Supporting papers

Pack B includes:

- agenda item 28

- Risk Management Framework that supports agenda item 14

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Paper	**Agenda Item**	Agenda Pack B
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points (two or three issues for the meeting to focus on)

The following reports, received and discussed by the People and Organisational Development Committee and Quality Committee, are presented today to be noted by the Board of Directors:

Medical Revalidation – The People and Organisational Development Committee took assurance that the Trust was meeting its statutory responsibilities in relation to medical appraisal and revalidation and that appropriate professional governance arrangements were in place.

Mortality report – The Quality Committee noted the mortality report and the absence of significant mortality concerns.

Guardian of Safe Working Hours – The People and Organisational Development Committee noted the Guardian of Safe Working Hours Report, including the key themes relating to workload, resident doctor cover, clinical supervision and service pressures.

Previous consideration (where has this paper previously been discussed – and what was the outcome?)

People and Organisational Development Committee held 19 August 2026
Quality Committee held 16 September 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE and CONSIDER the appended reports for information

Alignment to strategic objectives (indicate those that the paper supports)	
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X
Quality and safety plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			

Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	

Strategic Delivery Risks (indicate those that this paper supports)	
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X

System / Place impact (advise which ICB or place that this matter relates to)							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Refer to Agenda Pack B							

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	25.06.2026-The Responsible Officer (RO) for RDaSH at the time in writing this report is Dr Diarmid Sinclair, Chief Medical Officer

Comments:	Dr Sinclair was appointed as Chief Medical Officer in April 2025
Action for next year:	Dr Sinclair will continue to undertake appropriate CPD for the RO role

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	I am satisfied that the designated body continues to provide sufficient funding and resource for me to carry out my duties and responsibilities in relation to my RO role. Signed Dr Diarmid Sinclair, date: 10.07.2026
Comments:	
Action for next year:	Ensure there is sufficient resource to support the role as well as there being appropriate systems in place such as L2P.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	The list of prescribed connections is held on the GMC Connect website is regularly checked against staff lists held on the Electronic Staff Record (ESR) by a member of the Trust Revalidation Support Team who also receives notifications of staff changes from the Medical Staffing Team in the Workforce Directorate.
Comments:	
Action for next year:	Continue above processes, to regularly check the list of prescribed connections held on the GMC connect website against staff lists held on the Electronic Staff Record.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes

Action from last year:	The Medical Appraisal Policy is active on the Trust's website. The policy was agreed with BMA via the Joint Local Negotiating Committee. The policy was reviewed by JLNC before being ratified
Comments:	The Medical Appraisal Policy was submitted to People & Teams Meeting on 10.06.25. the policy was approved and is active on the Trust's public website
Action for next year	Continue to review the Medical Appraisal Policy in line with review schedule

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	The Regional Appraisal Network Meeting in Mental Health is attended by the RO; it forms a useful benchmarking and peer review system. Internally we hold annual reviews of our appraisal process and provide feedback to all our appraisers.
Comments:	
Action for next year:	We will continue attendance at the Regional Appraisal network meeting and have annual reviews of our appraisal process. The RO is exploring the possibility of a peer review from one of the neighbouring Trusts.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	We are guided by the GMC in terms of establishing RO responsibility. All of our doctors (locum and substantive) are invited to attend the monthly Consultants meetings and the Educational Programmes for CPD activity, and such data will be provided to locums and where appropriate their Agency

	RO's if/when required. We supply relevant clinical governance information to their own RO e.g. complaints, serious incidents etc.
Comments:	
Action for next year	As above.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	All doctors in this organisation are offered an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. Effective appraisals within the Trust are guided by our comprehensive Medical Appraisal Policy, they are monitored by 20% random sampling by the RO. This was completed in May 2026. Appraisals are predominantly undertaken in the period December-March remotely via Microsoft Teams or face to face. Centrally compiled data is used for individual doctors as a contribution to their supporting information. Complaints, Serious Incidents and IR1's is uploaded to the individuals L2P account (our current appraisal management software). The total number of employed doctors is 79 in the year 2025-2026. Out of 79, 72 had a completed Rdash appraisal, all of which have been submitted to the Appraisal Team and signed off.
Comments:	

Action for next year:	As above

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	There were 7 instances of doctors not completing an appraisal: • 1 Doctor on maternity leave • 1 appraisal due end of 2026 • 4 appraisals not completed due to long term sickness • 1 did not engage with the appraisal and will be referred to the GMC for non-engagement.
Comments:	
Action for next year:	Continue to monitor engagement with appraisal process.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Medical Appraisal Policy was approved and finalised in September 2025 Board of Directors meeting where final approval was given
Comments:	I can confirm the revised policy has been approved and is active on the Trust public website
Action for next year:	No action to be taken

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Appraiser Refresher Training takes place annually and is delivered by the Responsible Officer (Dr Diarmid Sinclair). In the year 2024-2025 period the Trust had 28 trained appraisers to cater to approximately 79 doctors. There has been no issue with our ability to carry out timely appraisals.
Comments:	In the year 2024-2025 period the Trust had 28 trained appraisers to cater to approximately 79 doctors.
Action for next year:	To offer new appraiser induction training and annual appraiser refresher training. The trust will continue to monitor how many appraisers it has versus the number of appraisees to ensure that there remains enough capacity.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	The Trust offers and monitors compliance with annual refresher training to ensure all appraisers are up to date and compliant. This is delivered by the Responsible Officer (Dr Diarmid Sinclair). Any appraisals undertaken by new appraisers are reviewed by the Responsible Officer and they are provided with feedback. Reminders are sent to all Appraisers that they demonstrate in their own appraisal how they keep up to date as an appraiser.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	In 2025 10 doctors have been trained to become an Appraiser. The training was delivered by the Responsible Officer.
Comments:	The Trust recruited Dr Andrew Heighton as Deputy Medical Director & Medical Appraiser Lead on 02.02.2026. The Trust to recruit Deputy Medical Director
Action for next year:	The Trust to recruit Deputy Medical Director

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	The Trust Revalidation Support Team (TRST) meets quarterly and is part of the appraisal quality assurance process. The agenda includes the management of the system for appraisals, data flow including (complaints, SI's, appraisers matching, policy review, new starter assurance checks). The meeting reviews the appraisal feedback and spots any trends or cause for concern to be actioned. This also includes targeted feedback to the new appraisers. On an annual basis the RO reviews a sample of 20% of all appraisers for quality and consistency and feeds this back to TRST and the doctors involved.
Comments:	
Action for next year:	As above

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes

Action from last year:	10 recommendations to the GMC were made during this appraisal cycle.
Comments:	
Action for next year:	The Revalidation & Appraisal team monitor when revalidation decisions are due and highlight this to the RO. Engagement is also monitored such that any requests to the GMC to bring forward revalidation decisions can be actioned.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	In this appraisal cycle 2025-26 of our 79 doctors, 7 required revalidations. • 7 were recommended for revalidation on time and revalidation was approved by the GMC
Comments:	
Action for next year:	As above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	The Trust has a system of governance and assurance that is approved by the Board of Directors. It includes a Board Assurance Framework, and formal sub committees of the Board which receives assurance regarding relevant areas

	such as serious incidents, complaints, audit activity and staff training. Relevant supporting information is supplied to doctors such as incident reports, complaints, and SI's.
Comments:	
Action for next year:	The Trust has instituted learning half days for all staff to enhance learning opportunities. For doctors with leadership positions there is also a leadership development programme in addition to the learning half days and regular CPD programme.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	The Trust system relating to the conduct and performance of medical staff is in accordance with the MHPS framework and is explicitly mentioned in the relevant policies. Serious concerns about medical performance are and should be managed outside of the appraisal system. Relevant information is supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g. complaints in relation to other parts of their whole scope of work.
Comments:	
Action for next year:	As above

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Relevant information is supplied to doctors for their appraisals, but doctors are expected to bring information of

	relevance that may not be known to the Trust e.g. complaints in relation to other parts of their whole scope of work.
Comments:	
Action for next year:	As above

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	We have agreed policy and processes and follow the detail of Maintaining High Professionals Standards.
Comments:	
Action for next year:	Relevant policies will continue to be reviewed and followed.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	
Action from last year:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step.

	Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2025-2026 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.
Comments:	
Action for next year:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2025-2026 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	We supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust. Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify

	their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.
Comments:	
Action for next year:	We supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust. Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	All staff must undergo relevant Mandatory/Statutory training e.g. Equality & Diversity, in addition the Trust must publish equality data in relation to certain protected characteristics (Race and Disability) every year. The organisation has developed an understanding with the Regional Appraisal Network, where concerns about a doctor is being assessed to consult an independent representative from with the Network.
Comments:	
Action for next year:	As above

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	The Trust has systems in place to review national guidance such as NICE guidelines to ensure that the standards are reviewed against current practice in the Trust. There are forums for national reports to be reviewed such that the Trust can determine whether any actions are necessary.
Comments:	
Action for next year:	As above

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	The Trust has policies in place to monitor performance of all staff against relevant professional standards. The Trust follows guidance from NHS improvement and operates a Just Culture.
Comments:	
Action for next year:	As above

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes

Action from last year:	A checklist system for new starters is in place and monitored by the Medical Staffing Team, and further checks are carried out by the Revalidation Support Team. For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.
Comments:	
Action for next year:	A checklist system for new starters is in place and monitored by the Medical Staffing Team, and further checks are carried out by the Revalidation Support Team. For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	The Trust has introduced leadership training for all leaders within the organisation. There are learning half days for all staff. For medical staff there are regular weekly CPD sessions.
Comments:	
Action for next year:	The Trust has introduced leadership training for all leaders within the organisation. There are learning half days for all staff.

	For medical staff there are regular weekly CPD sessions.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Equality and Diversity is mandatory part of Trust training for all employees. The Trust has implemented the principles of Just Culture and our HR processes are aligned to this. There are support networks to promote diversity and inclusion
Comments:	
Action for next year:	Equality and Diversity is mandatory part of Trust training for all employees. The Trust has implemented the principles of Just Culture and our HR processes are aligned to this. There are support networks to promote diversity and inclusion.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	The Trust has embedded PSIRF. The Trust has adopted the Just Culture framework. There is a Freedom to Speak up Policy and champions in place. Incident themes are regularly reviewed to look for patterns and learning.
Comments:	

Action for next year:	As above

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	There is a complaints process which has an underlying policy in situ. Additionally the Trust regularly solicits feedback from service users to provide feedback to both practitioners and service design. The Trust ensures that formal 360 feedback is received by every doctor every 3 years.
Comments:	
Action for next year:	As above

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2025-2026 appraisal year.

	In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.
Comments:	
Action for next year:	As above

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	The RO and Appraisal lead attends the appraisal and revalidation networks to allow for peer learning.
Comments:	
Action for next year:	As above and in addition the Trust will explore the possibility of organising a peer review from a neighbouring Trust.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	79
Total number of appraisals completed	72
Total number of appraisals approved missed	7
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	7
Total number of late recommendations	0
Total number of positive recommendations	7
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	19
Total number of trained case managers	19
Total number of concerns received by the Responsible Officer[2]	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	17 (13.6wte)
Total number of new employment checks completed before commencement of employment	17 (13.6wte)
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
- There has been one referral for non-engagement with appraisal, the GMC moved to remove this doctor's licence to practice but the doctor ultimately retired and let their licence to practice lapse. - One doctor has not had an appraisal without a valid exception - The RO is satisfied that all other necessary appraisals have been conducted in the appraisal cycle. - The lead for Appraisal has changed from Dr Sinclair to Dr Heighton - Network and Development event held annually with the Appraisers to share experiences and problem solve.
Actions still outstanding
• We still need to complete a peer appraisal with another Trust
Current issues

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- The Trust currently lacks a ROAG group. The Trust develop this over the coming year and seek to introduce this

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Dr Sinclair the Trust's RO will continue to undertake appropriate CPD for the RO role.

We will continue to ensure there is sufficient resource to support the RO role as well as there being appropriate systems in place such as L2P.

We will continue the process of regularly checking the list of prescribed connections held on the GMC Connect website, against staff lists held on the Electronic Staff Record.

We will continue to review the Medical Appraisal Policy in line with review schedule.

We will continue attendance at the RO network and have annual reviews of our appraisal process.
The RO will explore the possibility of a peer review from one of the neighbouring Trusts.

We will follow GMC guidance in terms of establishing RO responsibility. All of our doctors (locum and substantive) will continue to be invited to attend the monthly Consultants' meetings and the educational programmes for CPD activity, and such data will be provided to locums and where appropriate their Agency RO's if / when required. We will supply relevant clinical governance information to their own RO e.g. complaints, serious incidents etc.

We will continue to offer all doctors in this organisation an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

We will monitor effectiveness of appraisals within the Trust by our comprehensive Medical Appraisal Policy, they are monitored by 20% random sampling by the RO.

Appraisals will be undertaken in the period December-March remotely via Microsoft Teams or face-to-face. We will supply centrally compiled data is used for individual doctors as a contribution to their supporting information. Information on Complaints, Serious Incidents and IR1's will be provided to individuals directly into their L2P account (our current appraisal management software).

We will continue to monitor engagement with appraisal process.

We will continue to review appraisal policy as per the schedule.

We will continue to offer new appraiser induction training and annual appraiser refresher training.
The trust will continue to monitor how many appraisers it has versus the number of appraisees to ensure that there remains enough capacity.

We will continue to offer and monitors compliance with annual refresher training to ensure all appraisers are up to date and compliant, this is delivered by the Medical Appraisal Lead. Any appraisals undertaken by new appraisers are reviewed by the Medical Appraisal Lead and they are provided with feedback. We will send reminders to all Appraisers that they demonstrate in their own appraisal how they keep up to date as an appraiser

The Trust Revalidation Support Team (TRST) will meet quarterly and is part of the appraisal quality assurance process.
On an annual basis the RO will review a sample of 20% of all appraisers for quality and consistency and feed this back to TRST and the doctors involved.

The revalidation and appraisal team will monitor when revalidation decisions are due and highlight this to the RO. Engagement is also monitored such that any requests to the GMC to bring forward revalidation decisions can be actioned

The Trust has instituted learning half days for all staff to enhance learning opportunities For doctors with leadership positions there is also a leadership development programme in addition to the learning half days and regular CPD programme. The effectiveness of these will be monitored.

The Trust will continue to ensure its system relating to the conduct and performance of medical staff is in accordance with the MHPS framework and is explicitly mentioned in the relevant policies. Serious concerns about medical performance will and should be managed outside of the appraisal system.
Relevant information will be supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.

Relevant information will be supplied to doctors for their appraisals, but doctors will be expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.

Relevant policies will continue to be reviewed and followed when responding to concerns about a medical practitioner’s fitness to practice.

If the RO determines that there are serious concerns in relation to a medical practitioner, they will be brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance step.

Any formal MHPS processes against a doctor will be noted in the Private section of the Board of Directors.

In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.

We will supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust.
Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary, pass that information on to the RO; we will also inform the doctor that we have taken this action.

We will continue to require all staff undergo relevant Mandatory/Statutory training e.g. Equality & Diversity, in addition the Trust must publish equality data in relation to certain protected characteristics (Race and Disability) every year.

The Trust will use its links with the Regional Appraisal Network, where concerns about a doctor to consult an independent representative from with the Network.

The Trust has systems in place to review national guidance such as NICE guidelines to ensure that the standards are reviewed against current practice in the Trust and this will continue.
We will continue to use forums within the Trust for national reports to be reviewed such that the Trust can determine whether any actions are necessary.

The Trust has policies in place to monitor performance of all staff against relevant professional standards and these will continue to be utilised.

The Trust will continue to follow guidance from NHS improvement and operate a Just Culture.

We will continue to use a checklist system for new starters and this will be monitored by the Medical Staffing Team, and further checks will be carried out by the Revalidation Support Team.
For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.

The Trust has introduced leadership training for all leaders within the organisation and we will monitor its effectiveness

There are learning half days for all staff. For medical staff there are regular weekly CPD sessions. Attendance and effectiveness will be monitored.

Equality and Diversity is mandatory part of Trust training for all employees and will continue to be monitored.

The Trust has implemented the principles of Just Culture and our HR processes are aligned to this.
There are support networks to promote diversity and inclusion.

The Trust has embedded PSIRF and work will continue to ensure that this is effective in its implementation.

The Trust will continue to use the Just Culture framework.

We will continue to promote Freedom to Speak up, review its policy and ensure champions are in place.
Incident themes will regularly reviewed to look for patterns and learning.

There is a complaints process which has an underlying policy in situ and this will continue to be reviewed.

We will regularly solicit feedback from service users to provide feedback to both practitioners and inform service design.

The Trust will ensure that formal 360 feedback is received by every doctor every 3 years.

The RO and Appraisal will lead attend the appraisal and revalidation networks to allow for peer learning. In addition the Trust will explore the possibility of organising a peer review from a neighbouring Trust.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

There are no current concerns about the management of governance of systems and processes in the Trust to deal with medical appraisal and revalidation with assurance provided to demonstrate that they operate effectively.
The feedback from the medical staff in relation to their appraisals 2025-2026 was very positive.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Rotherham, Doncaster and South Humber NHS Foundation Trust

Name:	Toby Lewis
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Dr Diarmid Sinclair
Email address:	diarmid.sinclair@nhs.net

Rotherham Doncaster and South Humber NHS Foundation Trust

Mortality Report

May and June 2026

Executive Summary

The May–June 2026 Prevention of and Learning from Deaths (PLFD) report records 102 deaths across the Trust, comprising 59 in May and 43 in June. The largest number was reported by Doncaster Adult Mental Health & Learning Disability services (35 across the two months), followed by Physical Health & Neurodiversity (26), North Lincolnshire Mental Health & Talking Therapies (21) and Rotherham Adult Mental Health (20). Most deaths occurred among older people: 68% were aged over 65, with 41% of deaths within the 65+ group involving people aged 80 or above. The gender distribution was broadly even, with 52 male and 50 female deaths. Overall, 54% of deaths were recorded as expected natural deaths occurring within the expected timeframe.

The majority of cases progressed through routine review without identified problems in care. Across May and June, 71 deaths were reviewed and closed following the Mortality Operational Group (MOG) screening process, while 15 required further information from the reporting service. Four cases required a Structured Judgement Review (SJR), six were escalated to the Patient Safety Team for further consideration, and six had a learning response outstanding.

Learning emerging from LeDeR and SJR work highlights the importance of stronger mental-capacity decision-making and documentation, multi-agency management of self-neglect and high-risk cases, reasonable adjustments, escalation when health deteriorates, robust hospital/health passports, effective handover and discharge arrangements, and better documentation of changing physical and mental health needs.

South Yorkshire ICB Suicide Prevention Plan 2026–27, with emphasis on high-risk locations and vulnerable groups, real-time surveillance, postvention support, coronial audit and a more data-led approach to prevention.

Across the Regulation 28 cases outside of the Trust, the main coronial concerns centre on system-wide weaknesses in communication, information-sharing, risk assessment, escalation and documentation, particularly where vulnerable people are supported by multiple agencies. Recurring issues include failure to share important information about deterioration or risk; assessments that did not draw on all available information; delays or failures in escalating concerns and responding to changing risk; inaccurate or incomplete clinical records; inadequate monitoring and handover arrangements; and policies being either insufficient or applied too rigidly, limiting professional judgement. Some cases also highlight staffing and resource pressures and weaknesses in safeguarding across organisational boundaries. Overall, the cases reinforce the need for proactive multi-agency working, robust and dynamic risk assessment, clear escalation pathways, accurate contemporaneous documentation, adequate operational capacity and systems that enable professionals to recognise and act promptly on the totality of risk rather than considering individual pieces of information in isolation.

Mortality Report – PLFD
(Data focus May – June 2026)

1. Situation

The Chief Medical Officer for the Trust chairs the bimonthly Prevention of & Learning from Deaths Group, (PLFDG), previously the Mortality Surveillance Group (MSG)
A report is then provided to the Quality Committee (QC) and forms part of the Chief Medical Officers Quarterly report to the Board of Directors (Public)

2. Background

This report provides the Quality Committee with salient features and issues in relation to mortality surveillance management with a focus of data for May and June 2026.
The figures can increase due to late reporting on RADAR by services and the timescales of when the deaths occurred and subsequently reported. (Figures accurate at the time of the report). Any late reporting identified will be added to the next report.

3 Assessment

3.1 Mortality Reporting and Management

During the months of May and June 2026 there were 102 deaths reported in the Trust.

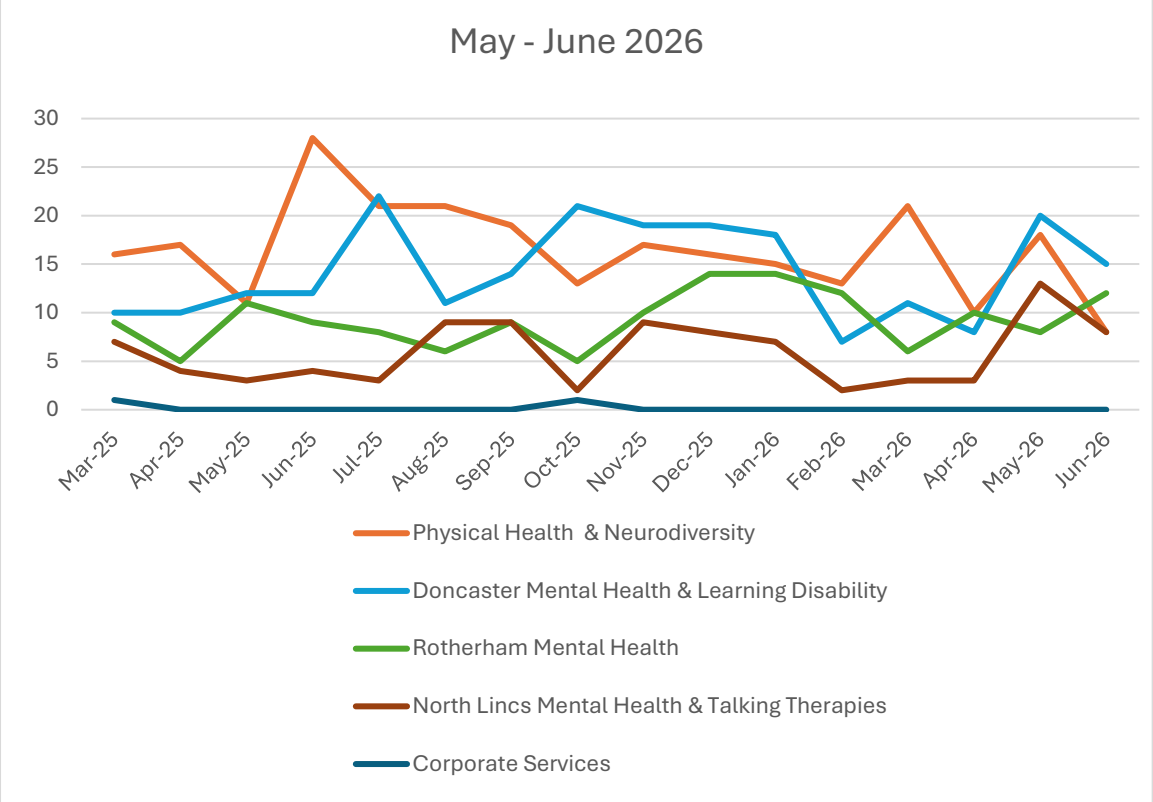
Table 1. – Status of deaths reported during May and June 2026.

Outcome of review	May	June
Reviewed by MOG and closed as no problem in care being identified	42	29
Reviewed by MOG, however , require further information and have been returned to the author	8	7
Reviewed and requires a Structured Judgement Review (SJR)	2	2
Reviewed and required further discussion in a Learning from Patient Safety Event meeting.	4	2
Awaiting further information from the coroner on cause of death	0	0

Awaiting review by MOG	0	0
Awaiting outcome of learning response	3	3
Total	**59**	**43**

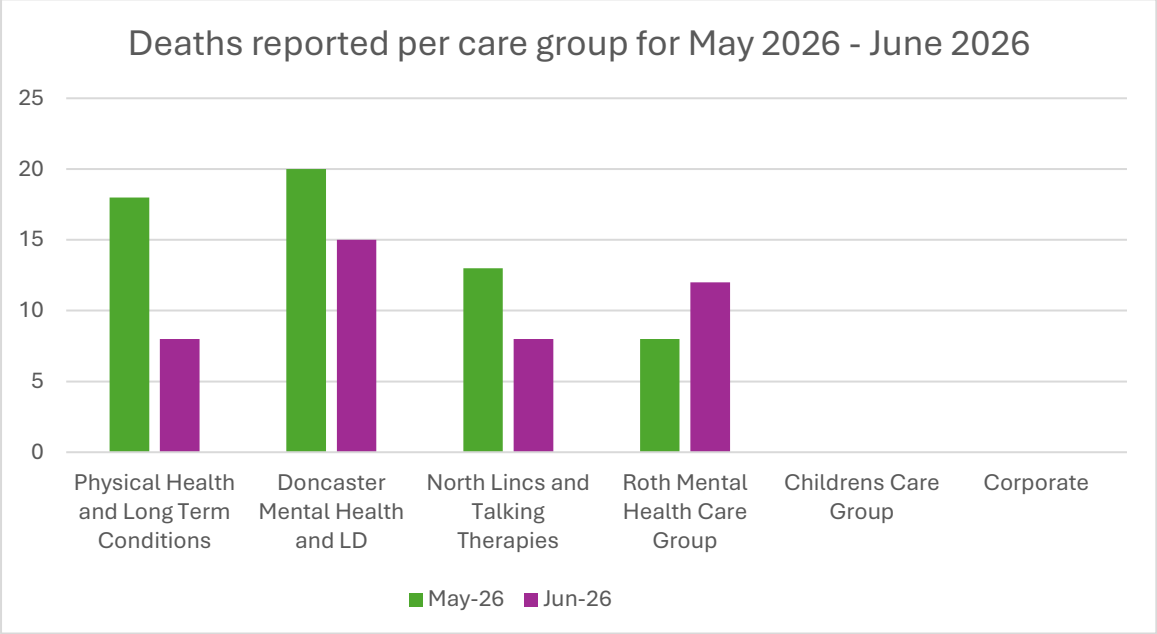
Deaths by Care Group from March 2025 - June 2026. Figures are offered in the longitudinal data as detailed below in graph 1.

Graph 1.



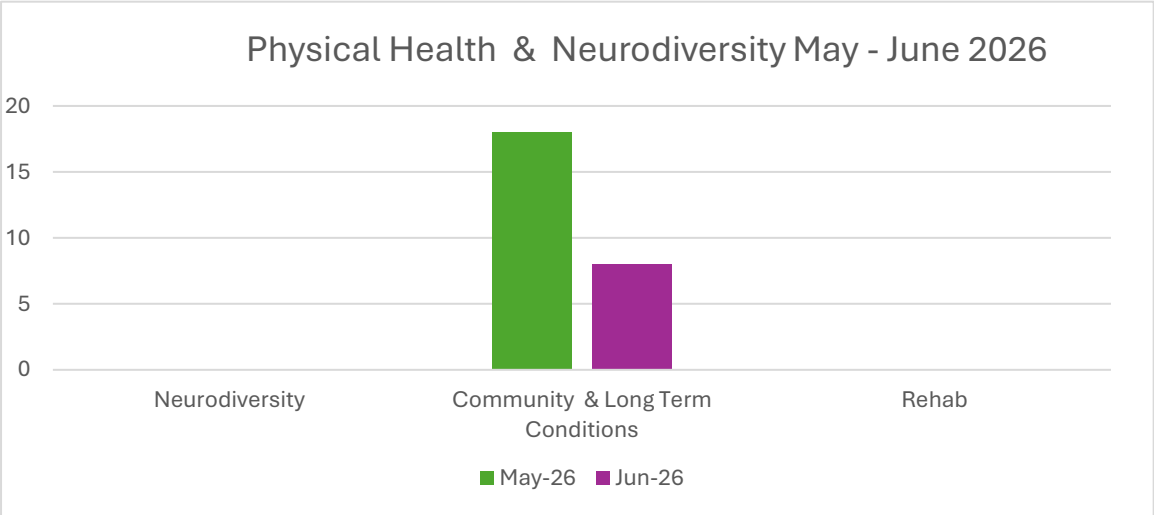
Graph 2 gives detail of the number of deaths as reported via the RADAR mortality forms from the care groups within the Trust during the months of May and June 2026.

Graph 2



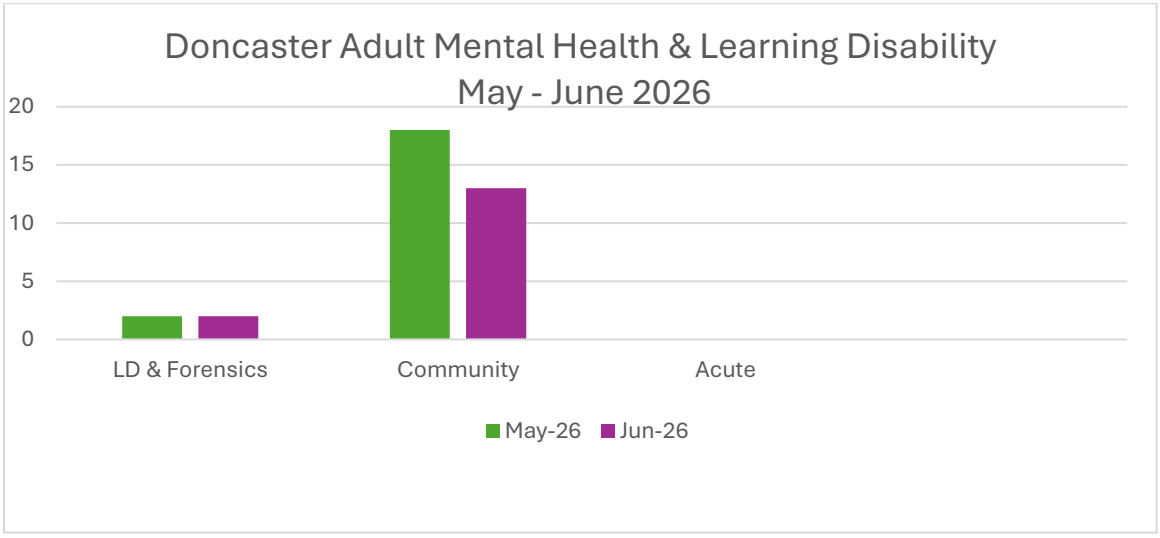
Graphs 2a – 2d offer a further breakdown of the data reported by individual care groups across the localities of the Trust.

2a Physical Health and Neurodiversity.



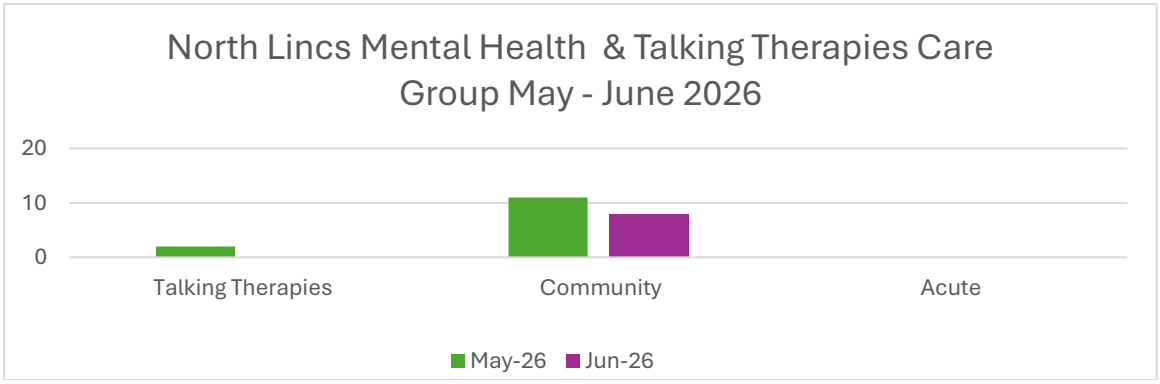
Highest figure of reported deaths from the Physical Health and Neurodiversity care group were as expected from the community and long-term conditions services.

2b Doncaster Adult Mental Health & Learning Disability



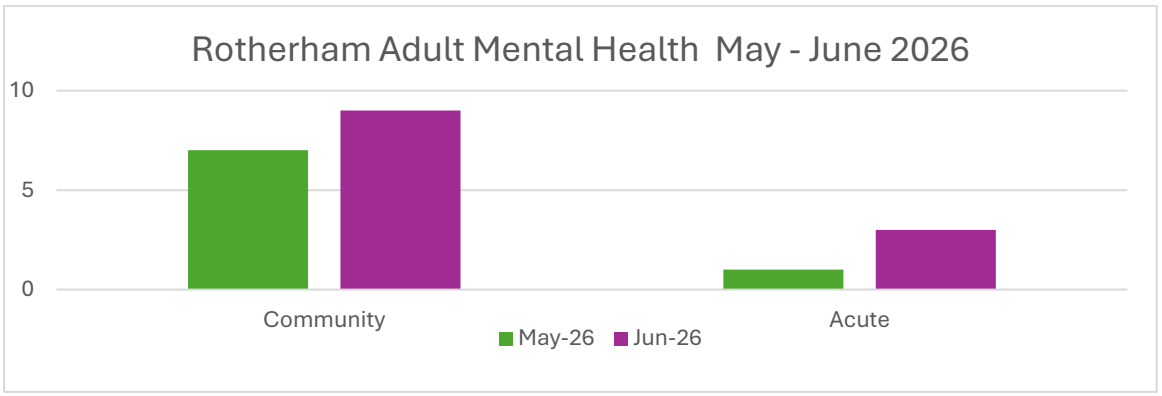
Highest numbers reported were from the community mental health teams. Learning Disability services reported 4 deaths during these two months.

2c North Lincolnshire Mental Health & Talking Therapies



During May and June , 21 deaths were reported by North Lincolnshire care group with 2 being from the Talking Therapies services across the Trust.

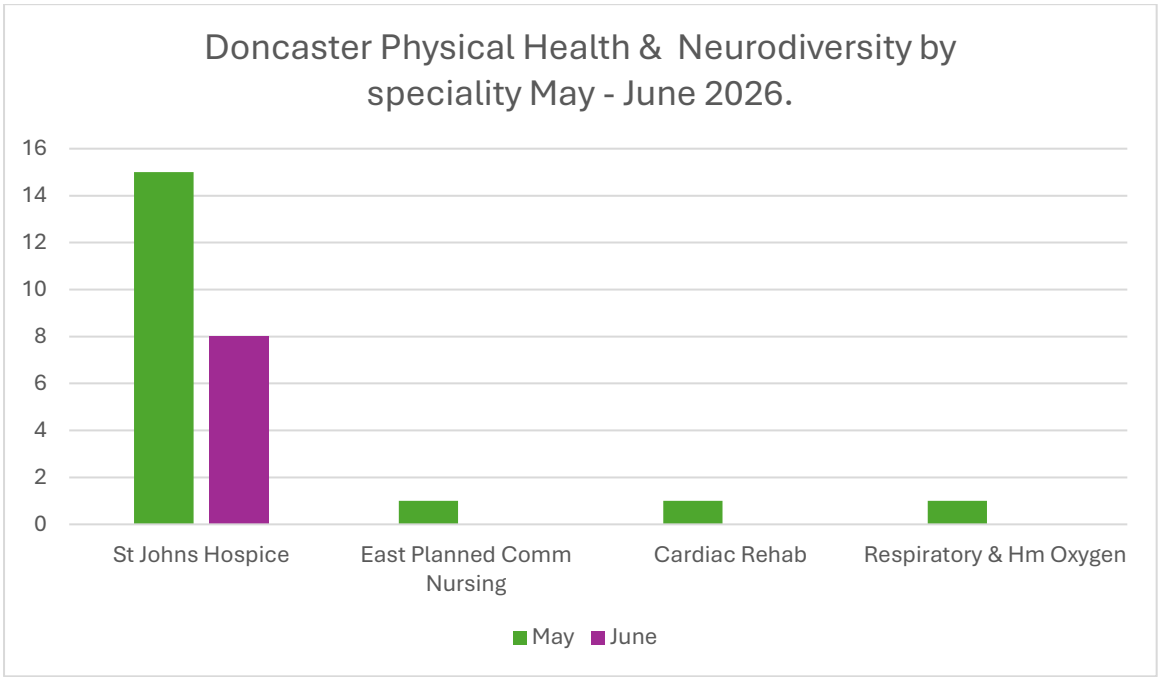
2d **Rotherham Adult Mental Health**



During the two months, 20 deaths were reported by Rotherham;16 being from the community services.

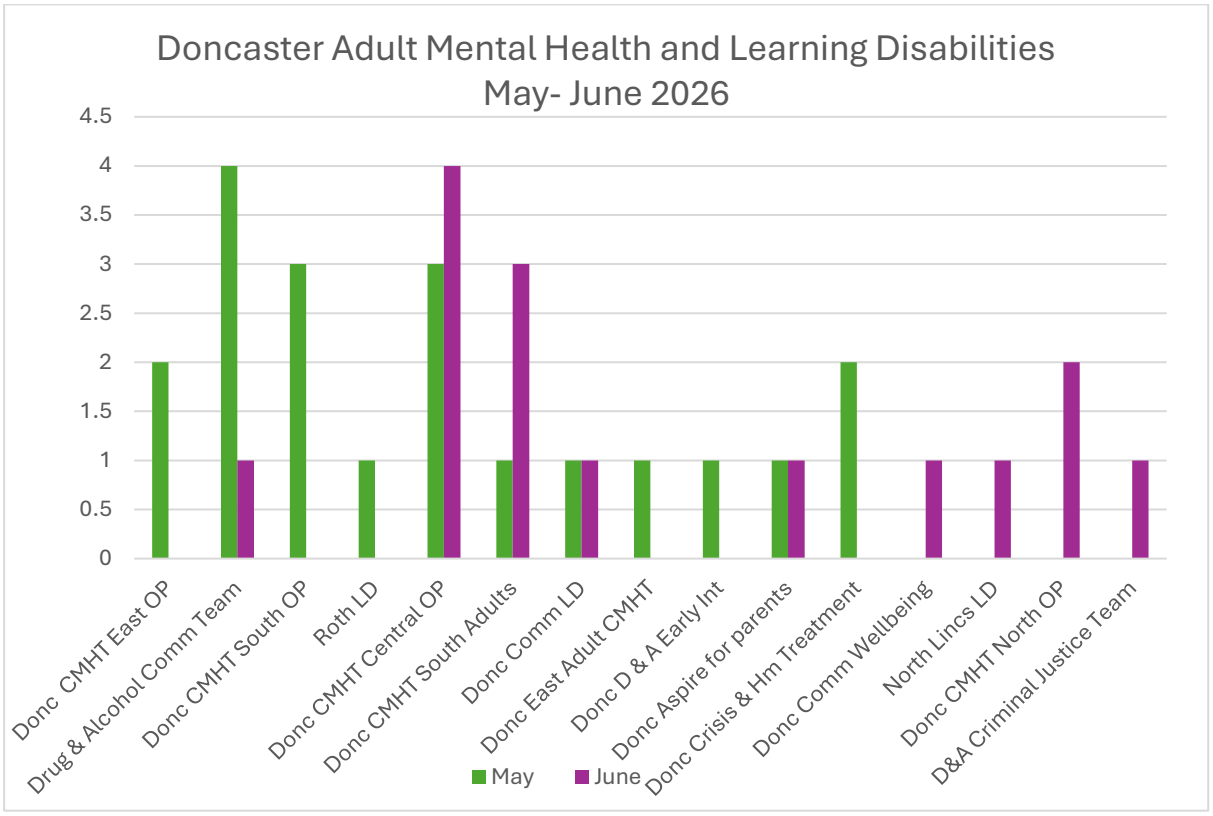
A further breakdown is offered in the following graphs 3a -3d, providing detail by specialty as reported from the RADAR system.

3a



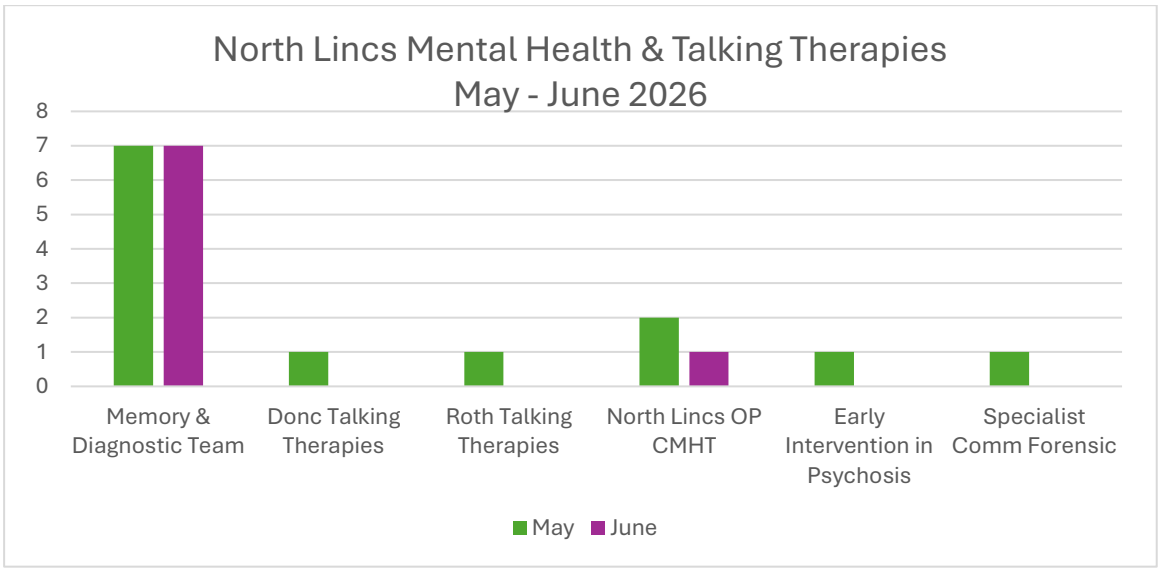
The highest percentage of deaths were reported from the hospice with 88 % of the overall figures. .

3b



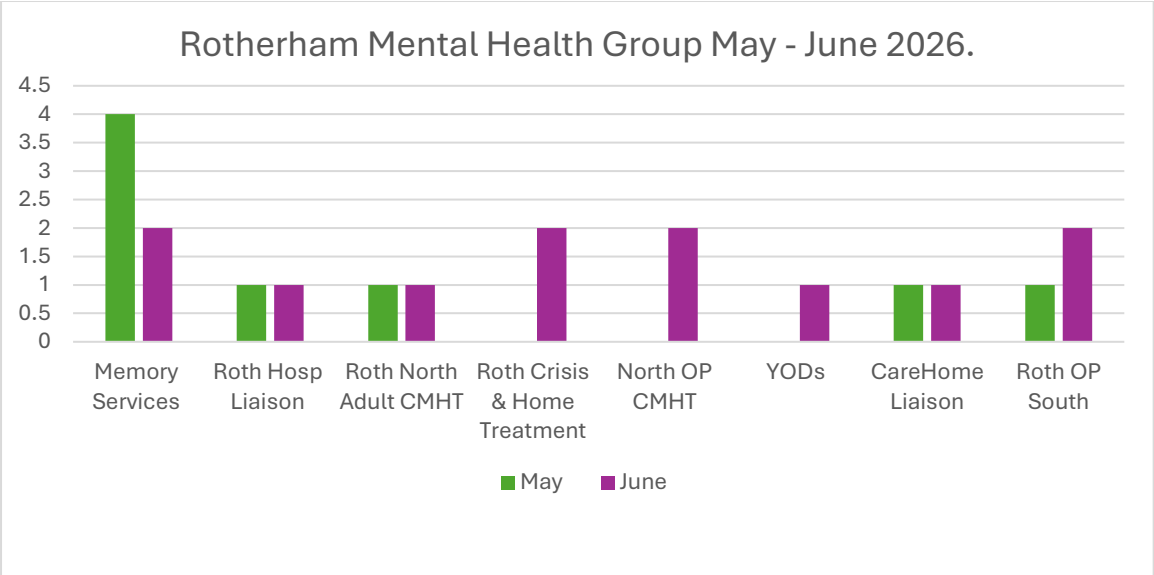
During May and June 35 deaths were reported from the Doncaster Adult mental health and LD services including 4 reported from the Learning Disability community teams across the organisation.

3c



Teams from the Memory and Diagnostic services in North Lincolnshire reported the highest numbers with 14 recorded out of 21 in total for the care group.

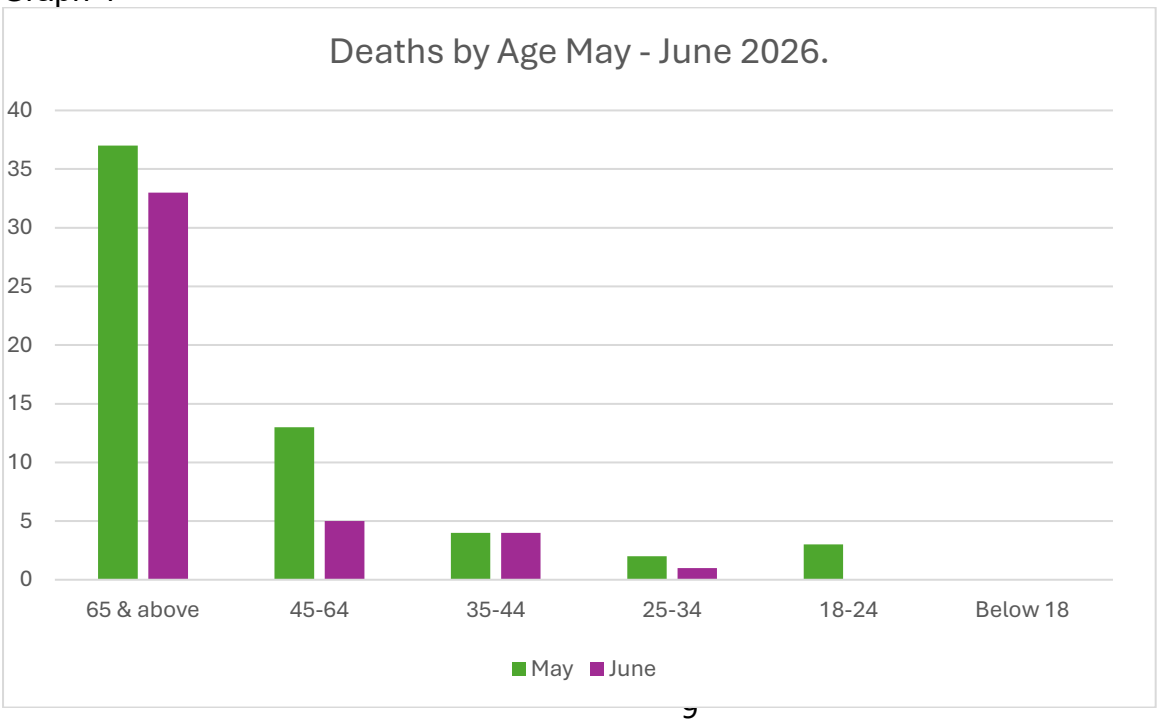
3d



Highest numbers of deaths reported by Rotherham Mental Health teams were from the older adult services, mainly the Memory Services team .

<u>Deaths reported by age, May – June 2026</u>

Graph 4

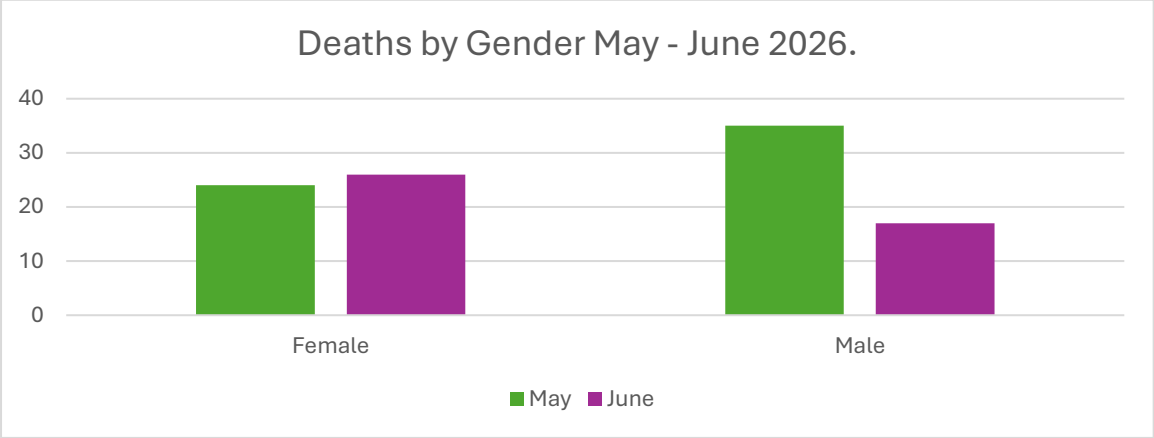


During the months of May and June the data showed that 41% of deaths reported in the 65+ group were for people aged 80 years and above, with 68% being over the age of 65 for the whole of the deaths reported.

Data identified that 31% of deaths reported were under the age of 65 years.

These figures were inclusive of the LD deaths and with further detail identified in later graphs.

Graph 5

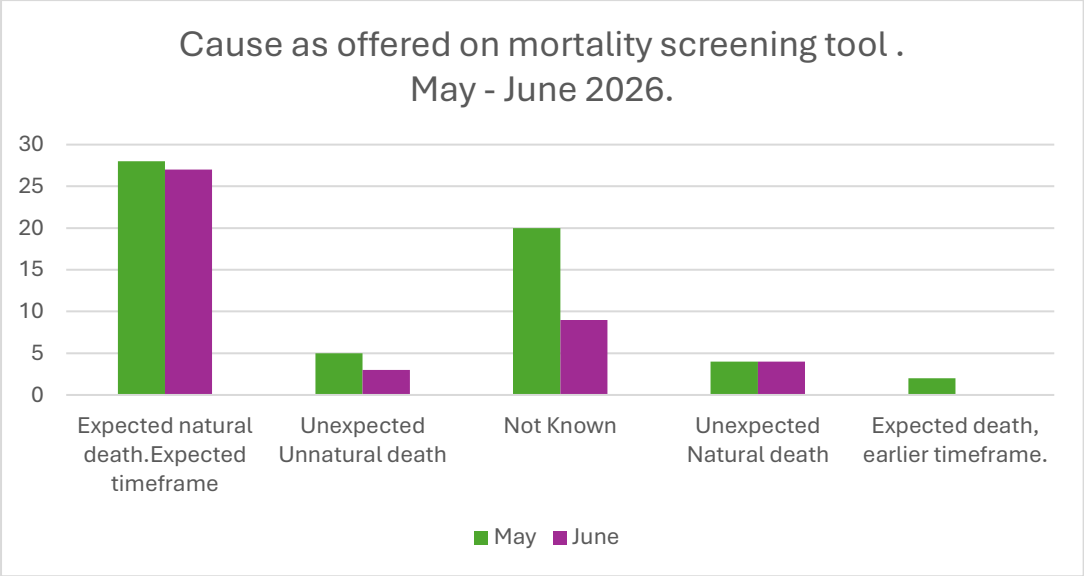


During May and June 2026, male deaths recorded were slightly higher than females, 52 compared to 50, respectively .

The hospice reported 15 female deaths in May and June with 8 deaths for males.

Graph 6 shows detail relating to timeframes in respect to the deaths 54% being an expected death in the expected timeframe.

Graph 6



3.2 Structured Judgement Review process

The Mortality Operational Group (MOG) reviews all deaths recorded via the RADAR reporting system. During which, any that have identified as a “Red Flag” the incident is escalated to either a Structured Judgement Review if the person is known to have a Learning Disability or is tasked back via RADAR to the author, care group, or service for a further review under the PSIRF approach options.

Should MOG request further detail to be added to the form, this is also tasked back to the author and once completed a further review takes place.

Once MOG are satisfied and with no further concerns are noted, the form will then be closed.

A member of the Patient Safety Team attends the weekly MOG and together discuss and decide if further escalation is required at the LFPSE meeting. If so, a decision will then be made at the LFPSE and the appropriate action proposed. This process allows for the opportunity for further learning and shared outcome responses.

Up to the end of June 2026 , 16 SJR’s are to be completed on RADAR.

Table 2

The table below indicates the detail of the monthly reviews of each death which was reported during May and June 2026 on the RADAR system.

Month	**May**	**June**
Total number of deaths reported	**59**	**43**
Total No of deaths reported by Care Group		
Donc AMH & LD	**20**	**15**
Physical Health and Neurodiversity	**18**	**8**
Rotherham AMH	**8**	**12**
North Lincs & Talking Therapies	**13**	**8**
Children’s services	**0**	**0**
Corporate Services	**0**	**0**
Cause group		
Expected natural death, expected timeframe	**28**	**27**
Expected natural death, earlier than expected timeframe	**2**	
Expected unnatural death		

Not known	**20**	**9**
Unexpected natural death	**4**	**4**
Unexpected Unnatural death	**5**	**3**
Gender		
Male	**35**	**17**
Female	**24**	**26**
Age Group		
<18	**0**	**0**
18- 24	**3**	
25-34	**2**	**1**
35-44	**4**	**4**
45-64	**13**	**5**
>65	**37**	**33**
MOG data		
Incident appraisal screening tool only	**42**	**29**
Await further information and returned by MOG to the author	**8**	**7**
SJR Inc for LeDer report	**2**	**2**
Escalated to Patient Safety Team	**4**	**2**
Await info from coroner re Cause of Death	**0**	**0**
Await review by MOG	**0**	**0**
Learning response to be done	**3**	**3**

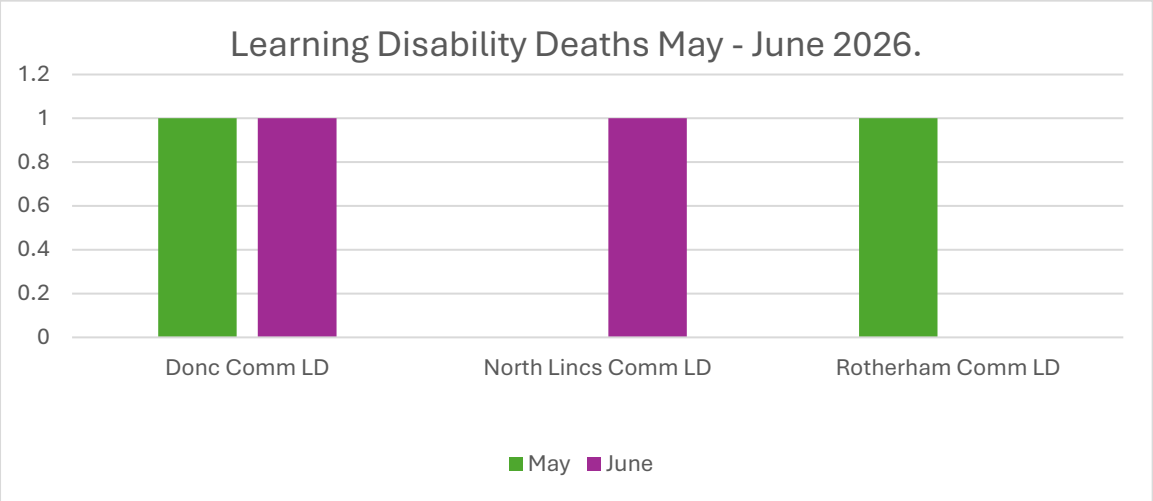
3.3 LeDeR reports & Structured Judgement Reviews.

During May and June 2026, 4 deaths were recorded from the Learning Disability services from across the Trust.

All of which are subject to a LeDeR review being completed as well as an SJR.
The " Learning from Lives and Deaths, LeDeR process reviews the health and social care records of individuals who have died and are known to have a learning disability or autism.
The graph below offers detail of the teams which have reported the death of someone known to their service during this data collection period.

Learning Disability Deaths

Graph 7

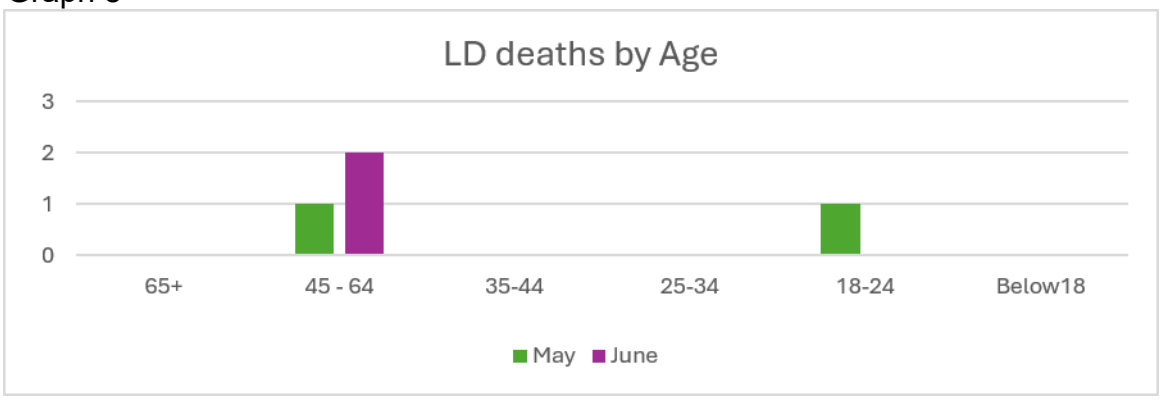


Detail offered in graphs 8 and 9 provides information in respect to the age and gender of people with a known learning disability and or autism who died during May or June 2026.

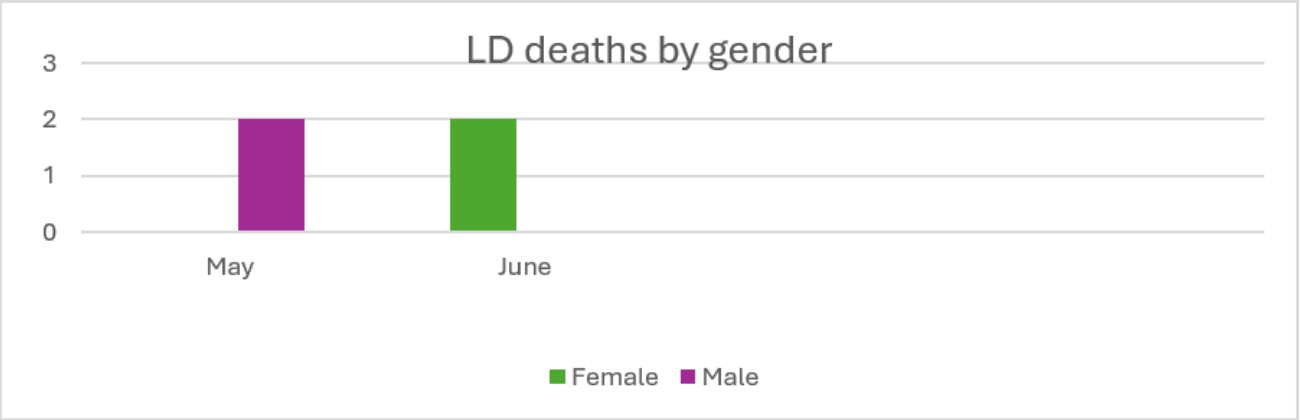
Two of the deaths were expected deaths and within the expected timeframe. Male aged 21 and female aged 61, respectively.

One death reported as cause unknown, male aged 61, by the author and one reported as an unexpected death with care concerns of a female aged 62.

Graph 8



Graph 9



Information detailed with in the LeDeR reports received in June offer the following actions to be taken by Doncaster local authority and organisations involved in the care of the deceased.

- To introduce clear Mental Capacity Trigger points for escalation
- Timely documentation is recorded and detailed in relation to specific decision-making regarding capacity
- Introduction and implementation of multiagency self-neglect pathway which includes risk stratification with regular reviews and to include the named coordinator
- Mandatory early MDT meetings for high-risk cases with the named lead professional with shared care and risk plans
- Community Learning Disability ,Speech and Language Therapy team to embed reasonable adjustment approaches including shorter staged assessments, consistent staff involvement use of trusted relationship and communication tools
- Need for escalation protocols linked to deterioration indicators associated with safeguard concerns
- Housing risks to be included in MDT discussion along with safeguard plans
- The introduction of verification checks and audit processes for continuing health care and key decision documentation
- to introduce standardized handover and discharge protocols with named receiving lead.
- Care staff to be involved in competency assessments , audits of practices and regular reviews to address any concerns promptly associated with diet and hydration
- Encourage early discussion relating to RESPECT reviews and timely involvement of palliative care services.

- Introduce concise escalation summary of health passports that clearly document baseline observations along with usual presentation and agreed thresholds.
- Complete regular audit of Mental Capacity Assessments and DOLs compliance along with Best Interest decision recorded correctly.

No additional update is available from RDaSH Learning Disability Services.

Findings identified by the Structured Judgement Reviewers with respect to incident forms from RADAR found similar concerns associated with hospital passports and updated documentation to reflect changes in known health conditions associated with both mental and physical health

presentations and comorbidities.

4. Learning from Deaths

The Chief Coroner for England and Wales is the most senior coroner, and they are appointed by the Lord Chief Justice of England and Wales in consultation with the Lord Chancellor. The past four Chief Coroners were all Crown Court judges at the time of their appointment to the role.
At an inquest, a coroner may issue a Regulation 28 Prevention of Future Deaths ,(PFD). report where it is believed that action should be taken to prevent future deaths. These can be issued during the inquest proceedings or at the conclusion of the inquest. The recipient of the report has a statutory duty to respond within 56 days.

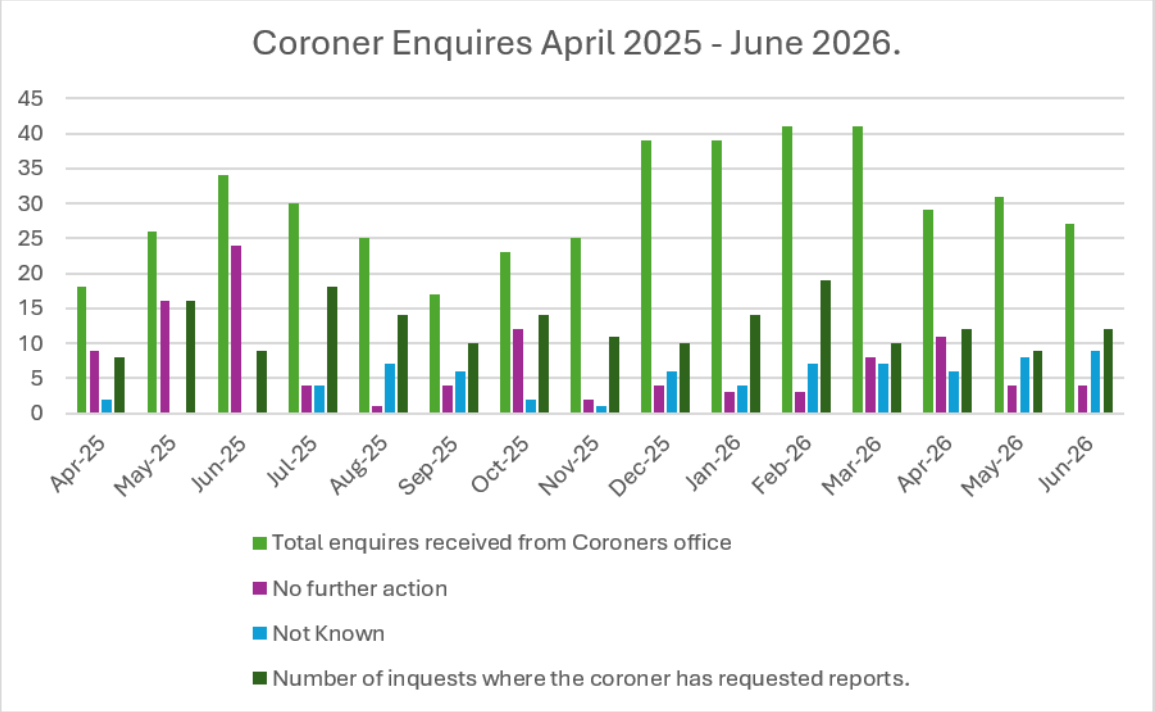
Whilst PFDs are rarely issued, they can offer valuable insight and opportunity for learning for the NHS and other authorities and these, along with other information received by NHS England, help to improve services .

Detailed in Appendix 1 of this report are a selection of PFD's along with the concerns raised from each of the concluded inquests which have been issued to other authorities and organisations and where it was felt that future attention was required in the prevention of future deaths. The selection is from several jurisdictions and offers opportunities for our Trust to be proactive in recognising areas for improvement in respect of continued learning and development from deaths.

4.1 Coronial inquests

Information below in graph 10, offers the detail of enquiries and inquests from several jurisdictions involving the Trust dating from April 2025 through to June 2026.

Graph 10



During May and June 2026 , the Trust received 58 enquiries from the coroner's office and local jurisdictions.

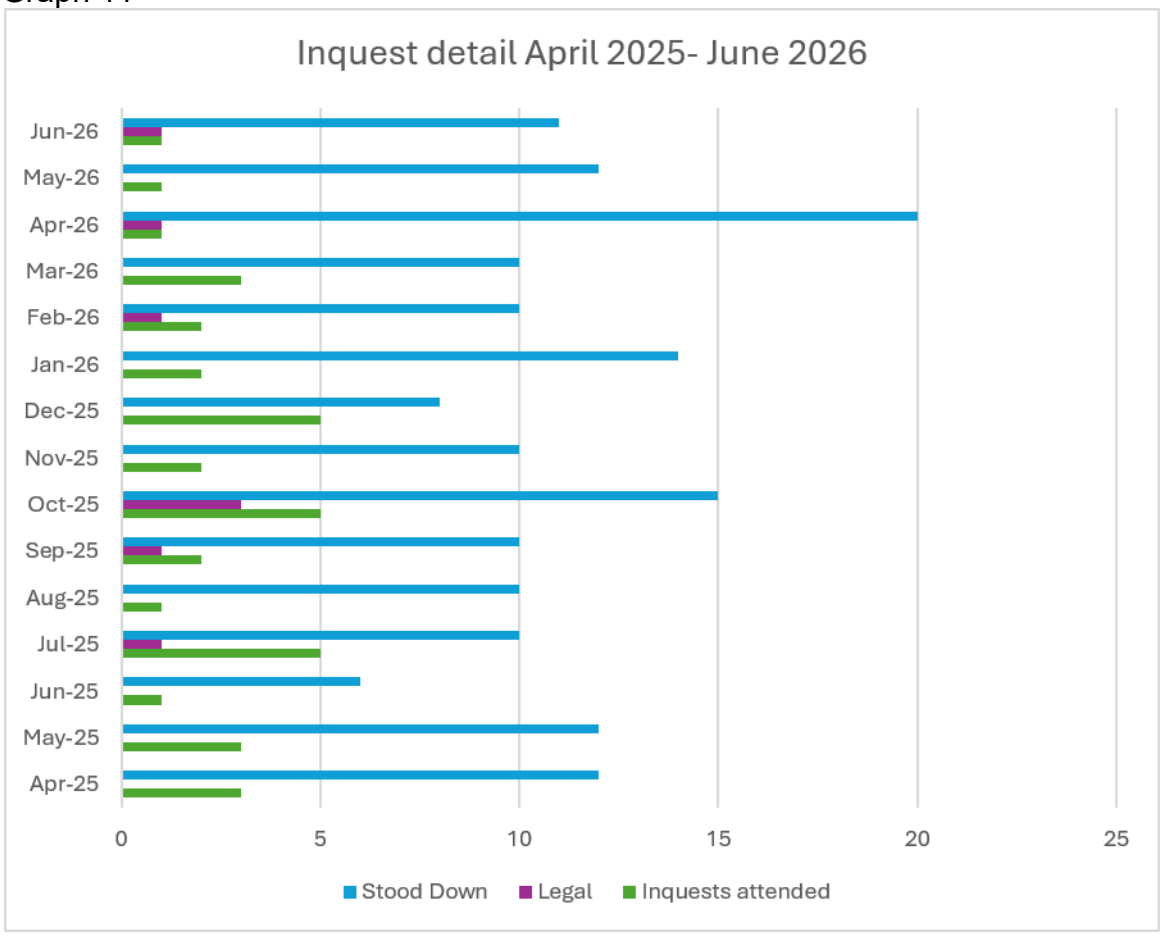
Following further detail provided to the coroner, formal requests were received from the coroner to the Truist on 21 occasions for statements or reports to be submitted.

In May and June, the Coroner and Mortality team attended 2 inquests. All of which were heard in Doncaster.

During these months, the Trust was stood down for 23 inquests as the evidence submitted to the court was accepted by the coroner and the families of the deceased, therefore evidence was read out in court under Rule 23.

This in turn offers clinicians and colleagues the opportunity to provide increased direct patient care by not being required to attend court.

Graph 11



Information offered in graph 11, offers detail over the time period of April 2025 – June 2026 the number of inquests where the Trust has had legal representation at inquest. Also, the number of occasions as to where the Trust has been stood down from being required to provide live evidence in court.

Over the past twelve months the team have offered face to face and Teams sessions to colleagues throughout the organisation providing awareness training and an insight into the process of an inquest

and what is expected in regards to the standard of information required in respect of reports and statements for the coroner .

The standard of reports has improved and this is supported by the team having a final review of each report prior to submission to court. This offers the opportunity to be proactive in respect of learning and possible actions required prior to inquest.

The sessions delivered to date have been welcomed with other dates planned throughout 2026.

4.2 Suicide prevention

The South Yorkshire ICB Suicide Prevention Plan for 2026 – 2027 have set clear aims and objectives for the forthcoming 12 months.

Within this plan are clear aims to reduce the number of suspected suicides in South Yorkshire and to support those who are affected or bereaved by suicide with a focus on the development and implementation of a programme of work building on place-based suicide prevention plans and the National Suicide Prevention Strategy for 2023- 2028.

Objectives set out include reducing the risk of deaths at high-risk public places including railways and motorways based on risk level and intelligence.

Also, consideration of inclusion groups –

- People who are neurodiverse along with recommendations from the 2026 LeDeR thematic review
- The inclusion of LGBTQ+ communities
- Older adults aged 60+ and recognising people with physical health comorbidities including long term conditions and pain
- People affected by domestic violence and abuse
- People within the criminal justice system
- People known to mental health services and at an elevated risk of suicide
- People experiencing drug and alcohol misuse including dual diagnosis.

Further objectives set out include

- The use of a data-led approach to informing training needs across the region of South Yorkshire
- Maintain and develop the existing real time surveillance workstream to monitor and respond to suspected suicides
- Maintain and develop the existing Postvention Support offer across South Yorkshire
- Completion of a South Yorkshire coroners audit and any recommendations
- Annual suicide memorial service
- Review of suicide prevention activity amongst South Yorkshire mental health trusts
- The development and implementation of a structured approach with academic partners to translate systems priorities into defined research questions which enable prevention activity and the evidence base across South Yorkshire.

There is an expectation that in Q3 of 2026 there will be an update from Mental Health Trusts in respect to the work planned and implemented focusing on Suicide Prevention.

Appendix 1

Sample of Prevention of Future Deaths Reports recently issued to authorities and organisation.

1	
Date published	06 May 2026
Coroner	Professor Paul Marks
Area	Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
Issued to	The Chief Constable of Humberside Police
Conclusion	Suicide
Circumstances	27-year-old lady with significant history of mental health issues dating back to adolescence years. Dependent on alcohol . Chronic pancreatitis. Lifestyle was extremely chaotic . Despite having her own premises and a room at her mother's house she chose to live in a tent in local park. Vulnerable and probably subject of mental , physical, and sexual abuse from others who live rough and also used the same park for drinking alcohol and use of illicit substances. Found suspended. Date of death 08.12.2025.
Concerns raised by the coroner	The park frequented by individuals who sell and abuse drugs , drink alcohol and in addiction , many sleeping rough in the park. Criminal activities of various sorts occur frequently and vulnerable individuals are at high risk as a consequence
Action to be taken	Review the policing and police presence in the area.
2	
Date published	19 June 2026
Coroner	Professor Paul Marks Senior Coroner
Area	Hull and East Riding
Issued to	The Secretary of State for Health
Conclusion	Accident
Circumstances	78-year-old gentleman who during the last eighteen months of life had been losing weight unintentionally and becoming frail. Prone to falls. Following three admissions from Oct 2025 where bladder cancer was diagnosed up until Dec 25 with a working diagnosis of hypoactive delirium secondary to sepsis of unknown origin , malnutrition, and frailty. High risk of falls. Had an unwitnessed fall on the 9th December on the ward not associated with traumatic brain injury, he did have a second fall on the 10th December, which was complicated by intercranial hemorrhage , constitutional damage to the brain and early post traumatic epilepsy that resulted in death on the 10th Dec. After his first fall he should have received 1-1 nursing care and observations should have taken place . Had he done so he would not have fallen , sustained traumatic head injuries leading to death.
Concerns raised by the coroner	This gentleman should have received one-to-one nursing care but due to a combination of understaffing and more pressing cases on the ward, he did not receive such care. Evidence was heard that had he received such care he would not have fallen and died. Evidence was also heard that within the Hull Trust and probably throughout the NHS, resources are critically stretched and whilst improvements are being proposed, I believe that the current situation makes it probable that similar deaths will occur.
Action to be taken	Opinion action should be taken to prevent future deaths and I believe you and your department has the power to take such action, possibly by reviewing funding and staffing numbers within the NHS at large.
3	
Date published	30.06.2026

Coroner	Lorraine Harris Area Coroner
Area	East Riding of Yorkshire and City of Kingston Upon Hull.
Issued to	NHS Pathways
Conclusion	Catastrophic bleed following loss of integrity in the dorsal pedal artery and vein.
Circumstances	82-year-old gentleman, Medical cause of death 1 a Hemorrhagic shock , exsanguination 1 Erosion of blood vessel dorsum of left foot The gentleman made a call to the ambulance service due to the fact he was unable to stop a catastrophic bleed on his foot, he indicated that he was on blood thinning medication. During the call, the gentleman ceased responding. Due to high demand, an ambulance was not available to attend for 1 hour and 20 minutes. When the crew arrived at his home, the gentleman had died. Pathology revealed that his artery and vein had lost their integrity. It would be unsafe to say exactly when the gentleman died and whether an ambulance arriving more promptly would have been able to save his life. Previously the gentleman led a healthy life and he was able to maintain this until 2022 when his health began to deteriorate. He became unsteady on his feet, in 8-9 months before death had become clumsy. In December 2024 during an admission to hospital, it was noted that he had a non-occlusive thrombus of the left long saphenous vein and was advised by a hospital consultant to commence a 3-month course of Rivaroxaban. This blood thinning medication should have been ceased by the surgery on 10th March 2025. There was a human error regarding how this medication was input on to the system which led to it being given to the gentleman as a repeat prescription. The gentleman had interactions with the surgery and hospital both before and after the recommended end date for his blood thinning medication, providing multiple opportunities to identify the issue with the prescription being incorrectly recorded as on repeat. On 14th and 23rd January 2025, he suffered bleeding from foot. On those occasions he had telephoned nearby family first. On 17th September 2025 he telephoned 999 ambulance service and reported that a scab had come off his foot and he was unable to stop the bleeding. It would be unsafe to say exactly how the bleed began, evidence stated it could have happened spontaneously for reasons such as a peak in high blood pressure, or something as minor as knocking the scab off. o Pathology found that the bleed was at the dorsum of the foot. There was an ulcer in the location. o Both the dorsal pedal artery and the vein had lost their integrity and hence the bleed became catastrophic. o The fact the gentleman was on blood thinning medication would have impacted his blood's ability to clot. o It would also be unsafe to say how long it was after the bleeding commenced that he made the decision to call o The call went through to the Welsh Ambulance Service who were dealing with calls on behalf of the Yorkshire Ambulance Service. o The call was categorized at this stage as a category 2. There were no available resources to dispatch at that time due to high demand (staffing levels were regarded as appropriate). o Where an ambulance response is delayed and a patient is a high risk of deterioration like an uncontrolled bleed, it is good practice for a healthcare professional to support and try to manage the situation until

	help can arrive. The Clinician who sought to do this was unable to make contact with the gentleman as the line had been left open. o I find with all the knowledge that was known (the catastrophic bleed that was uncontained) at the point he stopped responding, the call should have been a category 1. Given the availability of the ambulances and the distance of the nearest available ambulance I do not find that upgrading the call would have prevented the gentleman's death.
Concerns raised by the coroner	Calls are taken by control room staff who do not have medical training, they ask a series of questions and on receipt of answers are able to categories the priority of response required. At the time of the incident the Advanced Medical Priority Dispatch System was utilized. The ambulance service now use the NHS Pathway system. The ambulance service, correctly pre-empting coronial concerns about categorisation especially in light of the duty to prevent future death, sought to check that if provided with similar information, the new NHS Pathway system would recognise the seriousness of an uncontrolled bleed. It appeared that NHS Pathway may have misunderstood the concern raised by the service and did not wish to "endorse" what was being stated, which was not the reason for the referral by the ambulance service. In the new NHS Pathway system there appeared to be an insufficiency in the questions to correctly identify the seriousness of an uncontrolled bleed (there is no question regarding whether the bleed is controlled or not). This could lead to the categorisation of the call being incorrect and a delay in treating a catastrophic event needing immediate attention. It is my understanding that the Yorkshire Ambulance Service are willing to work with NHS Pathways to assist them to fully understand the concern raised.
Action to be taken	Opinion, unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
4	
Date published	17July 2026
Coroner	Hannah Berry
Area	South Yorkshire (West)
Issued to	Chief Executive Barnsley Metropolitan Borough Council |Chief Executive Southwest Yorkshire Partnership NHS Trust | Headmaster Barnsley Community Academy
Conclusion	Suicide 1a Compression to the neck Died at Barnsley hospital from hanging
Circumstances	O had complex needs with suspected neurodiversity, identity confusion and there were concerns she was being bullied at school. On 19 and 26 September 2023 O self-harmed at school, on 21 November 2023 she attempted to self-ligature and on 4 December 2023 she attempted an overdose. Following these incidents O was supported by the mental health services crisis team until her discharge on 11 March 2024 when it was assessed that she was no longer in crisis. On 4 October 2023 O was put on the waiting list for psychosocial intervention from mental health services and was eligible to start this intervention in June 2024. Due to poor communication between agencies, O was discharged from the service due to no contact and therefore no psychosocial intervention occurred. This was a missed opportunity for O to remain under the care of mental health services. There were additional missed opportunities due to lack of communication when additional self-harm attempts were not reported to mental health services. It cannot be said whether the missed

	opportunity to receive additional support from mental health services caused or contributed to her death. There was suspicion of borderline personality disorder and at times it was reported that she struggled with body identity. She had changed her pronouns at varying times in her life. She did not enjoy school and was bullied at times during her time at school. O first voiced suicidal ideation on 9 November 2022 and had sessions with the school counsellor. On 19 September 2023 whilst in school she cut her wrist [REDACTED]. A week later on 26 September she used [REDACTED]. Following the second incident she was taken to hospital and referred to the child and adolescent mental health service (CAMHS) within Southwest Yorkshire Partnership NHS Trust and on 4 October 2023 was put on the wait list for psychosocial intervention with CAMHS. On 23 November 2023 she admitted to the school counsellor that she had attempted to self-ligature two days prior and on 4 December she was taken to hospital following an attempted overdose. Following this O and her family were allocated a targeted early help support worker at Barnsley Metropolitan Borough Council. O was supported from the crisis team within CAMHS until she was discharged on 15 February 2024 as it was assessed that she was no longer in crisis. O had a period of absence from school as it was felt that school and bullying were a trigger for her and on 22 February 2024 she returned to education with a carefully managed integration. On 16 April O reported to the deputy designated safeguarding lead at school that she had suicidal thoughts. Early help were notified but CAMHS were not. On 14 May O's early help support worker was notified by O's mother that O was self-harming. This was not notified to CAMHS. On 11 June, just over 9 months after O had been put on the wait list for psychosocial intervention, she was allocated a psychologist. The psychologist was unable to make contact with O's mother by phone or post and so after making enquiries with the school that O was in full-time education she was discharged from CAMHS. Neither O's school nor early help were notified of this discharge and remained unaware that O was closed to mental health services. Had early help have been made aware then they would have been able to inform CAMHS that O's mother was having problems with her telephone and of other issues that may have meant that contact could have been made. O and her mother were also unaware that she had been discharged. On 6 June, the early help support worker was notified that O had been pulling her hair out. CAMHS were not notified. On 9 September, the early help support worker contacted CAMHS to get an update on O's waiting list status and was advised that she had been discharged. On 6 October O took her own life. During the inquest, evidence was heard from O's school that O had not asked to be known by anything other than her birth name of W at school. Evidence was also heard from early help that engagement had occurred with school on the importance of using O's chosen name and pronouns. There was no record of this being noted and actioned.
Concerns raised by the coroner	There was poor communication and engagement between the agencies involved with supporting O. This led to missed opportunities for O to continue to receive the support of mental health services. 1) Poor communication and engagement between the agencies involved

	with O including her school, CAMHS and targeted early help. 2) A lack of communication and engagement between targeted early help and CAMHS despite both agencies being aware that the other was involved. This led to a confusing picture and a missed opportunity for O to remain open to CAMHS and receive psychosocial intervention and continued support from CAMHS. 3) There was no record of important discussions that occurred between early help and the school and O's preference in relation to pronouns was not acted upon.
Action to be taken	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
5	
Date published	17 July 2026
Coroner	Mary Hassell
Area	Inner North London
Issued to	Chief Executive North London NHS Foundation Trust
Conclusion	Natural Causes
Circumstances	55-year-old gentleman found unresponsive in his mental health bed at approx. 7:24 am on the 3 01 2025 He was resuscitated but died in intensive care the following day. Had been suffering from complex lung disease but no evidence that this had developed as a consequence of exposure to asbestos. Medical cause of death 1a acute on chronic cardiorespiratory failure 1b interstitial lung disease of uncertain aetiology in an individual with a markedly raised body mass index. Further detail- On general observations in a secure mental health ward. A member of staff was meant to look through the observation panel of his bedroom once every hour, on the half hour, to make sure that he was safe and well. The member of staff was required to satisfy themselves that their patient was breathing and then record the fact of the observation.
Concerns raised by the coroner	The clinical support worker who had been tasked with conducting NNs observations recorded that she had observed NN at the following times: 4.30am 5.30am 6.30am She reiterated that in her statement and in her oral evidence at inquest. She did not volunteer the fact that her record was wrong. It was only when I put it to her in quite robust terms that she accepted this. In fact, the ward CCTV showed that she looked through the observation panel at the following times: 4.48am 6.18am Thus, the record she made did not reflect the actions she took. The consequences of this are as follows: 1. A patient's medical record was wrong. Any healthcare professional seeking to understand when NN had been observed to be well by reading the record would have been given the wrong information. 2. The fact that this record was wrong casts doubt on the remainder of the record, both in terms of this individual (was he actually well at the

	times recorded?) and the other patients (were they observed when the record indicates that they were observed?). 3. The court was misled. Observations should be conducted when they are meant to be conducted, but if they are not then this fact must be recorded contemporaneously. It was put to me by the trust's solicitor, because the clinical support worker later looked through the observation panel at 6.36am, this meant that the number of observations recorded was accurate and so the later observation somehow made good the lack of earlier observation and corrected the wrong recording. That is simply not the case. Proper patient care demands that patient records are accurate and not in any way fabricated. Regarding the giving of inaccurate evidence in court, this may amount to a contempt of court, it may amount to perjury, it may be punishable by a fine or even by a term of imprisonment. For your patients, it obstructs learning from deaths.
Action to be taken	In my opinion, unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
6	
Date published	17 July 2026
Coroner	Gareth Lewis
Area	Carmarthenshire and Pembrokeshire
Issued to	Hywel Dda University Health Board
Conclusion	Asphyxia by hanging . Suicide
Circumstances	54-Year-old gentleman died as a result of hanging himself in February 2020 at his home address. Circumstances that he was struggling with his mental health and in the absence of a thorough mental health risk assessment being undertaken. Family , police, and the ambulance service all had concerns for his mental health which culminated in a GP making an emergency referral for a Mental Health assessment. 24 feb 2020 assessed by CPN . After hearing evidence, I found that there was an overreliance on what T told the nurse, a failure to review medical records and a lack of investigation or scrutiny into an abundance of background information that was available. With hindsight, had all of that information which was readily accessible been reviewed then a referral to the Mental Health Crisis Team would have been appropriate. T sadly took his own life on 27th February 2020.
Concerns raised by the coroner	During the inquest I heard evidence which concerns me about the approach taken by those undertaking mental health assessments within the Community Mental Health Team. Whilst I have received evidence from the Senior Nurse for Pembrokeshire Adult Community Mental Health Service to say that there is a more robust system in place now (compared to when T died in 2020) and that there is an aide memoir which has been implemented to support practitioners to systematically collate the information required from referrers when receiving referrals for assessment, I still have concerns.

	The reasons for my concerns are that contrary to the above, I also received evidence during the inquest from a Community Psychiatric Nurse who said: “it’s not my job” to seek out information, “that is the duty of the referrer” and “the Role of the Duty Officer (i.e. the person doing the assessment) is to assess the information not gather it.” Furthermore, the evidence of the Senior Nurse for Pembrokeshire Adult Community Mental Health Service was that “The process places emphasis on the referrer to provide a comprehensive and accurate handover. Responsibility for the accuracy and completeness of information provided, particularly in relation to identified or potential risks, rests with the referrer at the time the referral is made.” “There is no explicit requirement for the Community Mental Health Team to proactively seek information from partner agencies at the point of handover, unless the partner agency is the referring service.” For as long as that approach or attitude continues, I fear that mental health risk assessments in Pembrokeshire may be incomplete, perfunctory, and inadequate. There needs to be a change in culture to a more collaborative approach where those undertaking the assessment adopt a more inquisitive and information-seeking style to ensure that as much relevant information as possible is available when undertaking these very important risk assessments. In this particular case, notwithstanding the fact that this was an emergency referral from a GP, the Risk Assessment was completed without knowledge of the significant police and ambulance involvement with T in the preceding week, the fact that a noose had been found at T’s home, his family were very concerned for his mental wellbeing, his previous suicide attempts and his previous involvement with the Crisis Response Home Treatment Team. There was an abundance of relevant information available had the assessor made some basic enquiries. There needs to be a shift of onus to a more collaborative approach so that those undertaking the assessment explore what information is available to them and do not simply rely on the details provided by the referrer. Ultimately, it is the assessors’ name on the risk assessment and they need to be satisfied that it is a thorough and robust assessment of the risk.
Action to be taken	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
7	
Date published	02.July 2026
Coroner	Nicholas Graham
Area	Oxfordshire
Issued to	Director of Adult Social Services Oxfordshire County Council
Conclusion	Narrative conclusion C H had a long-standing diagnosis of severe mental illness. In August 2022, she refused to continue taking her monthly antipsychotic medication, and her mental health deteriorated. Information relating to CHs’ decision to stop taking her medication, as well as concerns raised by Thames Valley Police about a decline in her mental health, was not passed on to the Adult Mental Health Team. Consequently, they were unable to supervise her adequately. On 26 July 2023, CH was found deceased at her home. Although it has not been possible to ascertain a medical cause of death due to decomposition, it is likely that she died from a natural cause, exacerbated by self-neglect.’

Circumstances	CH attended a monthly clinic to receive her antipsychotic medication. Evidence was given that at the time there was no clear process for passing information onto the Adult Mental Health Team (AMHT) should patients not attend and/or decline to take their medication. Had the AMHT been notified then evidence was given that they would have undertaken intensive and assertive follow-up. Nor was CH's GP notified of this development.
Concerns raised by the coroner	n March 2023, Thames Valley Police passed on a report about CH to the Mult- Agency Safeguarding Hub (MASH) which raised concerns about her behaviour and mental state and disheveled appearance. The report stated that it was, 'Shared in the interests of safeguarding as may be having relapse.' MASH undertook a review of the report and concluded that CH was not at risk but may have needs for care and support from the local authority. The information was passed to the Council's Adult Social Care Team who in turn passed the information onto CH's GP. Evidence was given that the Adult Social Care Team were unable to directly refer to AMHT, even if they had considered it necessary. As the GP was not made aware that CH had declined to attend the clinic to receive her medication, she saw no need to refer the Police report to AMHT. Evidence was given that AMHT took a different view regarding the Police report and would have viewed the report as evidence of CH relapsing. AMHT's view was that such a report met the criteria for being shared with them, and with their knowledge of CH's past history of self-neglect and non-compliance with taking medication, it ought to have been shared with them; and had it been done so it would have been followed up assertively and urgently including undertaking home visits and the possible use of compulsory powers under the Mental Health Act. My concern is that important information regarding a deterioration in mental health was not shared with the appropriate Team who may have been able make appropriate interventions and to have taken steps to avoid a fatal outcome. You should consider a review of how such information is assessed and shared between the respective agencies.
Action to be taken	Action should be taken to prevent future deaths, and the coroner believes that your organisations have the power to take such action.
8	
Date published	July 28, 2026
Coroner	Patricia Harding
Area	Kent and Medway
Issued to	South London & Maudsley NHS Foundation Trust | Metropolitan Police Service | College of Policing
Conclusion	
Circumstances	CM aged 37-year-old female . Took her own life while suffering from anxiety and depression . 1a Multiple injuries Diagnosed with mixed anxiety and severe depressive disorder. On 27th August 2024 CM travelled to Eastbourne with the intention of ending her life [REDACTED Her parents reported her missing to Metropolitan Police Service (MPS) and it was quickly established by MPS that CM was at an intermediate station when she answered a call made by the police. She was safely brought back home by police on that occasion.

	CM was taken to St. George's Hospital by her parents and was admitted as a voluntary patient to Lewisham Hospital under South London and Maudsley NHS Foundation Trust (SLAM) which was the service provider of her registered address (not the address where she was then living). On 4th September 2024 CM left the ward at 10.30. This was her first period of unescorted leave. She had agreed to return to the ward by 12.00. It was only discovered that she had not returned when her mother attended to take her for lunch at 12.50. Ward staff reported CM missing to MPS at 13.17. Applying the Right Care Right Person Policy and Affinity Protocol MPS declined to investigate because CM's registered home address had not been visited. At 13.28 CM's father rang MPS to report her missing, providing information in relation to the earlier suicide attempt and detailing that she would not return to the registered address. MPS again declined to investigate. At 14.02 CM's father again contacted MPS to confirm that she was not at her flat. MPS passed the case to South West London BCU which covers Wimbledon. The CAD was returned to the despatch unit to reassign to South East London BCU covering Lewisham. South East London BCU received the CAD at 14.26, Thrive+ summary recording the risk as high. The morning Operations Inspector (400) was covering for the afternoon inspector who was on a training course and marked the CAD for her to deal with without reviewing it himself. He was unaware of a number of calls from despatch alerting him to the CAD as he was away from his desk. When the afternoon operations Inspector arrived, she went straight into a meeting without reviewing the CAD. At 15.39 CM's father called MPS as there had been no response by the police. This was passed to the operations room. At 16.02 the 400 was informed of the phone call from CM's father and read the CAD, putting in train enquiries to establish the level of risk (some of which was already known to the police). The CAD was graded as high risk at approximately 17.00 and the Missing Persons Unit (MPU) started an investigation. They received information from a phone trace request approximately 60 minutes later that CM's phone was within the Dover area and informed H.M. Coastguard (HMCG). MPS notified Kent Police and requested an area search. HMCG mobilised when they were informed CM's cell site showed her near Dover Castle. Information about financial transactions confirmed her to be in Dover and at 18.59 cell site data placed her at [REDACTED A HMCG search team arrived in the area a few minutes later. A Kent Police resource was despatched at 19.13. HMCG located CM at the cliff edge at 19.45 and engaged with her. Kent Police arrived on scene at 19.47. CM jumped to her death at 20.16 The jury found the following failures by MPS possibly contributed to the death: 1. The call handler and despatch team applied the Right Care Right Person policy and Affinity Protocol too rigidly by not registering previous suicide intention resulting in a delayed deployment; 2. The Metropolitan Police categorising CM as a high risk in an untimely manner; 3. Internal communication: a) did not utilise existing information held within all available CADs which resulted in delays to the investigation b) No inspector cover during senior leadership team meeting policy c) Lack of prioritisation policy

	The jury also identified non-causative failures by SLAM ward staff: 1. Unescorted leave not signed out by registered mental health nurse; 2. Nurse in charge unaware CM had been given unescorted leave; 3. Ward staff unaware CM had not returned from leave at 12.00/12.30; 4 General observation sheets incorrectly recorded.
Concerns raised by the coroner	South London & Maudsley NHS Foundation Trust: 1. Risk assessments in respect of leave were not being conducted in accordance with NICE Guidelines 2.The systems in place for recording and communicating leave for a voluntary patient were inadequate 3. The system for monitoring return from leave was inadequate 4.Ward staff appeared to take a different approach to leave and return depending upon the status of the patient as a detained or voluntary patient 5. A photograph of the patient was not included in the grab pack, unlike detained patients there was no checklist for voluntary patients as to the measures taken to locate the patient Metropolitan Police Service 1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment 2. A call handler informed SLAM to call London Ambulance Service to do a welfare check at the home address of the patient in circumstances where the ambulance service will only attend an address if the resident is known to be there College of Policing 1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment South London & Maudsley NHS Foundation Trust: It is recognised that the Trust has identified and put in train work that needs to be undertaken to address the issues that arose at the inquest. Much of the work has not yet been implemented or is not yet complete and until this is done the following remain as concerns: 1. Evidence was given at the inquest that although dynamic risk assessments were undertaken in advance of leave being authorised, risk assessments were not consistent with NICE Guidelines; 2. The systems in place for safeguarding voluntary patients in respect of leave and recording the decisions was inadequate and decisions were largely communicated by word of mouth, which led to differences of understanding what had been agreed, the basis on which it had been agreed and by whom it was agreed. Documentation in respect of leave was incomplete and did not comply with policy. The nurse in charge was not informed of the decision for leave or the circumstances in which leave was granted; 3. The system for monitoring leave was inadequate, reliance being placed on hourly checks. The nurse conducting the hourly check at 12.00 when CM was due to return was not aware that she was on unescorted leave and did not escalate the matter to the nurse in charge with the result that the ward only became aware that she had not returned when her mother arrived at 12.50. Consideration was not given to the appropriate amount of leeway to be given to the patient before escalating the fact of them not having returned, with patients being given 30 minutes or more; 4. Ward staff appeared to take a different approach to leave and return depending upon the status of the patient as a detained or voluntary

	patient; 5. A photograph of the patient was not included in the grab pack. Unlike detained patients there was no checklist for voluntary patients as to the measures taken to locate the patient Re: Metropolitan Police Service: It is recognised that MPS has identified and put in train procedures to address the issues that arose at the inquest particularly in relation to the approach of MPS following a decision to transfer a CAD to the BCU MPU. The following remain as concerns: 1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment. Even where call handlers have real concerns that someone not returning to a mental health unit is a high-risk missing person, the outcome of the toolkit not to deploy is the same if the individual's address has not been visited, even when told that they would not go there. The way in which the policy was applied removed any discretion by call handlers and despatchers to deploy whilst checks at the address were being conducted. Evidence was given at the inquest that the call handler in the second call to MPS attempted to convey her concerns that there should be immediate deployment to her supervisors in despatch and was advised the police would not deploy; 2. A call handler informed SLAM to call London Ambulance Service to do a welfare check at the home address of the patient in circumstances where the ambulance service will only attend an address if the resident is known to be there; Re: College of Policing: It was recognised by MPS at the inquest that there was an overly rigid approach to the Right Care Right Person policy and Affinity Protocol resulting from the robust application of the policy and protocol (see above). Some changes have been made within MPS within the parameters allowed given national guidance and standards, but evidence was given to the effect that training as to the application of the policy, protocol and toolkit could result in the professional judgement of call handlers/despatchers/supervisors being restricted resulting in delays to deployment
Action to be taken	In my opinion, unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

Rotherham Doncaster and South Humber NHS Foundation Trust

Guardian of Safe Working Hours (GoSWH)'s Report on Resident Doctors

01 June 2026 to 31July 2026

Dr Babur Yusufi
Guardian of Safe Working Hours

13 August 2026

RDaSH nurturing the power in our communities

EXECUTIVE SUMMARY

This report covers a period of four months; from 1 June 2026 to 31 July 2026.

In keeping with the implementation of Exception Reporting Reforms on 4 February 2026 and introduction of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Version 14 on 1 June 2026, this report contains details of trainees currently subject to TCS, information on Exception Reporting and GoSWH's Fines and a summary of Issues highlighted at the Resident Doctors' Forum (RDF). A short summary of important themes and issues is provided in the end. As per the new process, educational exception reports are managed by the Director of Medical Education (DME), while the rest by Medical HR. GoSWH retains oversight of all exception reports, to identify exception reporting patterns to ensure reports are accurate, valid and adhere to the purpose of exception reporting.

Since the start of new rotation in August 2026, there are 52 Resident Doctors in the Trust, with 8 vacant posts. A total of 100 exceptions reports were filed: 81 from Rotherham, 1 from Doncaster and 18 from North Lincs. Most reports were about hours worked beyond the day shift, i.e. from 09:00hrs to 17:00hrs (n = 72). There were three reports of Immediate Safety Concern, 15 for Missed Educational Opportunity and 1 for hours worked beyond On-Call shift, i.e. from 0900hrs to 21:30hrs (GoSWH's fine was issued for this). Most ERs were resolved appropriately, with some being delayed due to incompletion of Work Schedule Reviews and delayed response by the Resident Doctors.

There were no major gaps in the Rota.

Current balance in GoSWH's Fines' Account is £0.

Main points discussed at RDF (Resident Doctors' Forum) and key themes over the last two months were; (1) Deployment of an appropriate number of Resident Doctors on the wards, to ensure good workload management and cross-cover (2) Prompt organisation of Locum Cover in case Training and Middle Grade Medical Staff absence (3) Assurance of a clearly identified Clinical Supervisor, for all Resident Doctors, at all times (4) Provision of multi-disciplinary services like Phlebotomy to take away clinical workload from Resident doctors, which is not appropriate to their training.

INTRODUCTION

A revised version of Terms and Conditions of Service for NHS Doctors and Dentists in Training England (TCS 2016) was introduced on 1 June 2026, which is applicable to all higher, core, foundation and GPVT residents within the Trust.

This report covers a period of two months; from 1 June 2026 to 31 July 2026.
The report provides details of trainees currently subject to TCS, information on Exception Reporting and GoSWH's Fines and a summary of Issues highlighted at the Resident Doctors' Forum (RDF). A short summary of important themes and issues is provided in the end. As per the new process, educational exception reports are managed by the Director of Medical Education (DME), while the rest by Medical HR. GoSWH retains oversight of all exception reports, to identify exception reporting patterns to ensure

CURRENT RDASH DOCTORS IN TRAINING

There are 52 trainees working in the trust with 8 vacant posts, starting from the start of the new rotation in August 2026. A breakdown of their grades is as follows:

	GP	CT	F2	F1	HT ST	**Total**	Vacant
Doncaster	3	5	3	3	4	**18**	0
Rotherham	2	8	2	4	6	**22**	3
North Lincolnshire	2	2	1	3	4	**12**	5
TOTAL	**7**	**15**	**6**	**10**	**14**	**52**	**8**

The above figures do not include the Hospice Doctors: x1 GP and x1 HT ST

EXCEPTION REPORTING (ER) MANAGED BY MEDICAL HR

This feedback only covers ERs submitted for Extra Hours Worked (Beyond Day and Night On-Call Shifts), more hours Worked than Paid For during First On-Call and Mandatory Rest Conditions for Second On-Call.

Between 01 June 2026 and 31 July 2026, the Medical Staffing team received processed 75 Exception Reports, compared with 84 reports raised between 1 February 2026 and 31 May 2026.

The 75 exception reports received between 01 June 2026, and 31 July 2026 were distributed as follows:

Rotherham: 57
Day Time - Inpatient: 53
Day Time - Community: 3
First On-Call Shifts: 0
Second Non-Resident On-Call: 0
More Hours Worked During First On-Call then Paid For: 1

Doncaster: 0
Day Time – Inpatient: 0
Day Time - Community: 0
First On-Call Shifts: 0
Second Non-Resident On-Call: 0
More Hours Worked During First On-Call then Paid For: 0

North Lincolnshire: 17
Day Time - Inpatient: 15
Day Time - Community: 0
First On-Call Shifts: 1
Second Non-Resident On-Call: 1
More Hours Worked During First On-Call then Paid For: 0

Doncaster Physical Health (Hospice): 1

This represents a decrease of 09 reports compared to the previous two-month period.

Categories of Exception Reports
Exception reports are categorised as follows:

- Unscheduled late finish
- Unscheduled early start
- Breach of on-call working pattern

During the reporting period, 75 exception reports were submitted. Of these, 71 (95%) related to unscheduled late finishes, indicating that extended working hours remain the primary reason for exception reporting.

The distribution of unscheduled late finish reports was as follows:

Service Area	Number of Reports	Average additional Time Worked
Rotherham	54	1 hour 11 minutes
Doncaster Mental Health	0	
North Lincolnshire	15	35 minutes
Doncaster Physical Health (Hospice)	1	1 hour 18 minutes

There are currently five unresolved exception reports:

Rotherham

- x1 awaiting review by DME
- x1 awaiting resident to withdraw as relates to additional hours worked during an on-call shift.

Doncaster

- x2 awaiting resident to withdraw as relates to additional hours worked during an on-call shift.

North Lincs

- x1 awaiting consent from the resident to share the exception report with the DME

Follow-up requests have been made on multiple occasions; however, no response has been received to date

Please refer to the following tables for more details.

Key to the tables is as follows.

KEY:

1. n = Total Number
2. IP = Inpatient
3. CM = Community
4. UR = Unresolved
5. PAY = Payment
6. TOIL = Time-off in Lieu
7. WSR = Work Schedule Review
8. Comments Options:

a. Escalated to GoSWH for Work Schedule Review for a pattern observed; two or more in two ERs in Two Consecutive Weeks.
b. In case of UR:
   - Clarification from Doctor/ GoSWH Sought
   - Extra-contractual Report not actioned
   - Extra-contractual Report actioned

Table 1: WORKING BEFORE 0900hrs – DAY SHIFT (n= 2)

ROTHERHAM (n = 2)									
Grade	**Loc.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
CT3	IP	1	1		2				
	CM								

DONCASTER (n = 0)
NORTH LINCS (n = 0)

Table 2: WORKING AFTER 1700hrs – DAY SHIFT (n= 70)

ROHERHAM (n= 54)									
DOCTOR'S DEPARTMENT: GENERAL ADULT									
Grade	**Loc.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP	19	10	1	25	5			
	CM								
FY2	IP	2	1		3				
	CM								
CT2	IP	3	8		6	5			
	CM								
CT3	IP	4	2	1	7				
	CM	2		1	3			1	

DONCASTER (n= 0)

NORTH LINCS. (n= 15)									
DOCTOR'S DEPARTMENT: General Adult									
Grade	**No.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP =	14			14				
	CM =								
CT1	IP =		1		1				
	CM =								
HOSPICE. (n= 1)									
DOCTOR'S DEPARTMENT: General Adult									
Grade	**No.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
ST4	IP =		1		1				
	CM =								

Table 3: WORKING BEYOND ON-CALL SHIFT (>12.30hrs) (n= 1)

GRADE	NO.	REASONS	OUTCOME
NORTH LINCS (n=1)			
CT1	1	1. Staying Two Hours beyond Day Shift (9AM-5PM Work) plus Twilight Shift (5-9:30PM) – Total Shift Duration 14:30hrs 2. Reason: Sickness of Speciality Doctor during the day and work carried over to the On-Call Shift.	1. Payment to the Doctor for Extra Work 2. GoSWH's Fine for Breach of Shift Duration X 2 Hours 3. Work Schedule Review with DME

Table 4: MORE HOURS WORKED DURING ON-CALL THAN PAID FOR (n = 1)

GRADE	NUMBER	COMMENTS
ROTHERHAM (n = 1)		1. These figures do not include reports withdrawn by the Resident. 2. Hours Worked during On-Call are calculated through a six-monthly On-Call Monitoring Audits and Payments determined based on that. Therefore, these reports are for Information Only.
CT 1	1	
DONCASTER (n = 0)		
NORTH LINCS. (n = 0)		

Table 5: BREACH OF MANDATORY REST FOR SECOND ON-CALL (n = 1)

GRADE	NO.	REASONS	OUTCOME
NORTH LINCS (n=1)			
ST6	1	5-hour Rest Breach during Second On-Call	1. TOIL to the Doctor for Extra Work 2. GoSWH's Fine for Breach of Shift Duration

EXCEPTION REPORTING (ER) MANAGED BY DIRECTOR MEDICAL EDUCATION (DME)

Following is the feedback from the Interim DME, in absence of substantive DME.

TABLE 6: MISSED EDUCATIONAL OPPORTUNITIES (n= 15)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n= 14)		1. Heavy workload 2. Cancelled MDT due to no consultant cover 3. Staffing issues 4. Uncertainty around clinical supervision	Reinstate educational opportunity Recommend work schedule review
CT3	14		
DONCASTER (n= 0)			
NORTH LINCS. (n= 1)			
FY1	1	1. Staffing issues on the ward	

TABLE 7: WORK SCHEDULE REVIEWS COMPLETED (n=1)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n= 1)		Unable to take portfolio time due to staffing issues. The data from medical staffing for the last month but does not show short staffing except on one day but given the reported repeated problems this would benefit from a work schedule review	
CT3	1		
DONCASTER (n= 0)			
NORTH LINCS. (n= 0)			

EXCEPTION REPORTS (ERs) MANAGED BY GoSWH

TABLE 8: THE INADEQUECY OF CLINICAL SUPPORT/ROSTERED SKILL MIX (n= 5)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n=5)		1. Medical Staff Shortage. 2. Covering Emergency Absence of a Colleague 3. Lack of Consultant Cover Three episodes recorded as Retrospective **Immediate Safety Concern**	Work Schedule Review and discussion with DME
CT2	1		
CT3	4		
DONCASTER (n= 0)			
NORTH LINCS. (n= 0)			

TABLE 9: THE INABILITY TO TAKE CONTRACTUAL BREAKS (n= 4)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n= 4)		| 1. Medical Staffing Shortage 2. Excessive Workload	Did not reach the Threshold i.e. unable to take scheduled breaks on at least 25 per cent of occasions across a four-week reference period. Recommended raising this in Clinical Supervision and considering Work Schedule Review
CT 2	1		
CT 3	3		
DONCASTER (n= 0)			
NORTH LINCS. (n= 0)	0		

IMMEDIATE SAFETY CONCERN (ISC) (n = 3)

There were 3 Retrospective Reports of Immediate Safety Concerns due to Staff Shortages and Lack of Consultant Cover in Rotherham. All were referred to the Interim DME for Work Schedule Review.

GOSWH's FINES

There were two episodes of application of GoSWH's fines during the last two months, both in North Lincs

TABLE 10: APPLICATION OF GOSWH's FINES (n=2)

GRADE	NO.	REASONS	OUTCOME
NORTH LINCS (n=2)			

CT1	1	1. Staying Two Hours beyond Day Shift (9AM-5PM Work) plus Twilight Shift (5-9:30PM) – Total Shift Duration 14:30hrs 2. Reason: Sickness of Speciality Doctor during the day and work carried over to the On-Call Shift.	1. Payment to the Doctor for Extra Work 2. GoSWH's Fine for Breach of Shift Duration X 2 Hours 3. Work Schedule Review with DME
ST6	1	5-hour Rest Breach during Second On-Call	1. TOIL to the Doctor for Extra Work 2. GoSWH's Fine for Breach of Shift Duration

FEEDBACK FROM RESIDENT DOCTORS' FORUM DATED 16 JULY 2026

1. **Resident Doctors' Staffing Levels/ Locum Cover**: Concerns were raised around deployment of a minimum number of doctors on the wards, particularly in Rotherham, to manage workloads and ensure doctors/patients' safety. Process for arranging Locum Cover during Sickness or Absence, and the need for clear Escalation procedures, were also discussed. Trust will put a proposal around the above in the next JLNC, for resolution.

2. **Ongoing issues with Phlebotomy Service:** A particular issue in Doncaster, which is consuming significant Resident Doctors' time and impacting training and workload; will be discussed further outside of the meeting and reported back at the next forum.

3. **Clinical Supervisor Cover in Rotherham:** Due to forthcoming vacancies, concerns were raised about Workloads and availability of appropriate Clinical Supervision arrangements, in Rotherham. It was confirmed this was being addressed with the Chief Medical Officer and Chief Executive, who have a good understanding of the Risks and are working towards a solution.

4. **Resident Doctors' being left without a Clinical Supervisor**: Concerns were raised about the incidents when Resident Doctors were left without a clearly identified Clinical Supervisor. It was stated that all Resident Doctors must have access to a Clinica Supervisor all the time. Strengthening of escalation process in absence of an identified Clinical Supervisor was discussed. This was discussed at the School of Psychiatry meeting with Chief Medical Officer, outcome to which will be brought to the Forum, in due course.

5. **Feedback from Trainer/ Trainee Meeting:** Several Resident Doctors described ongoing pressures caused by staffing shortages, incidents of lack of identified Clinical Supervisors, burnout and fatigue and reduced access to educational opportunities. GoSWH confirmed in case of any of above, appropriate Exception Report must be submitted, raising Immediate Safety Concerns if there is a risk to doctor's/ patient's safety. It was also highlighted, in such cases, the DME would act immediately to move the Resident somewhere else to enable regular clinical and

educational supervision and provide support. Feedback from the Resident Doctors focused on, perceived barriers preventing doctors from escalating concerns, a belief amongst some Resident Doctors that concerns are raised repeatedly without resulting in meaningful change and importance of creating visible responses to concerns raised by staff. A suggestion was made to reach out to the Freedom to Speak up Guardian, in case of above and invite them to RDF, on a regular basis.

6. **Proposal for JDF Risk Register:** It was suggested to for the concerns at the RDF to be formalised in a Risk Register. Resident Doctors will be reached out about their ideas about this.

7. **GoSWH's Feedback:** GoSWH highlighted that monies collected as fines had been fully disbursed. There were some reports requiring responses from Resident Doctors, which had not come through, causing a delay in resolution. Resident Doctors were advised to process their Exception Reports within in the given time frame. Prevalent themes of Exception Reports were also discussed.

8. **Feedback from Medical HR**: It was stated that Allocate access would be provided to all SAS and LED Doctors, from August 2026, to submit Exception Reports, for information and evidence of work, only. It was highlighted while most of the vouchers from GoSWH's Fines fund had been distributed, some remained due to lack of response from doctors. Medical HR were trying to reach out to them.

KEY THEMES:

The are as follows and discussed in detail, above.

1. Deployment of an appropriate number of Resident Doctors on the wards, to ensure good workload management and cross-cover.
2. Prompt organisation of Locum Cover in case Training and Middle Grade Medical Staff absence.
3. Assurance of a clearly identified Clinical Supervisor, for all Resident Doctors, at all times.
4. Provision of multi-disciplinary services like Phlebotomy to take away clinical workload from Resident doctors, which is not appropriate to their training.

Dr Babur Yusufi
Guardian of Safe Working Hours (GoSWH) for RDaSH

August 2026

Rotherham Doncaster and South Humber NHS Foundation Trust

Risk Management Framework

Part 1: The Framework

Governance, appetite, escalation and assurance

Document control

Version	13.0
Unique Reference Number	1075
Ratified by	Board of Directors
Date ratified	
Name of originator / author	Head of Risk Management
Name of responsible committee / individual	Director of Corporate Assurance Risk Management Group
Summary of changes	**Summary of changes** This version restructures the Framework into three parts and makes the following main changes: • A Risk Escalation Schedule for each level of the Trust • Escalation based on appetite and tolerance rather than score bands • The Low, Moderate, High and Extreme grading bands withdrawn • A rebuilt risk scoring matrix with new impact domains • Two treatment states: treated or tolerated • Target scores set at the appetite level for each risk category • Evidence based assurance levels for operational and strategic risk • Temporary acceptance of risks outside tolerance by CLE • Risk closure delegated to directorate risk leads, with tighter grounds for closure • Six monthly reviews of tolerated risks • Issue logs withdrawn • Risk management performance indicators • Terminology and cross references made consistent throughout
Date issued	
Next review	Three years from the date of issue, with an annual check by the Risk Management Group
Target audience	All staff

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How to use this Framework

This Framework is one document in three parts. Each part is written for a different reader. You do not need to read all three. The parts say the same things; the later ones say them more simply.

If you are	Read
All colleagues across the Trust	Part 3. It is short and tells you how to recognise a risk, how to report one, and what happens after you do.
A risk owner, a risk lead, or a colleague with wider responsibility for risk	Part 3, then Part 2. Part 2 is the working guide: writing a risk, scoring it, choosing controls, recording evidence, reviewing and closing.
A member of the Risk Management Group, the Clinical Leadership Executive, a Board Committee or the Board, and senior leaders across the Trust, particularly those who approve the opening and closing of risks	Part 1, and Part 2 when you are challenging how a risk has been written or scored.
Internal Audit, external audit, a regulator or an inspector	All three parts.

These three rules apply throughout

1. Every risk has one record, one accountable owner and one route for decisions at any point in time. Other groups may see a risk for advice or oversight, but only one route decides.
2. Risks are managed and resolved at the lowest level that has the authority and resources to do so. Escalation is for what that level cannot settle.
3. Only risks within the Board's appetite may be tolerated. Everything above appetite is treated, with a plan.

Risk Management Framework

Part 1: The Framework

Governance, appetite, escalation and assurance

Part 1 sets out how risk is governed at RDaSH: the principles we work to, the appetite the Board has set, who is responsible for what, how a risk moves through the Trust, and how the Board and its committees know the system is working. It is the part the Board approves and the part that Care Groups, the Risk Management Group and Board Committees work from.

1. Introduction

Risk management is part of good governance and part of delivering safe care. At RDaSH, managing risk well supports our strategic aims, our day to day operations and our duty of care to patients and staff. This Framework sets out what we expect of everyone, so that risks are recognised and managed in the same way across the Trust.

Managing risk well helps us plan, decide what matters most, and respond quickly when circumstances change. If we are to meet our objectives, improve services and use public money well, risk has to be part of how we plan and decide, not a separate exercise carried out alongside them.

Risk is present in everything we do. This Framework is not about adding processes. It is about making sure that thinking about risk is part of how we lead, manage and deliver.

How well this works depends on the people operating it. Our risk culture has to be open, welcome challenge, and encourage people to raise concerns and ask for help. Managing risk is everyone's responsibility.

What good risk management gives us

- It supports the safe delivery of care.
- It supports the achievement of the Trust's objectives.
- It helps us avoid failures, or reduce their effect when they happen.
- It helps us use our resources well and get value for money.
- It helps us meet our legal and regulatory obligations.
- It helps us manage changes and pressures coming from outside the Trust.
- It helps us take opportunities and support innovation.

2. Scope

This Framework is the Trust's overarching document for risk. It sets out how risk is managed at RDaSH and applies to everyone working on Trust business, including directly employed staff, bank and agency staff, contractors and volunteers.

It covers operational risk held on the Trust's directorate risk registers and strategic risk held within the Strategic Delivery Risk. The Board identifies and monitors the strategic risks to the Trust's aims and objectives. Staff throughout the Trust identify and manage operational risks day to day.

3. How we manage risk

This Framework follows HM Treasury's Orange Book, which sets out principles for managing risk in the public sector, and draws on the COSO enterprise risk management framework.

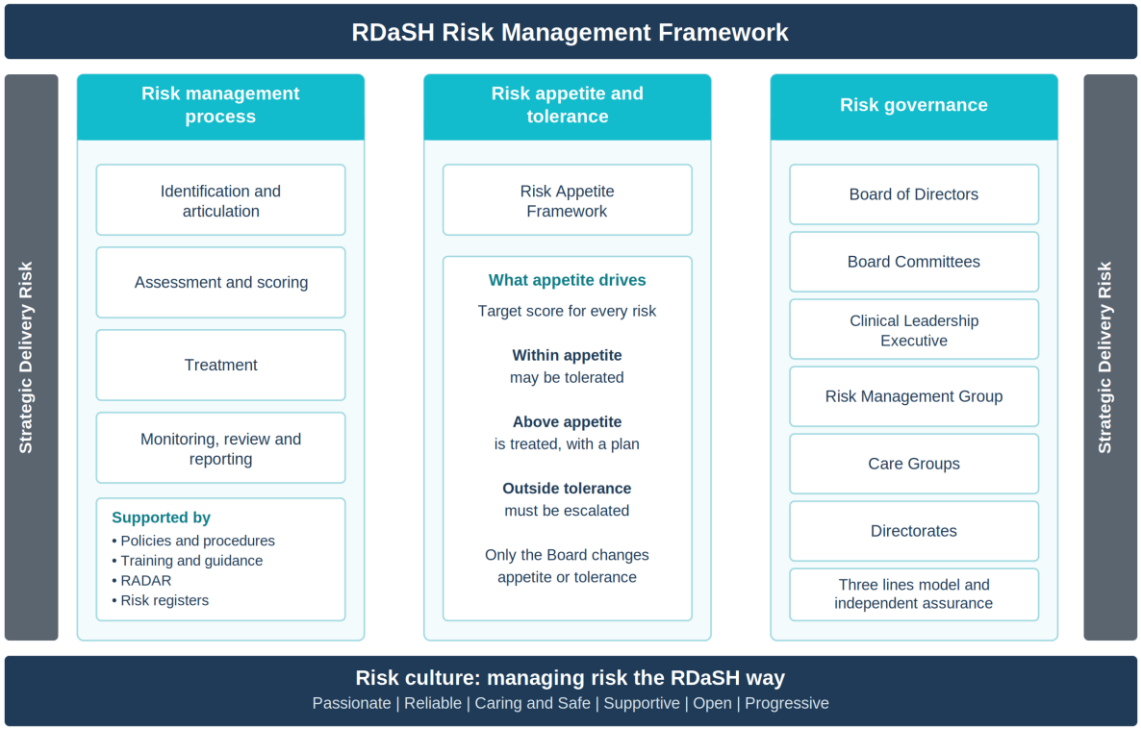

Figure 1: The Risk Management Framework

Our approach is guided by the Orange Book principle of PACED. It means our risk management should be:

Proportionate. We scale the effort to the significance of the risk. More attention goes to risks that could seriously affect patient safety, service delivery or the Trust's finances.

Aligned. Risk management supports the Trust's objectives and priorities, and is part of business planning and decision making rather than separate from it.

Comprehensive. We identify and manage risk across clinical, operational, financial and strategic areas, looking at pressures from inside and outside the Trust.

Embedded. Risk management is part of normal work: written into our processes, our policies and our decisions, rather than an additional task.

Dynamic. We keep our approach flexible. Through regular review, horizon scanning and engagement with staff and partners, we adapt as circumstances change.

4. Risk culture: managing risk the RDaSH way

Our approach to risk is shaped by our core values: Passionate, Reliable, Caring and Safe, Supportive, Open and Progressive. Managing risk the RDaSH way means:

Passionate. We take risk management seriously because it protects the standard of care we give.

Reliable. We follow the same process across the Trust, so that a risk is treated the same way wherever it is raised.

Caring and Safe. Patient safety and staff wellbeing sit at the centre of how we judge and treat risk.

Supportive. People are supported to raise concerns and are helped to manage the risks they own. Raising a risk is not a failure.

Open. We report early, describe risks honestly, and are frank about what our controls do and do not cover.

Progressive. We look ahead, learn from what has happened, and improve how we work.

5. Key terms

These terms are used throughout all three parts of this Framework and mean the same thing in each.

Term	What it means
Risk	The chance of something happening that would affect our objectives. A risk may be a threat we want to make less likely or less damaging, or an opportunity we may be able to take. For something to be a risk it must meet two thresholds: it must be a future uncertainty, and it must have an impact on something we are trying to achieve.
Issue	Something that has already happened or is happening now. An issue is not a risk, although an issue often creates one.
Control	Something already in place that reduces how likely a risk is, or how bad it would be. Controls are not the same as actions: an action is something still to be done.
Current score	The level of risk as it stands today, with existing controls working as they currently work. Impact multiplied by likelihood.
Target score	The appetite level set by the Board for that category of risk. This is where the risk is being managed to.
Risk appetite	The amount of risk the Board is prepared to accept in pursuit of the Trust's objectives, set by risk category.
Risk tolerance	The outer limit of exposure the Board will accept in a category. Tolerance is the escalation trigger: a risk beyond it must be escalated.
Treated	A risk that is being actively reduced. It has a plan, named actions with owners and dates, and is reviewed monthly. Every risk above appetite is treated.
Tolerated	A risk we have decided to accept as it stands, with no further action planned. It is reviewed six monthly. Only risks within appetite may be tolerated.
Outside tolerance	A risk beyond the tolerance limit set by the Board for its category. These are the Trust's extreme risks. They cannot be tolerated and follow the escalation route in section 11.

Term	What it means
Trust wide risk	A single risk that affects more than one part of the Trust and cannot be managed by any one directorate or Care Group acting alone. Trust wide describes the scope of the risk, not the register it sits on.
Risk owner	The person accountable for a risk: for keeping it current, for the actions against it, and for escalating when it moves beyond what they can manage.
Accountable Director	The executive director accountable for the risk alongside the risk owner.
Risk lead	The person in each directorate with delegated authority for the quality of that directorate's register, including closing risks.

6. Risk appetite and tolerance

The Trust cannot deliver its services or achieve good outcomes without taking risk. Only by taking risk can the Trust do what it exists to do. It must, however, take risk in a controlled way, keeping its exposure at a level the Board is prepared to accept. That level is the Trust's risk appetite, defined in the Orange Book as the amount of risk an organisation is prepared to accept, tolerate or be exposed to at any point in time.

The Trust's long term sustainability depends on delivering its strategic objectives and on its relationships with the communities it serves, including service users and their families, the public and our partners. Patient and staff safety come first, and the Trust holds a low appetite for risk to the safety and quality of care. That does not mean the Trust holds no such risk; it means that risk of this kind is actively managed, closely monitored and reduced wherever it can be. The Trust operates in a demanding environment, and has a greater appetite for considered risk where this is needed to improve services, innovate and make better use of its resources.

The Board approves the Trust's risk appetite and the tolerance limits that go with it. These are set out in the Risk Appetite Framework, and are expressed by risk category so that appetite reflects the nature of the risk being taken.

6.1 What appetite and tolerance do

Appetite and tolerance are not descriptive. They drive how risks are treated, how often they are reviewed and when they must be escalated.

- The **target score** for every risk is the appetite level for its category. RADAR generates it from the category, so it is set the same way on all 24 registers.
- A risk **within appetite** may be tolerated.
- A risk **above appetite** is treated. It carries a plan to bring it back towards appetite and is reviewed monthly.
- A risk **outside tolerance** must be escalated and follows the route set out in section 11.

6.2 When further reduction is not proportionate

Sometimes a risk sits above appetite, the controls are sound, and no further action would be proportionate to what it would achieve. Recording actions that will not be taken makes the register less reliable. Where further reduction is not proportionate, the Trust should say so.

Where a risk owner and Accountable Director judge that a risk above appetite cannot be reduced further at proportionate cost, the position is reported to the Risk Management Group with the reasoning. Where the same position appears across a category, the Risk Management Group refers it to the Board through the Clinical Leadership Executive as evidence that the appetite for that category may need to be recalibrated. Appetite is the Board's to set and the Board's to change.

6.3 Strategic Delivery Risk

The Trust's Annual Governance Statement is signed by the Chief Executive and underpinned by the Strategic Delivery Risk. This gives the Board assurance that its systems are subject to proper scrutiny, and that it is informed of the strategic risks to the Trust's objectives.

The Strategic Delivery Risk records, for each strategic risk: the current and target score; the lead Board Committee and lead Director; the key controls; the sources of assurance that those controls are working; any gaps in control or assurance and the actions to close them; and the appetite for that risk.

In agreeing the Strategic Delivery Risk, the Board considers and agrees an appetite position for each strategic risk.

7. Risk registers

A risk register is the formal record of the risks a part of the Trust has identified, and the tool used to manage them. There are 24 risk registers in the Trust, one for each directorate. All are held on RADAR.

There is no separate corporate or Trust wide risk register. Every risk in the Trust sits on a directorate register, including risks that affect the whole Trust. Section 8 explains how those are handled.

7.1 Registers held elsewhere in the Trust

Some specialist areas keep their own registers to meet specific operational or compliance requirements, including counter fraud, emergency preparedness and health and safety. Risks on those registers that reach the Trust's tolerance limits, or that need action beyond the specialist area, are escalated to the Risk Management Group and recorded on the appropriate directorate register so that the Trust holds a single view of its significant exposure.

7.2 Partnership and shared risks

More of the Trust's risks are now shared with partners, including the Integrated Care Board, local authorities, provider collaboratives and the voluntary sector. For these risks some of the causes, and often some of the controls, sit outside the Trust.

Partnership risks are identified early, when a partnership is being formed, and assessed jointly with the partner organisation where possible. A shared risk is recorded on the register of the directorate that leads the Trust's side of the partnership, flagged as shared, with the partner and the joint arrangements recorded against it. A shared risk with no register home is a risk nobody reviews.

Where a shared risk cannot be managed by any single directorate, it is handled under the Trust wide arrangements in section 8.

8. Risks needing coordinated Trust wide management

Trust wide describes the scope of a risk, not the register it is held on. There is no separate Trust wide or corporate risk register.

A Trust wide risk remains a single risk, owned by the directorate with the greatest authority over the principal controls, even where the exposure affects several Care Groups or several directorates. Related local risks may stay on individual directorate registers where they represent genuinely distinct local exposure, controls or actions, and are linked to the Trust wide risk.

8.1 When a risk is Trust wide

A risk may be designated as Trust wide where:

- there is one identifiable risk affecting more than one part of the Trust;
- no single directorate or Care Group can manage the whole exposure;
- coordinated Trust wide controls or action are required; and
- managing the risks separately would leave a material part of the exposure unmanaged, or would cost more to manage.

A risk does not become Trust wide simply because it is high scoring, longstanding or appears on several registers.

8.2 How a risk is designated as Trust wide

The Head of Risk Management reviews the Trust's registers and proposes risks for designation against the criteria above. The Risk Management Group considers each proposal, approves or declines the designation, confirms which directorate holds the risk, and agrees the oversight arrangements.

This ensures that risks crossing several registers are identified through a systematic review, and that the decision to manage a risk at Trust level, and the ownership that follows, is made by the Risk Management Group.

9. Risk governance

Risk governance is the set of roles, responsibilities and structures through which risks are identified, escalated, decided on and monitored. It connects the day to day management of risk in services with the strategic direction set by the Board.

The Board sets the Trust's strategic direction, approves its risk appetite and tolerance, and oversees strategic risk through the Strategic Delivery Risk. The Audit Committee examines how well the Trust's system of internal control and risk management is working. The Clinical Leadership Executive makes executive decisions on risks that need authority, resource or Trust wide reprioritisation beyond what sits below it. The Risk Management Group provides the Trust wide view of operational risk and decides what further action or escalation is needed. Directorates own and manage the risks on their registers, and escalate to the Risk Management Group. Care Groups have sight of the most significant risks across their directorates and coordinate the response where it crosses more than one of them.

9.1 The three lines

The Trust's governance model follows the three lines model.

First line. Directorates, services and corporate teams. They own risks, operate the controls and manage the risks on their registers day to day.

Second line. The Risk Management function and other oversight functions such as health and safety, information governance and counter fraud. They set the framework, provide tools, training and advice, challenge the quality and consistency of what the first line records, and report on it. The second line is part of management. Its work is oversight and challenge, not independent assurance.

Third line. Internal Audit, and external audit and regulators. They provide assurance that is independent of management on how well governance, risk management and internal control are working.

10. Roles and responsibilities

This section sets out what each role and forum is responsible for. Every forum named in the Risk Escalation Schedule at section 11 has an entry here.

Board of Directors

- Sets the vision, strategic direction and objectives of the Trust, and approves the Trust's risk appetite and tolerance limits.
- Approves this Framework and makes sure resources are available to operate it.
- Receives and reviews reports on strategic risk through the Strategic Delivery Risk, and holds executives to account for managing significant and emerging risks.
- Decides whether the approved appetite or tolerance should be changed where evidence shows the current position is no longer right.
- Makes sure roles and responsibilities for risk are clear, so that decisions, escalation and delegation work as intended.
- Assesses compliance with the Corporate Governance Code and records any departures in the annual governance statement.

Audit Committee

- Reviews and challenges this Framework, and how well the arrangements it describes are working in practice.
- Provides independent scrutiny of the Trust's system of internal control and risk management.
- Receives the risk management performance indicators, the annual evaluation of this Framework and the annual maturity self assessment.
- Receives the Trust's position on risks that have been temporarily accepted outside tolerance.
- Advises the Board on significant risks or weaknesses in the Trust's risk arrangements, and makes recommendations for improvement.

Chief Executive

- As Accounting Officer, is accountable for the Trust's risk management arrangements.
- Makes sure the values and behaviours that support an open risk culture are communicated and expected at every level.
- Demonstrates leadership on risk and makes clear its value to the Trust.
- Makes sure risk is considered when options are appraised and decisions are made.
- Allocates resources for managing risk.

Clinical Leadership Executive

- Makes executive decisions on risks referred to it by the Risk Management Group: those needing significant resource, Trust wide reprioritisation, or a decision beyond delegated authority.
- Decides whether to approve temporary acceptance of a risk outside tolerance, on the terms set out in section 11.
- Makes sure risk management is part of how the Trust's business is run, and that risk activity supports the Trust's objectives and appetite.
- Refers material strategic matters to the relevant Board Committee or the Board.
- Receives the outbrief from the Risk Management Group.

Risk Management Group

- Provides the Trust wide view of operational risk.
- Receives all risks outside tolerance, all risks scoring 15 or above, risks with a potentially catastrophic consequence, risks needing Trust wide coordination, and risks that remain unresolved after local action.
- Challenges the risk position, confirms ownership and appetite position, and decides what further intervention is required.
- Returns risks to the owning area with direction, refers them for specialist advice, refers them to the Clinical Leadership Executive for action or resource, or escalates through the appropriate governance route.

- Approves or declines the designation of Trust wide risks proposed by the Head of Risk Management, and agrees the oversight arrangements for each.
- Refers a risk to the Clinical Leadership Executive where it has remained outside tolerance for six consecutive monthly reviews despite agreed actions.
- Holds a standing emerging risks item at each meeting.
- Approves the risk management performance indicators and their thresholds.
- Advises the Clinical Leadership Executive or the Audit Committee where this Framework is not being applied effectively.
- Makes sure risks to the delivery of the Trust's strategy are reflected in the risk registers or, where relevant, the Strategic Delivery Risk.

Care Groups (through Care Group business meetings)

- Have sight of the most significant risks held by their directorates at each business meeting.
- Challenge the risk position, the score and the plan.
- Coordinate the response where a risk affects more than one of their directorates.
- Agree actions and commit Care Group authority or resources where appropriate.
- Support directorates in obtaining what a risk needs, without taking ownership of the risk.

Specialist groups

- Provide advice or assurance to the Risk Management Group on risks in their area of expertise when asked.
- Do not take ownership of a risk and do not form a separate escalation route.

Director of Corporate Assurance and Board Secretary

- Makes sure the Trust's risk and assurance processes are designed, implemented and in use across the Trust.
- Reports significant issues arising from the operation of this Framework, including non compliance or lack of effectiveness found through monitoring.
- Advises the Board, Chief Executive and senior leaders on gaps in governance or assurance that could expose the Trust to unacceptable risk.

Accountable Director

- Is accountable, alongside the risk owner, for a risk assigned to them.
- Confirms the risk position, the score and the plan, and makes sure the risk is escalated when it moves beyond what the directorate can manage.
- Commits directorate resources to the treatment of the risk, within their delegated authority.
- Supports the risk owner in getting the authority or resources a risk needs.

Head of Risk Management

- Maintains, updates and communicates this Framework and the procedures supporting it.
- Reviews the Trust's risk registers to identify risks that need coordinated Trust wide management, and proposes them to the Risk Management Group for designation.
- Carries out sample based quality checking of risk entries across the registers and gives feedback to directorates.
- Grants, monitors and where necessary withdraws the delegated authority of directorate risk leads to close risks.
- Provides tools, training and advice to risk owners, risk leads, managers and project managers.
- Prepares risk analysis and reporting for the Risk Management Group, the Clinical Leadership Executive, the Audit Committee and the Board.
- Maintains the risk management performance indicators and reports against them.
- Administers RADAR and keeps it aligned with this Framework.

Risk owners

- Are accountable for the risks assigned to them: the description, the score, the controls, the actions and the review.
- Keep the risk current on RADAR and review it at the required frequency.
- Bring a tolerated risk back for review before its due date if its controls, environment or exposure change materially.
- Escalate a risk that moves beyond the authority or resources available to them.
- Record the evidence supporting the assurance level given to each control.

Directorate risk leads

- Are responsible for the quality of their directorate's register: that risks are written, scored and classified in line with Part 2.
- Carry out the first line quality check on new and revised risks before they go to the Care Group.
- Hold delegated authority to close risks on their register, on the terms set out in Part 2. This authority is granted after training and may be withdrawn by the Head of Risk Management where risks are closed without proper basis.

Line managers

- Make sure risks in their service are identified, recorded and assigned to a named risk owner.
- Support risk owners in delivering the actions agreed against a risk.
- Escalate risks that move beyond what the service can manage.

Project managers

- Identify and manage project risks throughout the life of a project, in line with this Framework.
- Make sure project risks that will outlast the project, or that affect the wider Trust, are transferred to the relevant directorate register before the project closes.

All staff

- Identify and report risks, incidents and near misses promptly.
- Follow the Trust's policies, procedures and controls.
- Take part in risk management training.
- Tell their manager when something happens that makes a known risk more likely or more serious.

11. Risk Escalation Schedule

The Escalation Schedule sets out what each level of the Trust does with a risk: what comes to it, what it must do, and where the risk goes next. It is the operational route for risk. Board and Board Committee oversight of material and strategic risk is provided through the Trust's wider governance and reporting arrangements, described in sections 6.3 and 13, and so is not shown as a level within this schedule.

11.1 Core principles

- Each risk has one named owner and one Accountable Director.
- Risks are managed at the lowest level able to manage them effectively.
- A risk remains on the relevant directorate risk register when it is escalated for oversight, advice or decision. Escalation moves the work, not the risk.
- Risks outside the Trust's approved tolerance must be escalated.
- The Risk Management Group provides the Trust wide view of operational risk and determines what further action or escalation is required.

How a risk moves

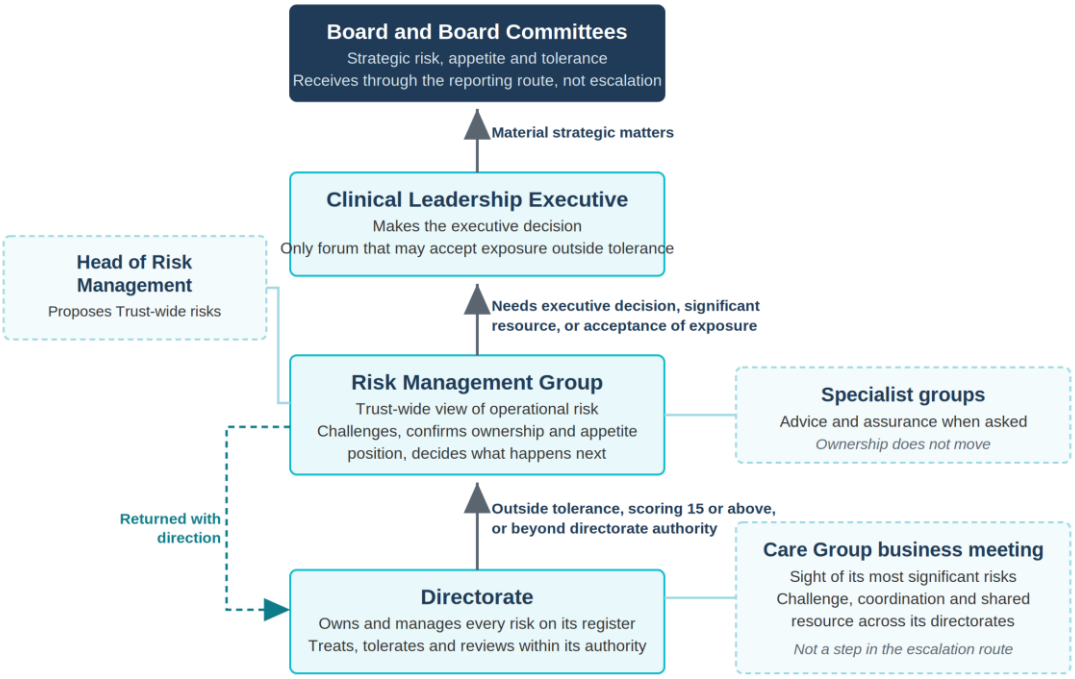

Figure 2: How a risk moves through the Trust

11.2 The escalation route

Level	What comes here	What happens	Where next
Directorate	All risks owned by the directorate.	Reviews the risk, controls, actions, score and position against appetite. Manages the risk using its delegated authority and resources.	Risks outside tolerance, or requiring support or authority beyond the directorate, are escalated to the Risk Management Group. Backbone directorates escalate directly to the Risk Management Group.
Care Group *(through Care Group business meetings)*	Risks requiring coordination, challenge or support across its directorates.	Challenges the risk position, agrees actions and uses Care Group authority or resources where appropriate.	Risks outside tolerance and risks that cannot be resolved within the Care Group are considered by the Risk Management Group.
Risk Management Group	All risks outside tolerance. All risks scoring 15 or above. Risks with potentially catastrophic impact. Risks requiring Trust wide coordination.	Provides Trust wide challenge, confirms ownership and appetite position, and decides what further intervention is required.	May return the risk to the owning area with direction, refer it for specialist advice, refer it to the Clinical Leadership Executive for action or resource, or escalate a material matter through the appropriate governance route.

Level	What comes here	What happens	Where next
	Risks that remain unresolved following local action.		
Clinical Leadership Executive	Risks requiring an executive decision, significant resource, Trust wide reprioritisation, or acceptance of exposure beyond delegated authority.	Makes the executive decisions as well as trustwide	Material strategic matters are reported to the relevant Board Committee or the Board.

The Risk Management Group may seek advice or assurance from specialist groups where required. This does not transfer ownership of the risk or create a separate escalation route.

11.3 Risk appetite and tolerance decisions

Position	Who decides	What happens	How long, and what next
Within appetite	Risk owner and Accountable Director	The risk may be tolerated, provided the controls and assurance remain appropriate.	Reviewed six monthly, and sooner if anything material changes.
Above appetite but within tolerance	Risk owner and Accountable Director	The risk cannot be tolerated. It is treated: actions are agreed to reduce the exposure towards appetite, with escalation where additional authority or resources are needed.	Reviewed monthly, until it returns within appetite or requires further escalation.
Outside tolerance	Clinical Leadership Executive, following Risk Management Group review	The risk cannot be tolerated. Where the exposure cannot be reduced after six consecutive monthly reviews, the Clinical Leadership Executive may approve temporary acceptance for up to six months, with the rationale, conditions, actions and review date recorded.	Maximum six months before the position must be reconsidered.
Recalibration of appetite or tolerance	Board	The Board decides whether the approved appetite or tolerance should be changed, where evidence shows the current position is no longer appropriate.	Any approved recalibration remains in place until formally reviewed or changed by the Board.

11.4 What tolerance and acceptance do and do not mean

Only risks within appetite may be tolerated. Temporary acceptance of exposure outside tolerance is an executive decision and is not the same as selecting tolerate as the risk treatment.

The Risk Management Group reviews and challenges risks outside tolerance and recommends the required response. It does not itself tolerate or formally accept the exposure.

Where the Clinical Leadership Executive or the Board receives a report or list of risks outside appetite, this should not be for noting only. The forum should acknowledge that the exposure is outside the limits the Board has set, and confirm whether it supports the current management position, the actions and the recovery trajectory.

That acknowledgement does not mean the risk has been tolerated or formally accepted, or that appetite has changed. It confirms that the governing body understands the exposure and supports the way it is being managed while action continues to bring it back within appetite.

All risks outside tolerance are subject to Risk Management Group oversight. Where a risk remains outside tolerance for six consecutive monthly reviews despite agreed actions, the Risk Management Group must refer it to the Clinical Leadership Executive for formal consideration of the exposure. The Clinical Leadership Executive may approve temporary acceptance outside tolerance for a maximum of six months, subject to defined actions, conditions and a review date. If the risk remains outside tolerance at the end of that period, it must return to the Clinical Leadership Executive for a further decision.

Being outside tolerance does not automatically mean the Trust should change its appetite. Where the exposure represents a sustained change in the level of risk the Trust is prepared to accept, any recalibration must be approved by the Board.

11.5 Standing visibility

Two rules apply automatically, whatever band a risk sits in:

- any risk scoring 15 or above is on standing view at the Risk Management Group; and
- any risk with a consequence score of 5 is on standing view at the Risk Management Group.

This ensures that a serious risk held within a higher appetite category, or a risk with a catastrophic consequence but a low score, remains visible above directorate level. Risks on standing view are watched at each meeting and discussed when they change.

12. Assurance over controls

Assurance over controls answers two questions:

1. Is the control well designed for the risk it addresses?
2. Is there evidence that the control is working?

The two are answered differently and by different people. Design is a judgement made by the risk owner. Evidence that a control is working comes from a source outside that judgement. Both are recorded against each control as separate fields.

This ensures that a control which is well designed but untested is not recorded as assured.

12.1 Control design

The risk owner records whether the control, operating as intended, addresses the cause or the impact of the risk. This is a first line judgement, quality checked by the directorate risk lead. It is management self assessment and is recorded as such.

12.2 The assurance levels

The assurance level is decided by who produced the evidence and whether it is current. It is not a judgement of how well the control is working. The same four levels are used for operational risk and for the Strategic Delivery Risk, so that the Board and its committees read one vocabulary.

Level	What it means	Examples
Not evidenced	No evidence is recorded against the control, or what is recorded is out of date against its own stated frequency.	None.
Partially evidenced	The evidence is produced and reviewed within the team or function that owns the control.	Local monitoring, self reported compliance, records of training delivered, a policy published.
Well evidenced	The evidence is produced or reviewed outside the owning team but within the Trust, to a stated frequency, and is current.	Trust performance reporting, clinical audit, compliance reporting, health and safety inspection, second line review, and a lead Board Committee's scrutiny of a strategic risk.
Fully evidenced	The evidence comes from outside Trust management and is current.	Internal Audit, external audit, a regulator, an accredited external review.

These names differ from Internal Audit's opinion levels so that the two are not confused in the same paper.

12.3 Awarding the level on the Strategic Delivery Risk

The Strategic Delivery Risk records evidence against each control at first, second and third level. The assurance level for a control follows from which of those levels hold current evidence.

Level	Awarded where
Not evidenced	Nothing is recorded at any level, or what is recorded is out of date.

Level	Awarded where
Partially evidenced	First level evidence only.
Well evidenced	First and second level evidence, current.
Fully evidenced	First, second and third level evidence, current, and the third level finding is positive.

The aggregated assurance rating

Each strategic risk also carries an aggregated rating, using the same four levels. The aggregated rating is not an average of the controls. It is limited by the weakest evidence on any control addressing a principal cause of the risk, and by whether the recorded gaps have actions against them.

Aggregated rating	Awarded where
Fully evidenced	Every control is Well evidenced or above, and every gap in control and gap in assurance has an action with an owner and a date.
Well evidenced	Every control is Well evidenced or above, or one control is Partially evidenced, and every gap has an action with an owner and a date.
Partially evidenced	A control addressing a principal cause is Partially evidenced or Not evidenced, or any recorded gap has no action against it.
Not evidenced	The controls are not evidenced.

This ensures that a strategic risk carrying a gap with no action against it cannot be reported as fully or well evidenced, whatever the position on its other controls.

12.4 Awarding the level on directorate registers

On a directorate register a control usually has a single evidence source, so the level is awarded from that source using the definitions at 12.2.

Partially evidenced is the expected level for most operational controls and is not a failing. Well evidenced is what the Trust expects for controls on risks outside tolerance and risks scoring 15 or above. Fully evidenced will be uncommon, because Internal Audit covers a small number of areas each year by design, and it is not a target.

The evidence fields are required for every control on a risk outside tolerance and on any risk scoring 15 or above. For other risks, control design is recorded and the evidence fields are optional. This keeps the requirement proportionate across 24 registers.

Directorate registers do not carry an aggregated rating. The level sits on each control, and the overall position is held in the gaps in assurance field.

12.5 Gaps in assurance

A gap in control means something needed is missing. A gap in assurance means we do not know whether what we have is working.

The gaps in assurance field is required for any risk outside tolerance and for any risk scoring 15 or above. Where a risk of that kind rests only on controls that are Not evidenced or Partially evidenced, the gap is recorded with an action and a date, and the Risk Management Group considers what further evidence is needed.

13. Reporting

Reporting keeps each level informed about the Trust's risk exposure, the actions being taken and the trends emerging. This section sets out what each forum receives. What each forum does with a risk is in the Escalation Schedule at section 11.

13.1 Board of Directors

- All strategic risks within the Strategic Delivery Risk, for approval, as required.
- Any change to a strategic risk description or score, for approval, as required.
- Progress on the mitigation of strategic risks, three times a year.
- Risks scoring 15 or above, as identified.
- Any proposed recalibration of risk appetite or tolerance.
- A report on all risks currently outside tolerance, to acknowledge and confirm support for the position.

13.2 Board Committees

- Progress on the mitigation of the strategic risks assigned to the Committee, three times a year.
- Any change to the description or score of those risks, for comment and recommendation to the Board, as required.

13.3 Audit Committee

- An overview of risk management and the assurance it provides, at each meeting.
- The risk management performance indicators, twice a year.
- An annual evaluation of the operation and effect of this Framework, together with the annual maturity self assessment and the improvement priorities arising from it.
- The Trust's position on risks temporarily accepted outside tolerance, annually.
- Internal Audit's work on risk management and governance, on its normal cycle.

13.4 Clinical Leadership Executive

- The outbrief from the Risk Management Group, summarising decisions and areas of escalation.
- Risks referred for executive decision, as they arise.

- Risks outside tolerance for six consecutive monthly reviews, for formal consideration of the exposure.

13.5 Risk Management Group

- All risks outside tolerance, and all risks scoring 15 or above, at each meeting.
- Emerging risks, as a standing item at each meeting.
- Proposed Trust wide risk designations, as they arise.
- Longstanding risks and thematic reviews, on a rolling programme.
- Compliance data, including the frequency of reviews completed by risk owners, on a rolling programme.
- The risk management performance indicators, quarterly.
- Themes from Freedom to Speak Up concerns, suitably anonymised, periodically, as a source of risk identification.

13.6 Care Group business meetings and delivery reviews

- Oversight of the Care Group's risks, at each meeting.
- The current state of the relevant register, and its highest scoring risks, at each delivery review.

14. Measuring how well this Framework is working

The indicators below measure the risk management system rather than the risks within it. Each is a count produced by RADAR, and each has a clear action attached when it moves the wrong way.

Indicator	What it tells us
Overdue reviews, by directorate	Whether registers are being kept current.
Open actions past their due date, and actions whose due date has been extended more than once	Whether treatment plans are being delivered, or rescheduled in place of delivery.
Risks outside tolerance: how many, and how long each has been there	The Trust's exposure beyond the limits the Board has set, and whether it is moving.
Risks outside tolerance for six consecutive reviews	Whether referral to the Clinical Leadership Executive is happening when it should.
Risks above appetite with no open actions	Whether the rule that every risk above appetite is treated is being applied.
Risks outside tolerance, or scoring 15 or above, with assurance fields incomplete	Whether the Trust's most significant risks are evidenced.

The indicators are reported quarterly to the Risk Management Group and twice a year to the Audit Committee. The indicator set and its thresholds are approved by the Risk Management

Group, so they can be adjusted as the Trust's arrangements mature without amending this Framework.

The first year of reporting establishes the baseline. Thresholds are set by the Risk Management Group once there is a position to set them against.

14.1 Annual maturity self assessment

The Trust carries out an annual self assessment of its risk management maturity. The outcome, and the improvement priorities arising from it, are reported to the Audit Committee alongside the annual evaluation of this Framework.

15. Well Led and the Annual Governance Statement

This Framework is tested externally through inspection and through the annual accounts. This section sets out what it provides in each case.

15.1 Well Led

The arrangements in this Framework provide evidence against the Well Led lines of enquiry, in particular:

Area	What this Framework provides
Governance and management	The Escalation Schedule, roles and responsibilities, and the three lines model at sections 9 to 11.
Managing risks and performance	Risk appetite and tolerance, the treatment and review requirements, and the risk management performance indicators.
Learning, improvement and innovation	Named identification feeds from incident investigations, Freedom to Speak Up themes and quality and safety impact assessments, the emerging risks item, and the annual maturity self assessment.
Information management	A single risk system, one register per directorate, and consistent recording standards set out in Part 2.

15.2 Annual Governance Statement

Each year the Trust's risk management arrangements contribute the following to the Annual Governance Statement:

- the annual evaluation of the operation and effect of this Framework;
- the compliance data and performance indicators reported to the Audit Committee;
- the Trust's position on risks temporarily accepted outside tolerance; and
- the outcome of the annual maturity self assessment.

16. Training

All staff complete the mandatory risk management and governance training on ESR. Risk owners and directorate risk leads receive additional training from the Risk Management function, supported by written guidance.

Directorate risk leads must complete the training on risk closure before the delegated authority to close risks is granted.

This section should be read alongside the Risk Management Training Framework, which sets out the training required for each role.

17. Risk system

RADAR is the Trust's risk management system and the single place where risks are recorded, updated and reported. Staff log new risks, update records and view current information according to their access level. Access is tiered, so that the ability to view, edit, approve and close reflects each user's responsibilities under this Framework. The Head of Risk Management administers the system and keeps it aligned with this Framework.

18. Emergency preparedness, resilience and response

The Trust's EPRR team maintains a Trust wide register of EPRR risks, in line with the Trust's EPRR Policy. The EPRR Group reviews that register every two months and escalates risks within defined parameters to the Risk Management Group, with the risk recorded on the appropriate directorate register.

19. Reviewing this Framework

This Framework changes as the Trust's risks, structures and arrangements change. Proposed changes are documented, reviewed by the Head of Risk Management and the Director of Corporate Assurance, and approved by the Risk Management Group and the Board.

The Framework is formally reviewed every three years. The Risk Management Group carries out a lighter annual check in the years between, drawing on the performance indicators, the annual maturity self assessment and any findings from Internal Audit or inspection. Where an urgent issue or an audit finding requires it, the Framework is reviewed sooner. This ensures the document keeps pace with the Trust's risk arrangements while they continue to develop.

Risk Management Framework

Part 2: The working guide

Writing, scoring, controlling, reviewing and closing a risk

Part 2 is the practical guide. Part 1 sets out how risk is governed at RDaSH and what the Trust requires. Part 2 tells you how to do it: how to decide whether something is a risk, how to write it, how to score it, what to record against the controls, how often to come back to it, when to escalate it and when it can be closed.

It is written for risk owners, directorate risk leads, line managers and project managers. If you only need to know how to recognise a risk and report one, Part 3 is shorter and is the part for you.

Everything in Part 2 sits underneath Part 1. Where the two appear to disagree, Part 1 is the approved position and Part 2 is corrected to match it.

20. How to use this part

Part 2 follows the life of a risk in the order you meet it, from spotting something that worries you through to closing the record. Each section stands on its own, so you can come to the one you need without reading the rest.

Three rules from Part 1 run through everything here. They are repeated because they decide most of the questions people ask.

1. Every risk has one record, one accountable owner and one route for decisions at any point in time. Other groups may see a risk for advice or oversight, but only one route decides.
2. Risks are managed and resolved at the lowest level that has the authority and resources to do so. Escalation is for what that level cannot settle.
3. Only risks within the Board's appetite may be tolerated. Everything above appetite is treated, with a plan.

All risks are recorded on RADAR. There is no separate spreadsheet, local log or team list that counts as a risk register. If it is not on RADAR, it is not on the register.

21. Is it a risk?

Two tests decide it. Something is a risk only if both are met.

- **It is a future uncertainty.** It might happen. It has not happened yet, and it might never happen.
- **It affects something we are trying to achieve.** There is an objective, a service, a standard or a duty that would be damaged if it did happen.

If one of the two is missing, it is something else. The most common confusions are below.

What is raised	What it actually is	Where it belongs
Something that has already happened, or is happening now	An issue	Manage it through the operational or incident route. Then ask separately whether it creates a future uncertainty. If it does, that is the risk, and it is written as a risk in its own right.
A problem with no consequence for anything we are trying to achieve	A nuisance or a gripe	Deal with it locally. It does not belong on the register.
A task that has not been done yet	An action	Put it against the risk it protects against. An action is not a risk on its own.
A general worry about a whole subject, for example staffing or estates	A theme	Break it down. Find the specific event you are worried about, and write that.

What is raised	What it actually is	Where it belongs
The absence of something, for example no policy or no training	A gap in control	Ask what could happen because of it. That is the risk. The missing item is the cause.

21.1 Where risks come from

Risks do not only arrive when someone happens to think of one. The Trust expects risks to be picked up from the sources it already has, including:

- incident reports, patient safety investigations and themes from them
- complaints, concerns and Freedom to Speak Up themes
- internal audit findings, external audit findings and regulatory reports
- quality and safety impact assessments carried out on service change and cost improvement schemes
- business planning, budget setting and the workforce plan
- service change, new services, mergers and partnership arrangements
- staff survey results, appraisal and supervision themes, and safety huddles
- horizon scanning, national guidance and changes in law or regulation

A risk identified from any of these is entered on RADAR in the same way as any other. There is no separate route and no lighter standard.

22. Writing the risk

Every risk on the register is written in the same three part structure, so that anyone reading it can see what might happen, why, and why it matters.

> **Due to, or If, [cause], there is a risk that [event], which may result in [impact].**

22.1 The three parts

Part	What it is	The question it answers
Cause	The condition, weakness or pressure that exists now and makes the event possible.	Why could this happen?
Event	The thing that might happen. It is the risk itself. It must be a single, specific, identifiable occurrence.	What might actually happen?
Impact	The consequence for patients, staff, services, finances, compliance or reputation if the event happens.	Why does it matter?

The event is the part most often left out. A statement that names a cause and an impact, but no event cannot be scored or categorised properly. It helps to write the event as a single

clause. If that is difficult, it is usually worth talking the risk through with your directorate risk lead before recording it.

22.2 Due to, or If

The two openings are not interchangeable. Choose based on whether the cause already exists.

Opening	Use it when	Example
Due to	The cause is present now and is evidenced. It is a fact about today.	Due to a registered nurse vacancy rate of 18 per cent on the inpatient wards, there is a risk that shifts run below the agreed establishment, which may result in delayed observations, missed care and avoidable harm to patients.
If	The cause is conditional, planned or has not yet materialised. It depends on something happening first.	If the planned transfer of the community caseload to the new provider is not completed by the agreed date, there is a risk that patients remain on two systems at once, which may result in lost referrals, duplicated appointments and a break in continuity of care.

Using Due to for something that has not happened yet overstates the position. Using If for something that is already true understates it. Both distort the score.

22.3 Writing it well

A good statement is specific enough that someone outside your service can understand it without asking you a question. Keep to these:

- one risk per record, not several bundled together
- one event, named plainly
- no abbreviations or local shorthand unless they are spelled out the first time
- no blame, no naming individuals
- numbers where you have them, because a vacancy rate, a waiting time or a backlog figure tells the reader more than the word significant
- no solution in the statement, because what you plan to do about it belongs in the actions

22.4 Common problems and how to fix them

Problem	What it looks like	The fix
No event	Due to staffing pressures, there is a risk to patient care.	Name what might happen. Shifts run below establishment. Observations are missed. A ward closes.

Problem	What it looks like	The fix
The impact used as the event	There is a risk of harm to patients.	Harm is the impact. Ask what would have to happen first for harm to follow, and make that the event.
The cause used as the event	There is a risk that we have a high vacancy rate.	The vacancy rate is the cause. It already exists, so it is not uncertain. The event is what the vacancy rate might lead to.
A missing action written as a risk	There is a risk that the policy has not been updated.	The out of date policy is a gap in control. The risk is what could happen because of it.
Several risks in one	A statement joined by and, and, and	Split them. Each event gets its own record, its own score and its own owner.
Too vague to score	There is a risk of service disruption.	Which service, disrupted how, and for how long. Without that you cannot judge consequence or likelihood.

23. Choosing the category and subcategory

Every risk carries one category and one subcategory from the Trust's approved list. The choice is not administrative. It sets the appetite that applies, and the appetite sets the target score and the point at which the risk must be escalated. Getting it wrong changes how the risk is treated.

23.1 Categorise on the event

Categorise on the event, not the cause and not the impact. A risk caused by a staffing shortfall that could lead to a missed diagnosis is a clinical safety risk, because the event is clinical. A risk caused by a clinical pressure that could lead to a breach of a reporting deadline is a regulatory risk, because the event is regulatory.

Most risks in the Trust affect patients at some point in the chain. Categorising on the impact would place nearly everything under Patient Care, and the appetite set for each category would no longer distinguish between them.

23.2 The categories

Category	Subcategories
Financial	• Financial Planning, CIP and Sustainability • Counter Fraud • Financial Control and Oversight

Category	Subcategories
People	• Planning and Supply • Capacity • Well being and Retention • Capability and Performance
Patient Care	• Clinical Safety • Quality Improvement • Learning and Oversight • Patient Experience
Performance	• Emergency Preparedness • Capacity and Demand Management • Estates, Equipment and Supply Chain • Information Governance • Digital Infrastructure and Cyber Security
External and Partnerships	• Change and Improvement Delivery • Legal and Governance • Partnership Working • Regulatory • Delivering Our Promises

If a risk seems to fit two subcategories equally, it is usually two risks. Split it. If it genuinely is one event, choose the subcategory that describes what would happen first, and say so in the record.

24. Scoring the risk

The score is consequence multiplied by likelihood, on a five by five matrix. It gives a number between 1 and 25.

24.1 Score the event, not the worst thing imaginable

You are scoring the event as it is written, with the controls that are actually in place and working as they currently work. Two rules follow from that.

- **Score the event, not the cause and not the impact.** The consequence rating asks how bad it would be if the event happened. It does not ask how bad the underlying pressure feels.
- **Score the realistic outcome, not the theoretical maximum.** Almost any risk in a healthcare setting can be argued through to death if you follow the chain far enough. That is not what the consequence score measures. It measures the outcome that could reasonably be expected if the event occurred with current controls in place.

24.2 Being honest about consequence where patients are involved

Patient safety sits at the centre of what the Trust does, and there is a natural pull towards rating every clinical risk as catastrophic. Resist it. Where every risk is scored 5 for consequence, the register loses its ability to separate the most serious risks from the rest, and the Board cannot see which ones need its attention first.

Rating a clinical risk at 3 is not a statement that patients do not matter. It is a statement about what would realistically happen if that particular event occurred. The Trust's low appetite for clinical risk is already built into the appetite bands, so an honest score still escalates a clinical risk far sooner than the same score in a category with a higher appetite. Overstating consequence does not protect patients. It hides the risks that need attention.

24.3 The consequence table

Score the highest reasonably foreseeable consequence across the domains that apply. Consider severity, duration, reversibility, the number of people affected, and how far across the Trust the effect reaches. Do not add scores across domains. Reporting requirements, complaints, investigations and external scrutiny may indicate seriousness but do not determine the score on their own.

Record in the scoring rationale which domain you scored against. The domains describe the impact of a risk. They are not the same as the risk categories at section 23, which describe the risk itself, and there is no fixed relationship between the two.

Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient safety, physical harm	No harm, or harm needing no treatment beyond a single visit, dressing changes or a short course of medication.	Harm needing extra observation or minor treatment, with no effect on independence or on the success of existing treatment.	Harm needing healthcare beyond a single visit, but under two weeks additional inpatient care or under six months further treatment, or limiting independence for under six months.	Permanent harm or permanent alteration of physiology, harm needing immediate life saving intervention, or moderate harm to several patients arising from the same event.	Death, or permanent harm to several patients arising from the same event.
Patient safety, psychological harm	Transient distress needing no treatment beyond a single visit, with no effect on normal activities beyond a few days.	Distress needing a short course of treatment or additional support, with a brief effect on the therapeutic relationship.	Distress needing a course of treatment, or a deterioration in mental state requiring a change to the care plan, with effects expected to resolve within six months.	Distress or deterioration with a permanent or long term effect, retraumatisation, or disengagement from services by someone who needs them.	Psychological harm contributing to death or life threatening self harm, or long term harm to several people arising from the same event.
Staff and public safety	No injury, or injury needing no treatment and no time away from normal duties.	Minor injury or illness needing minor treatment and absence of up to seven days, or distress caused by verbal abuse or threats.	Injury or illness resulting in more than seven consecutive days of incapacity from normal duties, or psychological harm needing a course of treatment.	Serious injury such as a fracture, amputation, loss of sight or serious burns, injury leading to long term incapacity or disability, injury needing immediate life saving intervention, or psychological harm with a long term effect.	Death or life changing injury to a member of staff, contractor, volunteer, visitor or member of the public.
Quality of care and patient experience	Care falls short of the expected standard on a single occasion, with no effect on the person's care or experience.	Care falls short of the expected standard on more than one occasion, with a minor effect on experience and no effect on outcomes.	Repeated failure to meet internal standards within a team or service, with a measurable effect on the care people receive.	Sustained failure to meet expected standards across a service, with a significant effect on people's outcomes or experience.	Fundamental or systemic failure in care across more than one service.
Workforce and capability	A short term gap covered locally, with no effect on the service.	Recurring gaps requiring bank or agency cover, with the service maintained.	Sustained gaps or loss of experienced staff affecting the quality of care or delivery of a service.	Establishment cannot be filled to a safe level for a sustained period, or key staff are lost with no succession in place.	Staffing failure forcing the closure or suspension of a service, or the loss of a whole team or function the Trust cannot rebuild within the year.
Service continuity and access	Interruption to a non critical service for less than a day, with no effect on care, decisions or other directorates.	Interruption to a non critical service for more than a day, or to a critical service within its business continuity recovery time, with no effect on care or decisions.	Loss of a critical service or system, such as the electronic patient record, beyond its recovery time, affecting care, decisions or the work of other directorates, or waits beyond standard for a defined group.	Prolonged loss of a critical service or system causing significant disruption to care across more than one service, or sustained failure of access to a service.	Permanent loss of a service, or failure of a service the Trust or its partners depend on.

Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Statutory duty and regulation	Minor non compliance identified and corrected internally, with nothing externally reportable.	A single breach of a statutory or regulatory requirement, with no external notification required.	A reportable breach, external recommendations, a requirement notice, or a prevention of future deaths report.	Enforcement action, a warning notice, conditions placed on registration, or movement to a worse segment under the NHS Oversight Framework.	Prosecution, suspension or cancellation of registration, or placement in the segment for organisations in most need of support, with formal intervention in how the Trust is run.
Finance	Up to 50,000 pounds, with no effect on the directorate's budget position.	Over 50,000 and up to 250,000 pounds, requiring action within the directorate to stay within budget.	Over 250,000 pounds and up to 1 million pounds, affecting a care group's ability to deliver its budget or efficiency plan.	Over 1 million and up to 5 million pounds. The Trust cannot deliver its annual financial plan without unplanned recovery action.	Over 5 million pounds. The Trust cannot deliver its annual financial plan, or its financial sustainability is affected beyond the current year.
Legal proceedings	No legal consequence for the Trust.	A single claim handled through normal arrangements, with no wider implication.	Proceedings requiring external legal advice and significant management time, or attracting scrutiny beyond the Trust.	Proceedings that would expose a systemic failing, a group action, or a case setting a precedent for the Trust.	A finding of unlawful practice or a successful judicial review of a Trust decision.
Information governance and data protection	Loss, disclosure or misuse of information with no risk to anyone's rights and freedoms.	Loss, disclosure or misuse of limited personal information, unlikely to result in a risk to people's rights and freedoms.	Loss, disclosure or misuse of personal information likely to result in a risk to people's rights and freedoms, causing distress or loss of trust.	Loss, disclosure or misuse of sensitive personal information likely to result in a high risk to people's rights and freedoms, causing significant distress or risk to personal safety.	Loss, disclosure or misuse of personal information causing serious harm to individuals or affecting a large population.
Reputation and public confidence	Local concern or rumour, with no external comment.	Local media coverage, short lived, with no lasting effect on confidence.	Sustained local or regional coverage, or loss of confidence among a specific community, partner or commissioner.	National coverage, or formal concern raised by commissioners, NHS England or elected representatives.	Sustained national coverage or a public inquiry, with loss of confidence affecting the Trust's ability to recruit, operate services or hold its contracts.

Finance values are the in year impact. A recurrent impact scores one level higher.

24.4 The likelihood table

Score likelihood by predicted frequency where you can, because frequency is easier to evidence and harder to argue with. Where frequency does not work, use probability over a defined period, for example the life of a project or a care episode. Use the descriptor only where neither is possible.

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency: how often might it happen, or how often does it happen	This will probably never happen or recur.	Do not expect it to happen or recur, but it is possible it may do so.	Might happen or recur occasionally.	Will probably happen or recur, but it is not a persisting issue.	Will undoubtedly happen or recur, possibly frequently.
Probability	0 to 5 per cent. Extremely unlikely or virtually impossible.	6 to 20 per cent. Low but not impossible.	21 to 50 per cent. Fairly likely to occur.	51 to 80 per cent. More likely to occur than not.	81 to 100 per cent. Almost certainly will occur.

24.5 The matrix

The matrix converts a consequence score and a likelihood score into a risk score. Read the consequence down the side and the likelihood across the top.

Whether a score sits within appetite, within tolerance or outside tolerance depends on the appetite level for the risk's subcategory, so the same score falls in a different band in different categories. The four matrices below show the bands for each appetite level. Use the one that matches the subcategory you have chosen. C is the consequence score and L is the likelihood score.

Averse. Within appetite 1 to 2. Within tolerance 3 to 6. Outside tolerance 7 and above.					
Consequence	**L1**	**L2**	**L3**	**L4**	**L5**
C5	**5**	**10**	**15**	**20**	**25**
C4	**4**	**8**	**12**	**16**	**20**
C3	**3**	**6**	**9**	**12**	**15**
C2	**2**	**4**	**6**	**8**	**10**
C1	**1**	**2**	**3**	**4**	**5**

Low tolerance. Within appetite 1 to 5. Within tolerance 6 to 10. Outside tolerance 11 and above.					
Consequence	**L1**	**L2**	**L3**	**L4**	**L5**
C5	**5**	**10**	**15**	**20**	**25**
C4	**4**	**8**	**12**	**16**	**20**

C3	3	6	9	12	15
C2	2	4	6	8	10
C1	1	2	3	4	5

Moderate tolerance. Within appetite 1 to 8. Within tolerance 9 to 15. Outside tolerance 16 and above.					
Consequence	L1	L2	L3	L4	L5
C5	5	10	15	20	25
C4	4	8	12	16	20
C3	3	6	9	12	15
C2	2	4	6	8	10
C1	1	2	3	4	5

High tolerance. Within appetite 1 to 10. Within tolerance 11 to 20. Outside tolerance 21 and above.					
Consequence	L1	L2	L3	L4	L5
C5	5	10	15	20	25
C4	4	8	12	16	20
C3	3	6	9	12	15
C2	2	4	6	8	10
C1	1	2	3	4	5

24.6 Using the tables

1. Define the risk in terms of the adverse consequence that might arise from it.
2. Use the consequence table at 24.3 to determine the consequence score.
3. Use the likelihood table at 24.4 to determine the likelihood score.
4. Multiply consequence by likelihood to get the risk score.
5. Read the score against the appetite and tolerance bands for the risk's subcategory to establish its position, and follow section 25.

24.7 Current and target score

- **The current score** is where the risk sits today, with existing controls working as they currently work. It is the score that drives everything else.
- **The target score** is the top of the within appetite band for the risk's subcategory. RADAR generates it from the category, so it is set the same way on all 24 registers. You do not choose it.

Because the Trust uses four appetite levels, there are only four possible target scores.

Appetite level	Within appetite	Within tolerance	Outside tolerance	Target
Averse	1 to 2	3 to 6	7 and above	2
Low tolerance	1 to 5	6 to 10	11 and above	5
Moderate tolerance	1 to 8	9 to 15	16 and above	8
High tolerance	1 to 10	11 to 20	21 and above	10

Where the current score is already at or below the target, no further reduction is required. The risk is at target. It is not an instruction to let the risk rise to the target.

24.8 When to rescore

Rescore when something has actually changed, not to make the register look better. Rescore when:

- a new control is in place and operating, not merely agreed or purchased
- an existing control has stopped working, has been withdrawn or has failed a test
- the event has occurred, which tells you something real about likelihood
- the environment has changed, for example demand, staffing, funding, guidance or law
- new information changes what you now believe the consequence would be

Record the reason for every score change. A score that moves without a recorded reason will be queried and may be reversed.

25. What your score means

Once the risk is scored and categorised, its position against appetite follows automatically, and that position decides what happens next.

Position	What it means	What happens
Within appetite	The exposure is at or below the level the Board is prepared to accept for this kind of risk.	The risk may be tolerated if the owner and Accountable Director agree the controls and assurance are appropriate. If it is not tolerated, it continues to be treated.
Above appetite but within tolerance	The exposure is more than the Board wants, but has not passed the outer limit.	The risk is treated. Actions are agreed to bring it back towards appetite. It is reviewed monthly. It cannot be tolerated.

Position	What it means	What happens
Outside tolerance	The exposure has passed the outer limit the Board has set for this category.	The risk must be escalated to the Risk Management Group and follows the route in Part 1, section 11. It cannot be tolerated.

Two further rules apply whatever band a risk sits in. Any risk scoring 15 or above, and any risk with a consequence score of 5, is on standing view at the Risk Management Group. This catches a serious risk sitting inside a higher appetite category, and a risk with a catastrophic consequence but a low overall score.

26. Controls

A control is something already in place that reduces how likely the risk is, or how bad it would be. An action is something still to be done. The distinction matters because your current score is only defensible if it reflects controls that exist and operate.

	Control	Action
Exists	Now	Not yet
Affects	The current score	The future score, once complete
Recorded as	A control, with its design judgement and its evidence	An action, with a named owner and a due date
Example	Twice daily staffing huddle that reallocates staff across wards	Recruit to the four vacant band 5 posts by 31 March

A plan, a policy in draft, a business case, a training course that has been booked and a piece of equipment on order are all actions. None of them is a control until it is in use.

26.1 What makes a control worth recording

Record the controls that are genuinely holding the risk where it is. A list of every process that touches the subject makes the record longer without making it more reliable. For each control ask:

- does it act on the cause, making the event less likely, or on the impact, making it less severe
- would removing it change the score
- can you point to something that shows it operates

If the answer to the second question is no, it is background, not a control.

26.2 Recording control design

Against each control the risk owner records whether the control, operating as intended, addresses the cause or the impact of the risk. This is a first line management judgement. It

is quality checked by the directorate risk lead, and it is recorded as a judgement rather than as evidence.

Design and evidence are separate fields on purpose. A control can be well designed and completely untested. Recording them together would let that pass as assured.

26.3 Types of control

Knowing which kind of control you are recording tells you which half of the score it acts on, and shows up where a risk is being held together by only one kind.

Type	What it does	Effect on the score	Examples
Preventive	Removes or reduces the cause, so the event is less likely to happen at all.	Reduces likelihood	Access controls, staff vetting, planned maintenance.
Directive	Guides behaviour and process so people act in a way that avoids the event.	Reduces likelihood	Policies, standard operating procedures, training, leadership direction.
Detective	Identifies that something has gone wrong early enough to intervene.	Reduces likelihood and impact	Monitoring, audit, testing, alerting.
Corrective	Limits the harm once the event has happened. It must be in place beforehand to count.	Reduces impact	Business continuity plans, backup power, rapid response arrangements.

A risk held only by directive controls, meaning policies and training with nothing detecting failure, is usually weaker than its score suggests. That is worth saying in the gaps in assurance field.

27. Evidence and assurance levels

The assurance level answers one question only: who produced the evidence that this control is working, and is it current. It is not a rating of how good the control is, and it is not a score. The same four levels are used on the directorate registers and on the Strategic Delivery Risk, so that everyone reads one vocabulary.

Level	Awarded where	Typical evidence
Not evidenced	Nothing is recorded against the control, or what is recorded is out of date against its own stated frequency.	None.
Partially evidenced	The evidence is produced and reviewed within the team or function that owns the control.	Local monitoring, self reported compliance, records of training delivered, a policy published.

Level	Awarded where	Typical evidence
Well evidenced	The evidence is produced or reviewed outside the owning team but within the Trust, to a stated frequency, and is current.	Trust performance reporting, clinical audit, compliance reporting, health and safety inspection, second line review, a lead Board Committee's scrutiny of a strategic risk.
Fully evidenced	The evidence comes from outside Trust management and is current.	Internal Audit, external audit, a regulator, an accredited external review.

27.1 What to write in the evidence field

The evidence field should let a reader check the position without contacting you. Write what the evidence is, who produces it, how often, and when it was last produced. For example: monthly ward staffing compliance report, produced by the Care Group performance team, last produced 4 August 2026.

A named document with a date is evidence. The phrase ongoing monitoring is not.

27.2 Which risks need the evidence fields completed

Completing the evidence fields on all 24 registers for every control would not be proportionate. The fields are required for every control on:

- any risk outside tolerance
- any risk scoring 15 or above
- any risk with a consequence score of 5

For all other risks the control and its design judgement are recorded, and the evidence fields are optional but encouraged.

27.3 What good looks like

Partially evidenced is the expected level for most operational controls and is not a failing. Well evidenced is what the Trust expects for controls on risks outside tolerance and risks scoring 15 or above. Fully evidenced will be uncommon, because Internal Audit covers a small number of areas each year by design. It is not a target and chasing it is not a good use of anyone's time.

27.4 Gaps

A gap in control means something needed is missing. A gap in assurance means we do not know whether what we have is working. They are different problems with different answers, and the record should say which one it is.

The gaps in assurance field is required for any risk outside tolerance and any risk scoring 15 or above. Where a risk of that kind rests only on controls that are Not evidenced or Partially evidenced, record the gap with an action and a date. The Risk Management Group will consider what further evidence is needed.

28. Deciding the treatment

There are two treatment states on the register: treated or tolerated. Every risk is one or the other.

State	What it means	When it may be used
Treated	The risk is being actively reduced. It has a plan, named actions with owners and dates, and it is reviewed monthly.	Any risk. This is the default. Every risk above appetite is treated.
Tolerated	The Trust has decided to accept the risk as it stands, with no further action planned. It is reviewed six monthly.	Only a risk within appetite, and only with the agreement of the risk owner and the Accountable Director.

28.1 Where the four Ts went

If you have been trained elsewhere you will know the four Ts: treat, tolerate, transfer and terminate. The Trust has not abandoned them. Transfer and terminate are ways of treating a risk, so they sit inside treat rather than alongside it.

- Transferring a risk, for example through insurance, indemnity or a contract clause, is a control. Record it as one. Note that transfer moves the financial or legal consequence, not the operational or reputational one, and the residual risk stays with the Trust and stays on the register.
- Terminating a risk, by stopping the activity that gives rise to it, removes the cause. If the activity genuinely stops, the risk is closed under section 31. Until it stops, the decision to stop it is an action.

28.2 Actions

Every risk being treated carries at least one open action. Each action needs a named individual, not a team or a job title, and a due date that person has agreed. Write actions so that it is obvious when they are finished.

If an action's due date is extended more than once, that is reported. Repeated extension is usually a sign that the action is not going to happen and the risk needs a different answer, not another date.

28.3 When further reduction is not proportionate

Sometimes a risk sits above appetite, the controls are sound, and no further action would be worth what it would cost. Recording actions that nobody intends to take makes the register less reliable, not more.

Where the risk owner and Accountable Director judge that a risk above appetite cannot be reduced further at proportionate cost, do not invent an action. Record the position and the reasoning, and report it to the Risk Management Group. This is not the same as tolerating the risk. The risk remains above appetite, remains treated, and remains reviewed monthly. Where the same position appears repeatedly across a category, the Risk Management

Group refers it upward as evidence that the appetite for that category may need to be looked at again.

29. Reviewing a risk

A review is a fresh look at whether the record is still true. It is not a tick to say you have opened it.

29.1 How often

The risk is	Reviewed	Notes
Treated	Monthly	Applies whatever band the risk sits in, including a risk within appetite that still has open actions.
Tolerated	Six monthly	Only risks within appetite may be tolerated, so six monthly review only ever applies to a risk within appetite with no further action planned.
Any risk where something material has changed	Immediately	Bring the review forward. Do not wait for the due date.

A tolerated risk is brought back for review before its due date if its controls, environment or exposure change materially. The owner is responsible for noticing that and acting on it.

29.2 What a review must cover

At each review, confirm or change each of the following:

1. Is the risk statement still accurate? Has the cause changed, or the event, or what the impact would be?
2. Are the recorded controls still in place and still operating?
3. Is the evidence against each control current, or has it passed its own stated frequency?
4. Is the score still right, and if it has changed, why?
5. Are the actions progressing, and are the due dates still realistic?
6. Has the position against appetite changed, and does that trigger anything?
7. Is this still a risk at all, or does it now meet one of the closure grounds in section 31?

Record what you concluded. A review that records no change should say what you checked and that nothing had changed. Where nothing has changed, a short note saying so is enough.

30. Escalating a risk

Escalation moves the work, not the risk. The risk stays on your register, with your name against it, while another level helps with it or decides something you cannot decide.

30.1 When you escalate

- the risk has moved outside tolerance for its category
- the risk scores 15 or above
- the risk has a consequence score of 5
- the risk needs authority, resources or a decision beyond what your directorate holds
- the risk affects more than one part of the Trust and cannot be managed by your directorate alone
- something has happened that materially changes the risk and needs to be known about quickly

Where a risk moves outside tolerance, the Risk Management Group is notified through the Head of Risk Management.

30.2 What happens next

The full route is in Part 1, section 11. In short, the Risk Management Group will challenge the position, confirm ownership and appetite position, and then either return the risk to you with a direction, refer it for specialist advice, refer it to the Clinical Leadership Executive for action or resource, or escalate it further. You will be told which, and any referral carries a return date.

31. Closing a risk

A risk is closed when it has stopped being a risk. That means it no longer meets the two tests in section 21: it is no longer a future uncertainty, or there is no longer an objective it affects.

31.1 Grounds for closure

A risk may be closed only where one of these applies, and the ground must be named in the closure record.

Ground	What it means	Example
The cause is resolved	The cause has been fully removed, so the event can no longer happen.	The building with the failing electrical system has been vacated and handed back to the landlord.
The cause can no longer occur	Time has passed, or circumstances have moved on, and the cause cannot return.	The risk related to a transition window that has now closed, a contract that has ended, or a system that has been decommissioned.

Ground	What it means	Example
The event has happened and cannot happen again	The uncertainty has gone. What remains is an issue, managed through the relevant operational route, not a risk.	The one off migration failed. The failure is now an issue. The migration will not be run again.
The objective no longer exists	The service, project or activity the risk attached to has ended or transferred out of the Trust.	The service has closed, or has transferred to another provider along with its risks.

31.2 Where the event has happened but could happen again

Most risks on the register are recurring event risks. Violence towards staff, a shortfall in registered nurse cover, an information governance breach and a missed appointment can all happen more than once. When one of these events occurs, the risk of the next one has not gone anywhere.

So the test is not simply that the event happened. Close on this ground only where the event has occurred and cannot occur again, or where the event has occurred and what remains is an issue being managed rather than a continuing uncertainty. Where the event can recur, the risk stays open, and the occurrence is evidence for rescoring it rather than a reason to close it.

31.3 Where the event has happened, handing over to the issue route

When a risk closes because the event has occurred, the consequences do not close with it. Before the record is closed:

1. Confirm who is managing the consequence and through which route, for example the incident process, the patient safety route, a recovery plan or a project.
2. Name that person and that route in the closure record, so the trail from risk to issue is visible.
3. Ask what new uncertainty the occurrence has created. Anything that could still happen from here is a new risk, written and scored in its own right, and linked to the closed record.

31.4 What is not a ground for closure

These are the reasons risks are most often closed wrongly. None of them is sufficient.

- **The score has come down, including down to within appetite.** A reduced risk is still a risk. If it is within appetite it becomes a candidate to be tolerated, and a tolerated risk stays on the register and is reviewed six monthly. It is not closed.
- **All the actions are complete.** Actions are how a risk is treated. Finishing them does not remove the uncertainty. It usually means the risk is now being held by controls rather than by a plan.
- **The controls are working.** If the risk only stays away because a control keeps operating, it is a live risk being controlled. Stop the control and the risk returns. That is the test: if closure depends on something continuing to be done, the risk is not closed.

- **Nothing has happened for a long time.** A dormant risk is not a resolved one. Low likelihood is a score, not a closure.
- **Nobody has updated it.** An out of date record is a review failure. Bring it up to date and then decide.
- **It has been moved somewhere else.** Merging a risk into another record, or transferring it to another directorate register, is a housekeeping change, not a closure. Use the merge or transfer route and link the records so the history is kept.

31.5 Who closes, and what is recorded

Directorate risk leads hold delegated authority to close risks on their register. The authority is granted after training on risk closure and may be withdrawn by the Head of Risk Management where risks are being closed without proper basis.

Every closure records:

- which of the four grounds applies
- the evidence for it, for example the decommissioning date, the handover confirmation or the service closure notice
- where the event has happened, who is managing the consequence and through which route
- any new risks created, and their references
- the date and the name of the person closing it

Where the risk was outside tolerance, scored 15 or above, or carried a consequence score of 5 at any point in the last twelve months, the closure is reported to the Risk Management Group rather than logged locally. The Group does not have to approve it, but it must see it.

31.6 Reopening

A closed risk that returns within twelve months is not closed again locally. It goes to the Risk Management Group with the original closure record, so that the Group can see whether the closure ground was wrong, the cause was not actually resolved, or something new has happened. Repeated closing and reopening of the same risk is a sign that the record is being managed rather than the risk.

32. Particular kinds of risk

32.1 Project risks

Project risks are identified and managed throughout the life of the project, in line with this Framework. Before a project closes, the project manager identifies any risk that will outlast the project or that affects the wider Trust, and transfers it to the relevant directorate register with an owner who has agreed to hold it. A project risk that is simply closed with the project, when the exposure continues, leaves the Trust carrying a risk nobody is looking at.

32.2 Partnership and shared risks

A shared risk is recorded on the register of the directorate that leads the Trust's side of the partnership, flagged as shared, with the partner and the joint arrangements recorded against it. Score it on the Trust's exposure. Where controls sit with the partner, record them as controls and be clear in the evidence field that the evidence is produced by the partner, which affects the assurance level you can award. Giving every shared risk a register home makes sure it is reviewed alongside the rest.

32.3 Local records linked to a Trust wide risk

Where a risk has been designated as needing coordinated Trust wide management, it remains a single risk on the register of the directorate with the greatest authority over the principal controls. Your directorate may still hold a local record where you have genuinely distinct local exposure, controls or actions. Link it to the Trust wide risk. Do not duplicate the Trust wide risk on your register with the same statement, and never add scores together across records.

32.4 Risks on specialist registers

Counter fraud, emergency preparedness, health and safety, information governance and cyber security keep their own registers for specific operational or compliance reasons. Where a risk on one of those registers reaches the Trust's tolerance limits, or needs action beyond the specialist area, it is escalated to the Risk Management Group and recorded on the appropriate directorate register, so that the Trust holds one view of its significant exposure.

32.5 Quality and safety impact assessments

Where a quality and safety impact assessment on a service change or a cost improvement scheme identifies a residual risk that the scheme cannot design out, that risk is entered on the register of the directorate delivering the scheme, in the normal format, and linked to the scheme. The assessment is the identification source. It is not a substitute for a risk record, and a scheme should not proceed on the basis that the assessment has captured the risk somewhere else.

32.6 Opportunities

A risk may be an opportunity as well as a threat: something uncertain that, if it happened, would help the Trust achieve its objectives. Opportunities are written in the same three part structure, with the event being the thing that might happen and the impact being the benefit. They are flagged as opportunities on RADAR so that they are not read as threats in reporting. Appetite, tolerance and escalation apply to threats. An opportunity is not scored against tolerance and is not escalated for being large.

33. Quality standards

The Head of Risk Management carries out sample based quality checking of entries across the registers and feeds back to directorates. Directorate risk leads carry out the first line

check on new and revised risks before they go to the Care Group. Both checks apply the same standard.

33.1 What a complete entry looks like

Every entry on the register has:

- a risk statement in the cause, event and impact structure, with the correct opening
- one category and one subcategory, chosen on the event
- a named risk owner and a named Accountable Director
- a current score with a recorded rationale, and the target score generated from the category
- controls that exist and operate, each with a design judgement recorded
- evidence and assurance level recorded against each control where required by section 27.2
- a treatment state of treated or tolerated, with actions where it is treated
- a review date consistent with the treatment state
- a review history that shows what was checked and what changed

33.2 The most common reasons an entry is sent back

Reason	What to do about it
No identifiable event in the statement	Rewrite so the middle clause says what might happen.
Categorised on the impact	Recategorise on the event. Most of these are risks put under Patient Care because harm appears in the impact.
Consequence rated 5 with no explanation	Either justify it against the descriptor table or rate it honestly.
Actions recorded as controls	Move anything not yet in place into the actions.
Evidence field says ongoing monitoring	Name the document, the producer, the frequency and the date.
Score changed with no reason recorded	Add the reason, or the change will be reversed.
Owner is a team or a job title	Name a person.
Tolerated while above appetite	Only risks within appetite may be tolerated. Change the treatment state to treated and add actions.
Review completed with an empty comment	Record what you checked and what you concluded.

34. Quick reference

34.1 The risk in one line

Due to, or If, [cause], there is a risk that [event], which may result in [impact].

34.2 The decisions in order

Step	The question	Where to look
Is it a risk	Is it uncertain, and does it affect something we are trying to achieve?	Section 21
Write it	What is the cause, the event and the impact? Due to, or If?	Section 22
Categorise it	What kind of event is it?	Section 23
Score it	How bad, and how likely, with today's controls?	Section 24
Read the position	Within appetite, above appetite, or outside tolerance?	Section 25
Record controls	What is actually holding this risk where it is?	Section 26
Record evidence	Who says the controls work, and how recently?	Section 27
Choose treatment	Treated, or tolerated if within appetite?	Section 28
Review it	Monthly if treated, six monthly if tolerated, sooner if anything changes.	Section 29
Escalate if needed	Outside tolerance, 15 or above, consequence 5, or beyond your authority?	Section 30
Close it only if	The cause has gone, or the event has happened and cannot recur.	Section 31

34.3 The four target scores

Appetite level	Target score	Escalate at
Averse	2	7 and above
Low tolerance	5	11 and above
Moderate tolerance	8	16 and above

Appetite level	Target score	Escalate at
High tolerance	10	21 and above

34.4 Where to get help

The Risk Management function runs training, directorate support sessions and regular drop in arrangements for risk owners and risk leads. If you are unsure how to write, score or close a risk, get in touch and we will work through it with you.

Appendix A. Risk classification definitions

Use these definitions when choosing the subcategory at section 23. Remember that you are classifying the event, not the cause and not the impact.

Financial	The risk of financial loss, mismanagement or unsustainable planning that affects the Trust's ability to deliver services, invest in future priorities or comply with financial and regulatory expectations.
Financial Planning, CIP and Sustainability	The Trust's ability to balance income, expenditure and capital over the planning cycle, including delivery of cost improvement plans, cash flow, access to capital funding, and the capacity to achieve value for money through procurement, contract management, productivity benchmarking and whole life costing.
Counter Fraud	The adequacy of the measures that deter, detect and respond to fraud, bribery, corruption or other irregularities that could cause financial loss or reputational damage, from inside or outside the Trust.
Financial Control and Oversight	The effectiveness of financial governance in safeguarding resources, meeting regulatory requirements, and ensuring financial information reported internally and externally is true, fair and free from material misstatement.
People	The risk of not having a sufficient, healthy, capable and appropriately deployed workforce to deliver services safely and sustainably.
Planning and Supply	Securing and forecasting sufficient numbers and skill mix of staff, including recruitment, succession and training pipelines, for clinical and backbone services.
Capacity	Deploying the right mix of skills and capacity across services.
Well being and Retention	Retaining the right people with the right skills, and supporting the mental and physical health of staff to prevent burnout and stress.
Capability and Performance	Ensuring colleagues have the competence, training and productivity needed to meet clinical and corporate standards.
Patient Care	The risk that care delivered fails to meet required safety, quality and experience standards, including clinical harm, ineffective improvement, weak learning systems or poor patient involvement.
Clinical Safety	The potential for service users to experience physical or psychological harm because safety controls or practices are ineffective.
Quality Improvement	The potential for improvement initiatives to be poorly prioritised, resourced, designed, implemented or evaluated.
Learning and Oversight	Weaknesses in oversight, assurance, incident investigation, audit or organisational learning that limit continuous improvement of care quality.

Financial	The risk of financial loss, mismanagement or unsustainable planning that affects the Trust's ability to deliver services, invest in future priorities or comply with financial and regulatory expectations.
Patient Experience	Meeting patient, carer and family expectations of dignity, involvement, communication and satisfaction.
Performance	The risk that operational systems and supporting infrastructure fail to meet service, resilience or compliance expectations.
Emergency Preparedness	Readiness to withstand, respond to and recover from disruptive events such as pandemic, flood, cyber attack, mass casualty or utility loss, while maintaining critical functions.
Capacity and Demand Management	The ability to match beds, clinic slots, caseloads and workforce hours to actual and forecast demand so that waiting time, flow and productivity standards are met.
Estates, Equipment and Supply Chain	The condition, suitability and resilience of the estate, engineering plant, medical devices, fleet and supply chains, including personal protective equipment, drugs and consumables.
Information Governance	Having the right processes and systems for collecting, storing, managing and maintaining information in all its forms, including archiving and deletion, to support business needs and comply with regulation.
Digital Infrastructure and Cyber Security	The reliability, availability and performance of networks, servers, clinical applications and end user devices, together with the technical cyber defences that protect them.
External and Partnerships	The risk arising from the Trust's interface with external stakeholders, legal frameworks, strategic partners and regulatory bodies.
Change and Improvement Delivery	The capability to plan, resource, govern and realise the benefits of strategic programmes, digital deployments, estate redevelopments and service redesigns within agreed scope, time and cost.
Legal and Governance	Complying with statutory obligations, including the Mental Health Act, data protection law and health and safety law, and with corporate governance duties, so as to avoid litigation or sanction.
Partnership Working	Having effective partnership arrangements in place with health, social care, voluntary, local authority and private sector organisations.
Regulatory	Having effective processes for monitoring performance and progress against regulatory standards, including constitutional standards set out in the national contract, and for liaison with local and specialist commissioners.
Delivering our Promises	The possibility that the Trust fails to honour the commitments, service standards or partnership deliverables agreed with patients, communities, commissioners or partner organisations.

Risk Management Framework

Part 3: Risk and you

Spotting a risk, reporting it, and what happens next

Part 3 is for everyone who works at the Trust. It is short, and it is the only part most colleagues will need.

It covers what counts as a risk, how to describe one, who to tell, and what happens after you have told them. If you own risks or look after a directorate register, Part 2 is the working guide for you. Part 1 sets out how risk is governed across the Trust.

35. Why this matters

Risk management is not a form filling exercise. It is how the Trust finds out about the things that could go wrong before they do and does something about them.

Most risks are noticed first by the people closest to the work. You will see things that nobody above you can see. When you say something, it can be acted on. When it stays in your head, or in a team conversation, it cannot.

Raising a risk is not a complaint and it is not a sign that something has gone wrong in your service. It is one of the more useful things you can do at work.

36. What counts as a risk

Two questions. If the answer to both is yes, it is a risk.

1. Might it happen? It has not happened yet, and it might never happen.
2. Would it affect something we are trying to do? There is a service, a standard, a duty or an objective that would be damaged if it did happen.

If the answer to either is no, it is something else, and there is a better place for it.

What you have	What it is	What to do
It has already happened, or it is happening now	An issue or an incident	Report it through the incident process. Then ask whether it could happen again, or whether it leaves something else at risk. If it does, that is the risk.
A job that needs doing	An action	Raise it with your manager in the normal way. If it is a job that would reduce a risk, it belongs with that risk.
A general worry about a whole subject	A theme	Talk it through with your manager. Together you can usually find the specific thing you are worried about, and that is the risk.
Something is missing, for example a policy or some training	A gap	Ask what could happen because it is missing. That is the risk. The missing item is the reason for it.

If you are not sure which of these you have, raise it anyway. Working out what it is part of the job of the people who will look at it.

37. Describing and reporting a risk

You do not need to use any special language. Three questions cover it.

1. What might happen?
2. Why could it happen?

3. Why would it matter?

For example: because we are short of trained staff on nights, the observations we have agreed might not be completed on time, and someone could come to harm.

When it is written up on the risk register it will be put into the Trust's standard wording, which reads: Due to, or If, the cause, there is a risk that the event happens, which may result in the impact. Your risk lead will do that with you. Getting the wording right is not your job.

37.1 Who to tell

Tell your line manager. They will record it on the directorate risk register, or ask you to, and will make sure it reaches the right person.

If your manager is not available, or if the risk concerns them, speak to another manager in your service, your directorate risk lead, or the Risk Management team.

37.2 If something is unsafe now

Do not wait for the risk process. Deal with the immediate safety of the person in front of you, report it through the incident process, and tell your manager straight away. The risk record can follow.

38. What happens after you report it

1. Your manager and your directorate risk lead check that the risk is clear and that everyone reading it will understand it.
2. It is recorded on your directorate's risk register on RADAR, with a named owner who is responsible for managing it.
3. It is scored, based on how bad it would be if it happened and how likely it is to happen with the arrangements we have now.
4. The score is compared with the level of risk the Board is prepared to accept for that kind of risk. That decides how closely it is watched and whether it has to go further up.
5. Actions are agreed to bring it down, with named people and dates, and the risk is reviewed regularly.
6. If the directorate cannot deal with it on its own, it goes to the Risk Management Group, and beyond that to the executive team if it needs a decision or resources they hold.

You should hear back from your manager about what happened to the risk you raised. If you do not, it is reasonable to ask.

39. What is asked of everyone

- Identify and report risks, incidents and near misses without delay.
- Follow the Trust's policies, procedures and the controls that are already in place.
- Take part in the risk management training for your role.
- Tell your manager when something changes that makes a known risk more likely, or would make it worse.

- Say something when a control is not working in practice, even where it looks right on paper.

40. Where to get help

The Risk Management team runs training, directorate sessions and regular drop in arrangements. If you are unsure whether something is a risk, how to describe it, or who to tell, get in touch and we will work through it with you.

Your directorate risk lead is the first person to ask. They know your service and they hold the register you would be adding to.