive Impact - This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination
Negative Impact - This will have a negative or adverse impact which will cause disadvantage or exclusion
Neutral Impact - There is no likely impact on any of the protected groups

List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research
None identified

15.1 Analysing the equality information

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation.

Analysis of the effects and outcomes
This policy will ensure that risks to all staff in the workplace will be assessed and promotes the right to work in a safe environment. There is a need to ensure that training in awareness and understanding of this policy uses a variety of methods to ensure the specific communication needs to different groups are met.

15.2 Outcome of equality impact assessment

No major change needed	Adjust Policy / proposal	Adverse impact but continue	Stop and remove policy / proposal
✓	✗	✓✗	✗

15.3 Action plan

Give details of any actions required to remedy any negative impact(s) identified above:

Action to address negative impact	By whom	By when	Resource implication
NA			

15.4 Monitoring, review and publication

How will the policy be monitored?	See section 8 monitoring
Manager signing off EIA	**Date of next review**
Judith Green, Head of Corporate Governance	~~July~~ January 2028~~2025~~
Approved by	**Date sent to EDI Team** sth.equalityanddiversity@nhs.net:
Board of Directors	Date 28 June 2022
	Date published (if applicable)
	Date

16 Other impacts

Financial implications	Cost of ongoing risk management training
Training implications	An associated training needs analysis developed by the Quality Governance Department details the level of training required for specific staff groups.
Sustainability implications	None
Other	None

17 Document imprint

 Policy template version 2.4

Appendix A:

Board Risk Appetite Statemement – Approved November 2024

Sheffield Teaching Hospitals NHS Foundation Trust

Quality of Care

Risk Tolerance 12

AVOID	MINIMAL	**CAUTIOUS**	OPEN	SEEK

We have a **cautious** appetite for risk which compromises the delivery of high quality and safe services and jeopardises compliance with our statutory duties for quality and safety. We will accept some risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. At a patient level we recognise that in order to achieve the best outcomes from individual patient care and treatment there is a need for staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk.

Operational recovery and delivery

Risk Tolerance 15

AVOID	MINIMAL	CAUTIOUS	**OPEN**	SEEK

During some circumstances, including and following exceptional operational pressures, and in line with full clinical risk stratification, we are **open** to accept a higher threshold for risks such as delay in referral to treatment, limited access to some operations, cancellation of appointments, etc. We recognise and accept the impact of this on the Trust's performance against national and constitutional performance targets and will continually assess this based on evidence of impact on patient care and outcomes.

Workforce

Risk Tolerance 15

AVOID	MINIMAL	CAUTIOUS	**OPEN**	SEEK

While we will not accept risks which may compromise the safety of our staff or that contradict our Trust PROUD Values, we acknowledge that transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We are therefore **open** to accepting risks associated with the implementation of new models of working where these enhance or improve patient safety, quality of care or service delivery. We will support our people to adapt and thrive during change.

Finance

Risk Tolerance 12

AVOID	MINIMAL	**CAUTIOUS**	OPEN	SEEK

Our appetite for financial risk is **cautious**. We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting risks that may result in limited financial impacts or losses on the basis that there may be upside opportunities elsewhere within the Trust, including where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money. We adopt a zero-tolerance approach to fraud.

Appendix A:

Board Risk Appetite Statemement – Approved November 2024

Sheffield Teaching Hospitals NHS Foundation Trust

Digital

Risk Tolerance 20

AVOID	MINIMAL	CAUTIOUS	OPEN	**SEEK**

We recognise the significant benefits digital innovation can offer our patients and staff, and we are willing to **seek** these opportunities despite higher inherent risk. Whilst willing to seek risks in this area and embrace change / innovation, we do so within a controlled project management environment. This approach enables the early identification of potential risks and ensures such risks are managed at an appropriate level and in-line with our appetite. We have no tolerance, however, for taking risks that increase our exposure to cyber-fraud or incidents.

Sustainable healthcare through partnership working

Risk Tolerance 15

AVOID	MINIMAL	CAUTIOUS	**OPEN**	SEEK

We are committed to bringing value and opportunity across current and future services through system-wide partnership and are therefore **open** to accepting risks associated with collaborative and new ways of working. Our approach to environmental sustainability is **open** and we will consider and prioritise investment towards initiatives that support improvement in environmental sustainability.

Research and Innovation

Risk Tolerance 20

AVOID	MINIMAL	CAUTIOUS	OPEN	**SEEK**

We recognise the benefits and advantages of innovation and look to **seek** measured risks while innovating service delivery. Clinical research and innovation are vital to our position as a world class specialist healthcare provider. While we acknowledge that these efforts involve a higher level of inherent risk, we will manage these within a controlled environment, adhering to all relevant ethical protocols for clinical research.

Well-led

Risk Tolerance 12

AVOID	MINIMAL	**CAUTIOUS**	OPEN	SEEK

We have a **cautious** risk appetite to risks which will impact on our ability to meet our regulatory compliance requirements. Where the laws, regulations and standards are about the delivery of safe, high-quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set.