	**GOOD HOPE HOSPITAL NHS TRUST** **POLICY: Risk Management Strategy & Policy**
REFERENCE NUMBER: 52	
THE PURPOSE OF THE POLICY: Outline of the role of the Risk Management Strategy and its impact on all staff and its part in the Trust Governance Strategy.	
HOSPITAL/UNIT/DIRECTORATE/DEPARTMENT To which the document applies: All areas **THE MEMBER OF STAFF TO WHICH THE POLICY APPLIES: All staff**	
THE CONSEQUENCE OF NON-ADHERENCE TO THE POLICY: Increased risk of adverse outcome for patients and staff and organisational compromise to the Trust	
METHODOLOGY FOR COMMUNICATING POLICY TO STAFF: **Copies to: Clinical Group Directors } Who have responsibility** **Wards & Departments } for communicating** **General Managers } the policy to staff** **Policy to be available to all staff and stakeholders** **Comprehensive Trust-wide training programme**	
THE ORIGINATING DEPARTMENT: Clinical Governance/Risk Management	
NAME AND TITLE OF ORIGINATOR: Ruth Gibson, Risk Manager	
REVIEW INTERVAL: 12 months	**Review due by: September 2007**
THE DATE DOCUMENT IS TO BECOME OPERATIONAL: 22 December 2003	
DATE DOCUMENT WAS RATIFIED BY: Clinical Governance and Risk Management Committee (Board sub-committee) Trust Board: 22 December 2003 Review by Trust Board: 21 February 2005, 2 October 2006	
SIGNATURE OF CHIEF EXECUTIVE:	

Risk Management Strategy

Contents

Good Hope – Risk Management Strategy 2006-2007

1. What is risk management?

Systematic and structured risk management systems within healthcare are required by:

- legislation (ie health and safety legislation),
- regulatory bodies (Department of Health, NHS Litigation Authority, Healthcare Commission) and
- good practice (in line with other "safety critical" industries).

The NHS Executive defines risk management as:

> ***Identifying all risks which have potentially adverse effects on the quality of care and the safety of patients, staff and visitors; assessing and evaluating these risks; and taking positive action to eliminate or reduce them.***

The NHS has identified that lessons are not always learnt from incidents in hospitals. This can mean that the same mistakes are made more than once. This can cause unnecessary injury to patients, distress to staff and financial cost to the Trust. There has, therefore, been recognition at a national level that Trusts should have systems in place to learn from incidents or potential incidents and identify and minimise risks.

2. Setting the Scene – the Trust's Strategic Direction

2.1 Background – Trust's Strategic Direction

Good Hope Hospital NHS Trust ('the Trust') is committed to being every patient's first choice for acute healthcare locally, by maximising the potential of the hospital through strategic alliances with general practices and specialist providers.

2.2 At the same time the Trust needs to meet national imperatives and will require high quality information and systems in four key areas:

- ***To support patient care***, by providing clinicians with information systems and tools that can support patient treatment, supply information based on clinical guidelines and knowledge, and support collaborative working with primary care and other partners.
- To improve health and management through ***analysis of performance*** – for example, clinicians assessing local health needs and the effectiveness of care as part of Clinical Governance, general managers monitoring productivity and budgets, and the Trust Board reviewing performance against Performance Frameworks.
- To support the needs of ***the public and patients*** – e.g. by informing them of Trust services and performance, by answering their queries on health problems and treatments, and eventually enabling clinicians to advise and treat patients remotely in their own homes or in their local GP practice.
- ***To run the business***, by providing information and systems to help staff with the day-to-day support of business planning, managing budgets, managing and developing staff, procuring goods and services etc.

3. Statement of Intent

The Trust recognises that every event or activity around the hospital involves risks which can or do harm patients, staff and other stakeholders and acknowledges the important part that management of clinical and non-clinical risks plays in helping the Trust meet its objectives.

The Trust recognises it is vital to develop and maintain systems and procedures which systematically identify and minimise risks to patients, visitors, staff and others if it is to achieve its commitment to providing high quality care.

The Trust also recognises the part individuals play in identifying risks and helping to reduce their impact. The Trust is committed to embedding the principles of risk management as an integral part of the way its staff work every day and to carrying this out in the context of a "fair blame" culture.

The Trust believes that risk management is a process which is continuously developing and the more people identify and manage risks the better they, and the hospital as a whole, become at this. This strategy will also develop as risk management becomes a more central part of the way the hospital works.

The Risk Management Strategy is linked to the Trust's Corporate Objectives and Strategic Direction as an integral part of the Trust's corporate planning processes.

4. Risk Management Strategy Objectives and Aims

In line with:

- Trust's Corporate Objectives of providing patient centred hospital care locally and making a sustainable contribution to the community we serve and
- Trust's Strategic Direction (as set out in 2 above)
- The Trust values of accountability, excellence, honesty, learning, openness and partnership

this strategy has the following aims:

- **To develop and maintain a clear and effective structure of responsibility and accountability across the whole Trust and clear systems for identifying and managing risks,**
- **That all Trust employees will be able to play their part in dealing with risk,**
- **That this will lead to measurable improvements in patient and staff safety and performance, in line with the Trust's objectives.**

To achieve these aims the Trust has the following specific priorities and objectives:

- To use effective risk management in setting and achieving the Trust's objectives and as an integral part of its business and corporate planning activities
- To promote and support actively the risk management process, procedures and techniques across the Trust, in particular by a vigorous awareness and training programme
- For each individual to be aware of his or her responsibility for managing risk and to work in a way that actively embraces that responsibility
- For there to be a clear and effective structure for active management of both clinical and non-clinical risk across the Trust
- To use risk management to learn from our work in a fair way and for us to develop in every area to ensure the best patient care possible.

This strategy sets the strategic direction for Risk Management within the Trust but will respond to developments and initiatives as required by internal and external forces. The strategy and progress against the strategic objectives will be reviewed at least annually by the Trust Board and on a regular basis by the Clinical Governance and Risk Management Committee and Patient Safety and Risk Management Committee.

5. Good Hope's Risk Management Framework

There are a number of key external and internal standards and assessment schemes which require hospitals to put in place robust systems to deal with risks. These provide a framework for ensuring risks are adequately managed at all levels up to and including Trust Board.

These include primarily compliance with the "Standards for Better Health" (incorporating controls assurance), as assessed by the Healthcare Commission and though self-assessment, CNST and RPST, as assessed by the NHS Litigation Authority and the Trust's Statement of Internal Control and Assurance Framework as assessed by the Strategic Health Authority and the Trust's auditors.

The Trust will implement these standards and schemes and monitor compliance against these as a framework of ensuring effective risk management.

6. Accountability for and Communication of Risks

The Trust is committed to a structured approach to managing risk to ensure the process is systematic and effective. This will:

- promote certainty at all levels of the Trust that risks are being identified and actively dealt with in a consistent and appropriate manner.
- help ensure clear lines of accountability, up down and across the organisation.

The Chief Executive is responsible for Risk Management and has delegated responsibility to the Director of Nursing as the Risk Management Lead and Director responsible for Organisational Risk (supported by the Risk Management Department, which is accountable to the Director of Nursing). Responsibility for Financial Risk has been delegated to the Director of Finance and for Clinical Risk to the Medical Director.

Each individual has a responsibility to manage risk and the trust has defined responsibility levels for each management level. Full details of who is responsible for each stage and how the process is managed in practice are set out in the Risk Management Policy and supporting procedures and documentation.

Hazards and risks will be identified systematically from recommendations, guidelines and reports of external bodies and internally through incident forms, complaints, claims, audits, risk assessments and other methods, in line with the Trust's Risk Management Work Programme (Appendix 2).

Risks will be assessed and managed by the individuals through the structures as specified in the Risk Management Policy.

Good Hope Risk Management Policy

This policy should be read in conjunction with the Trust's Risk Management Strategy and any local/departmental Risk Management Strategy.

7. Accountability and Reporting Structures

i. Individual Executive Responsibility
ii. Other specific risk management responsibilities
iii. Local and Individual risk responsibilities
iv. Corporate Committee structure
v. Departmental Accountability and Structures

The Chief Executive, supported by Board Members, has overall responsibility for all areas of risk management within the Trust.

i. Individual Executive Responsibility

Trust Board members are accountable for assuring themselves that:

- The Trust's Management Team led by the Chief Executive is focused on significant risks faced by the organisation as identified through external and internal audit and risk assessment processes.

- The Trust's Risk Management Strategy and Policy encourage the development of a culture which actively supports a recognition of risk and of learning from risks in a fair way.

- The Trust's Corporate Risk Register and overall Risk Management activity within the Trust is reviewed and is in accordance with NHS Board Assurance Framework.

Each Trust Board member, whether an Executive or a Non-Executive member, has a role in setting the strategic direction of the Trust and overseeing the implementation of policies and objectives including those relating to risk management.

Chief Executive

The Chief Executive is personally responsible for corporate governance within the organisation, which includes risk management activities.

The Chief Executive receives papers of and minutes from the Clinical Governance Operational Group (CGOG) and Risk Management Committee (RMC). The Board receives regular reports and minutes from key risk management committees. Recommendations of CG&RM are made to the Trust Board where competing risk priorities are debated and agreed or accepted. Through these means, the Chief Executive provides leadership and strategic direction to the Risk Management processes. This responsibility includes consideration of the Trust's Risk Register and resource allocation relating to Significant Risks of the Trust.

Delegation of Risk Responsibility

The Trust has, in accordance with common NHS practice and controls assurance regulations, identified 3 generic risk areas:

Clinical Risk ie any risk resulting from providing direct or indirect care which has caused harm, or has the potential to harm a patient resulting in a short or long term adverse effect on a patient or a near miss which could have resulted in the above and/or to the organisation.
Financial Risk ie any risk primarily arising from the management of the Trust's financial resources, financial transactions to which the Trust is a party and financial governance arrangements.
Organisational Risk ie all risks other than financial and clinical risks, in particular Health and Safety and other risks which have caused harm or have the potential to cause harm to a member of staff, visitor, contractor, agency/bank staff or students and/or to the organisation.

The Chief Executive has delegated responsibility for these areas as follows:

- **The Medical Director** holds designated executive accountability for managing the strategic development and implementation of clinical and organisational risk management., including Health and Safety. The Medical Director is the Lead Director for Risk Management, to ensure an integrated approach
- **The Finance Director** holds designated executive accountability for managing the strategic development and implementation of financial risk management.

The Executive Directors with risk accountability sit on the Board Sub-Committee with responsibility for risk management and at Trust Board, and meet regularly with the Chief Executive to ensure that the strategic direction taken by the Trust is applicable to, and takes into account each of the Trust's risk categories. (See appendices 1 and 2 – organisational charts).

Medical Director

- As clinical lead within the Trust and H&S lead, the Medical Director provides a clear focus for the management of clinical and organisational risk.
- The Medical Director has delegated responsibility for managing the strategic direction and implementation of clinical and organisational risk management.
- The Medical Director has delegated responsibility for Health and Safety activities and for ensuring health and safety risks are on the risk register and that these are appropriately monitored.
- The Medical Director is responsible for:
    - leading the Trust's clinical risk management activities (including CNST)
    - ensuring that the Trust develops a system to ensure full compliance with the Department of Health Standards.
    - leading the Trust's Corporate Risk Management Activities, including management of the Risk Register and RPST.
    - ensuring the Trust develops systems to comply with Health and Safety and Infection Control requirements.
- The Medical Director chairs the Clinical Governance Forum (CFG) which is the operational clinical risk management group and the Patient Safety and Risk Management Committee (PSRMC), the operational risk management group.
- The Medical Director is a member of CG&RM. This is a strategic sub-committee of the Trust Board and is responsible for overseeing the work of CGF and PSRMC and specialist Risk sub-groups.

- The Medical Director's accountability for clinical risk management is directly to the Chief Executive and Chairman of the Trust.
- The Finance Director has accountability for financial risk so the Medical Director is responsible for ensuring that financial risk is integrated within the Trust's clinical and organisational risk management structure and activities.
- The Medical Director is responsible for ensuring clinical and organisational risks are included on the risk register and that these are appropriately monitored.
- Corporate development and clinical and organisational risk management should be informed by recommendations of CG&RM.

Financial Risk: Finance Director

- The Finance Director has delegated responsibility for managing the strategic development and implementation of financial risk management
- The Finance Director is responsible for ensuring:
  - that the Trust carries out its business of providing healthcare within sound Financial Governance arrangements
  - that those arrangements are controlled and monitored through robust audit and accounting mechanisms
  - that those mechanisms are open to public scrutiny on an annual basis.
  - that financial risks are recorded on the risk register and that these are appropriately monitored.
- The Finance Director is a member of CG&RM.
- The Finance Director's accountability for financial risk management and control is through the Chief Executive and Chairman of the Trust.
- The Financial Director should ensure there is a close working relationship with the Medical Director as lead for clinical and operational risk to ensure that financial planning and financial risk management is integrated with the Trust's general Risk Management activities.
- Financial Planning and financial risk management should be informed by the recommendations of CG&RM and the Audit Committee.
- The Finance Director will seek the Chief Internal Auditor's Opinion on the effectiveness of Internal Financial Control.

ii **<u>Other specific risk management responsibilities</u>**

To support the Directors referred to above in their roles, the following staff have designated Trust-wide risk management responsibilities:

Risk management processes will be overseen by the Trust's Head of Risk Management.

Additional support will be provided by the Health and Safety Manager and H&S Adviser, infection control team, back care office, fire safety adviser, security manager and members of CG&RM, CGF and PSRMC. Support in implementing risk management processes will also be provided by the Clinical Governance Manager, Corporate Governance Co-ordinator and the Complaints/PALS manager, who will be required to work closely with the Head of Risk Management.

The Clinical Governance Facilitators support clinical areas with development of specialty plans and risk/clinical governance groups, with investigation and follow up of incidents, claims and complaints and identification of trends arising from these and with clinical audit and clinical effectiveness and will therefore be vital in embedding risk identification and assessment processes in practice.

Head of Risk Management

The Head of Risk Management is responsible for providing advice on and facilitating the effective Management of Risk. This responsibility includes establishing dynamic systems and processes that form an integral part of routine organisational and departmental activity, so creating an enabling framework for all individuals and departments to achieve Risk Management excellence within the Trust. The provision of advice, guidance and recommendations about Risk Management to the Trust Board is facilitated by membership of CGF, PSRMC and CG&RM.

The Head of Risk Management will assist with identification (from internal and external sources), management and monitoring of risks and will provide reports, information and training as appropriate. The Head of Risk Management advises other Specialist Risk Management Groups and Committees and monitors proposed developments and initiatives to ensure these are compliant with good risk management practice.

The Head of Risk Management is responsible for maintenance and development of the overall risk register. Accountability is to the Medical Director.

iii Local and Individual risk responsibilities

Executive Directors

Executive Directors are accountable for ensuring risk management is embedded in their area of responsibility in line with the Trust's strategy and policy.

Non-executive Directors

Non-executive Directors are responsible for ensuring that the implementation of the Trust's Risk Management Strategy is monitored and challenged to ensure this is robust in practice.

Senior Managers/Senior Clinical Staff

Clinical Directors and Associate Clinical Directors, General Managers and other Senior Managers and Heads of Department/Services are responsible for ensuring that they engage with the Risk Management Aims and Objectives in section 3 of the Strategy and departmental responsibilities on page 14 of the policy, in order to ensure that their clinical and managerial responsibilities for risk management are met.

All Clinical Directors/ General Managers are responsible for:

- Ensuring that appropriate and effective risk management processes and structures are in place in their designated area(s) and scope of responsibility
- Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities, and that they receive appropriate information, instruction and training to enable them to work safely. These responsibilities extend to any one affected by the Trust's business, including visitors, contractors and members of the public.

- Preparing specific departmental/directorate policies and guidelines to ensure all necessary risk assessments are carried out within their area, with support and advice from specialist advisers as required.

- Ensuring a risk register is developed and maintained to cover risks relevant to their area.
- Ensuring that the risk register for their area is reviewed and updated on at least a quarterly basis and submitted to the Head of Risk Management, either directly or through the relevant Clinical/Non-Clinical Governance Facilitator.
- Ensuring that risks scoring 16+ are robustly reviewed and full action plans, supported by business cases where relevant, are developed before submission to the Head of Risk Management for approval.

Directors/managers are expected to take ownership of risk issues related to their management role. To this end they are responsible for implementing and monitoring any identified appropriate risk management control measures within their designated area(s) and scope of responsibility.

Operational aspects of this responsibility may be delegated to a specific risk lead within their area, although the Director/Manager will still be expected to take an active role in risk management.

It is expected that risks will be managed locally in the first instance. In situations where significant risks have been identified and/or where local control measures/resources are considered to be potentially inadequate directors/managers are responsible for seeking local resolution, and if this cannot be achieved, referring these to the Head of Risk Management with full details of actions taken and a business case supporting further resource required.

All Employees

Have a responsibility to be aware of and apply risk management principles and must:

- Ensure they work in accordance with all Trust policies and procedures
- Ensure they are aware of and discharge their duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the Trust's business
- Ensure they attend induction and regular mandatory update training on risk management policy and procedures
- Ensure they identify through risk assessment any risks they feel exist within their department or during the delivery of their services
- Ensure they provide incident reports and supporting documentation for any unexpected event or incident they are involved in.
- Ensure they comply with the standards of any relevant professional bodies.

Individual Clinicians Employed by the Trust

Have a responsibility to be aware of and apply risk management principles and must:

- Ensure they practice within the standards of their professional bodies, any other national standards and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible;
- Identify through their own department's self assessment process and line management arrangements any risks they feel exist within the service and their practice;
- Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided;

- Ensure they attend induction and regular mandatory update training on risk management policy and procedures

Specific guidance regarding responsibilities and levels of authority is identified in relevant sections of this strategy. Accountability and Responsibility requirements for individual Risk related activities are clearly defined in the wide range of Risk Management Policies and Guidelines.

iv Corporate Committee structures

In addition to the individual responsibilities outlined, there are a number of Trust committees with responsibility for risk management which ensure proper monitoring and reporting of risk issues.

- Trust Board – overall responsibility for approving the Risk Management Strategy of the Trust, reviewing strategic and high-level risks through the Risk Register and Assurance Framework and for ensuring adequate assurance is provided to allow it to approve key strategic documents ie Statement of Internal Control
- Audit Committee – a sub committee of the Trust Board responsible for independently overseeing governance and assurance processes to ensure that the Trust has risk and governance processes in place which meet national requirements and providing such independent verification.
- Clinical Governance and Risk Management Committee – sub committee of the Trust Board responsible for the management of significant risk including the Trust risk register and providing strategic direction for the risk management process.

The Audit Committee and CG&RM ensure lines of communication through shared membership (non-executive Directors sit on both committees) and reports and minutes from both committees go to the Board, where they are considered by members of each committee.

- Clinical Governance Forum (CGF) – a sub committee of CG&RM responsible for overseeing the management of clinical governance. This committee is the main forum for monitoring the achievement of the Trust's clinical risk objectives and reporting this through CG&RM to the Trust Board.
- Patient Safety and Risk Management Committee (PSRMC) - a sub committee of CG&RM responsible for overseeing risk management. This committee is the main forum for monitoring the achievement of the Trust's risk objectives and reporting this through CG&RM to the Trust Board. This forum provides support and advice to divisions and departments and reports to CG&RM on significant or unmanaged risks for further assessment and addition to/reprioritisation on the risk register.

CGF and PSRMC ensure lines of communication with each other and with Trust sub-Board committees through shared membership (a director who sits on CG&RM chairs each committee and minutes are reported to CG&RM). Please see appendix 1 – organisational chart

v Departmental Accountability and Structures

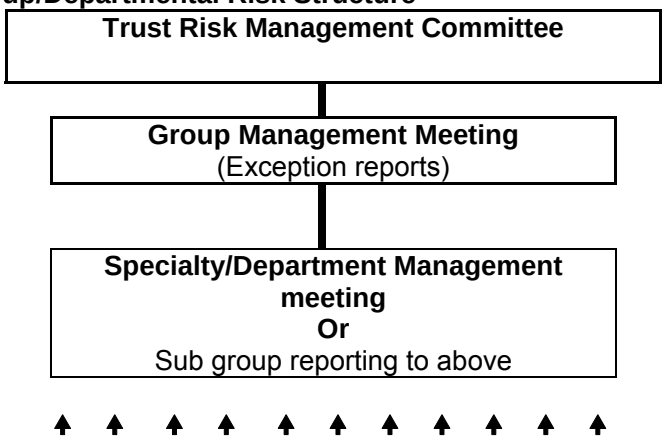
The Trust's **CG&RM**, through **CGF & PSRMC** is required to be assured that adequate structures and processes to manage risk exist within each department.

The committees must be informed of actions undertaken at a departmental level. This section should be read in conjunction with Local and Individual Responsibility (section 8 above) and the objectives and aims of this strategy.

- **The Specialty Clinical Director is accountable for risk management within the specialty**.

- Each department is required to have a regular **formal forum** which oversees clinical & organisational risk management, develops departmental policies and guidelines (with appropriate support as required), identifies and manages significant incidents and develops and maintains a risk register. The risk management role may also be combined with departmental clinical governance responsibilities. A model structure is described below, however, individual departments may want to implement a structure which is more appropriate to their needs:

Diagram 2: Group/Departmental Risk Structure



The specialty/departmental forum is responsible for developing and implementing a plan, which delivers the Trust's risk management objectives.

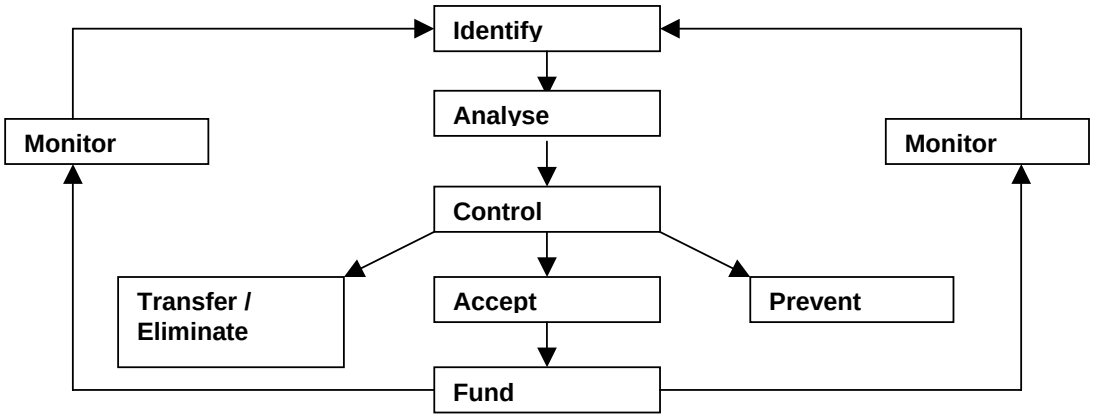
- The departmental forum should receive reports from within the department, which identify risk management initiatives, incident and complaint trends, lessons to be learned and quality improvements in line with the work programme.
- The forum is required to consider amber and red incidents to ensure these are properly actioned.
- The forum will ensure regular risk assessments are carried out and that risks identified from these and other sources are recorded on the group risk register. The forum will be responsible for ensuring the group risk register is reviewed in a proactive manner on a regular basis.
- The Departmental Risk Management forum should then report any areas of good practice or concern or significant risks to CGF/PSRMC, as appropriate.

Corporate risk management leads are available to provide training, support and advice in relation to all departmental risk management activity.

8. Risk Management Process – how to manage risk in practice

The management of risks is a well-established principle, first developed in high-risk industries such as the oil and nuclear industries. The basic principle can be applied to almost any sort of risk, whether clinical or non-clinical. The approach to assessing and managing is represented schematically below:

Diagram 3: Risk management process



i. Risk identification and assessment

The first step is to identify a hazard (ie a trailing cable). Hazards can be identified from a very large number of sources. These will be both internal and external to the work of the Trust. To ensure systematic identification of hazards the Trust has developed a programme of the main sources, together with who should identify the hazards and the frequency with which this should be done (appendix 2) and guidance is contained in the Risk Assessment Guide (appendix 5).

All areas must undertake a comprehensive risk assessment of the area annually. All clinical services will be expected to take into account recommendations from external reports such as Confidential Enquiries, National Audit Reports, findings from local clinical effectiveness audits and recommendations from NICE and the National Service Frameworks when identifying hazards and risks.

Once hazards have been identified, identify the risks the hazard could present (ie someone could trip) and who they might affect.

An analysis (“risk ranking” or “risk grading”) is then carried out using the standard Trust risk grading matrix (appendix 3). This establishes the severity of each risk by assessing the likelihood of the risk occurring and the consequences if it did occur.

The Trust has introduced standard tools to allow for systematic identification of hazards and risks arising from these and for grading risks (app 3 – work programme, app 4 universal grading matrix, app 5 - risk assessment guide, app 6 – Flow of risk management information) to make it easier to manage risks and to ensure risks are assessed consistently across the Trust.

Once the severity, or significance, is known, the risk can be compared with other risks facing the Trust and prioritised according to significance. The list of all risks facing the Trust, in order of significance, makes up the Risk Register, dealt with on page 18 below.

It is important that each assessment looks not only at the level of risk, but also the residual risk (ie the level of risk which still remains once any risk treatment has taken place).

ii. Risk control

Once identified, assessed and prioritised, ways of controlling the risk are identified. The main controls are (in order of preference):

- **Eliminate** ie avoid the risk altogether by working differently- replace a machine prone to break down
- **Transfer** ie avoid the risk by making someone else, say an external contractor, responsible if the risk materialises (although this may not prevent Trust staff, patients, visitors or contractors being harmed by the risk)
- **Treat** ie try to prevent the risk from happening by introducing a better system, giving better training etc
- **Tolerate** ie accept there may be no practical steps which can be taken to stop the risk, for example if there is a very low risk or if the steps to treat the risk are too expensive to implement – this should only be done if the Trust is prepared to accept the risk and if there is a specific plan to deal with the risk when it does occur.

Deciding what the most appropriate control should be will depend on a number of factors. It should be recognised that controls can themselves give rise to hazards and therefore create their own risks. This should be carefully considered when deciding how to control a particular risk. The implications of the cost of the control are considered in ii. below.

iii. Managers' Level of Responsibility for Managing Risk following assessment.(please also refer to page 12, Local and Individual Responsibility)

Once the level of risk has been identified from the matrix the risks should be prioritised according to risk level, be noted on the risk register and managed as follows:

Level of risk	Management responsibility
Green/Yellow	Managed at level of department where risk identified.
Amber	Managed within department, but reported to the specialty forum who will monitor actions.
Red	These risks actions will be prioritised by the specialty forum and reported to PSRMC.
Reds scoring 16-25	These are significant risks and must be prioritised through PSRMC (see 8viii p17 below). Action plans must be developed and reported to the Trust Board.

iv. Risk Funding

There are numerous ways by which risks can be controlled, many of which require little or no financial outlay such as producing up to date policies and procedures and

ensuring that people know about and understand them by improving communication, supervision, training and induction.

Each type of control will have resource implications. These implications should be considered as an integral part of the process of treating the risk. It is possible that the most desirable control is not acceptable because of resource constraints. The relationship between the cost of controlling risk, and the benefits to be gained, must be considered, as there will always be a limited budget to address the issues. It is not possible to create an environment that is entirely risk free.

Where risk actions require explicit additional funding which cannot be managed within local budgets (e.g. reflect significant non recurring expenditure or where the costs may impact significantly on service funding) then these should be reviewed by the specialty, scored and presented as part of the business planning process. This will allow a business case to be made on the basis not only of cost and quality but also of consequence and likelihood of risk.

Where urgent action is required outside the normal business planning round this should be identified as part of the action plans reported to the Trust Board and agreement reached with the relevant director.

v. Risk Monitoring

For each risk, the action to be taken to control the risk should be noted on the departmental risk register, together with details of the person responsible for taking the action forward and a realistic review date.

A vital part of the risk management process is that progress be kept under review, to ensure it is actually taking place. The risk must be re-assessed after a specific period of time or if an incident occurs to ensure its significance has not changed.

It is essential that those involved in the risk management process take responsibility for ensuring that monitoring is carried out rigorously to make sure the systems to avoid risks continue to work and the lessons continue to be learnt. A simple way of ensuring regular review is to make risk management a standing agenda item on the appropriate local group agenda and to nominate a suitable person to be responsible for maintaining the register.

vi. “Acceptable” risk

The Trust recognises that not all risks can be avoided or eliminated. Once a risk has been identified, actions to reduce the risk will then be identified. There will then be consideration of these actions, the consequences and likelihood of the risk and any other options available to reduce or eliminate the risk. If, following all of these steps, it is judged the risk cannot be reduced the Trust may decide to accept the risk. Generally, acceptable risks will be those risks which are noted on the Trust-wide risk register as being significant, or other lower graded risks where the costs of reducing or eliminating the risk are unreasonable and outweigh the benefits of that expenditure. The reasons for accepting a risk should be noted and these should be kept under regular review, as with any other risk.

vii. The Risk Register

The Risk Register is the main repository of information relating to risk within the organisation. The register will be reviewed and updated on a continuous basis in line

with the risk management process described at page 14 above and the work programme (appendix 2). The process is also represented in the Flowchart of Risk Management information (appendix 6).

Risks should be identified and risk treatment plans should be developed and the results recorded on the departmental risk register. All risks identified in the register will be assessed and prioritised. This will allow each department to build up a comprehensive picture of all key risks facing the area and the controls on these risks. These should then be fed through for entry on the Trust Risk Register. The risk manager will be responsible for maintaining the Trust risk register and ensuring it is reviewed and kept up to date.

Support and training will be provided to help departments develop risk assessment programmes and risk registers.

viii. Significant risks

Each Group will maintain a local risk register for their area of responsibility. Significant risks identified will be included in the Trust (Corporate) register. Significant risks are defined as high-level risks and those risks which threaten the key objectives of the Trust. These are generally risks rated at 16 and above, or those where the risk has been 'accepted' (ie where adequate controls cannot be put in place).

These are identified by each Specialty forum from the departmental registers and reported to the Risk Manager for inclusion on the Trust-wide Risk Register.

Before submission a risk scoring 16+ must contain full details of current controls and planned actions and be supported by appropriate business case(s) be confirmed by the General Manager and Executive Director

The Trust Board will review strategic risks on a quarterly basis as part of the review of the Assurance Framework (see ix below) Details of significant risks will be reported to the Trust Board along with appropriate action plans and confirmation of risk reduction activity to date.

Entries to the Risk Register which score 16 or over but which are not strategic risk will be reviewed quarterly by PSRMC. This committee reports to CG&RM and through this to the Board on a quarterly basis. When taken in combination with its review of the Assurance Framework this ensures the Board has the opportunity of reviewing all high-level significant risks on a regular basis.

ix. Strategic Risks/Assurance Framework

As part of the Trust's internal control mechanism the Board has developed an Assurance Framework. This sets out the Trust's strategic objectives and key risks that might prevent the objectives being achieved ('strategic risks'), together with associated key controls and assurance and gaps in control.

The Assurance Framework is reviewed quarterly by the Board. As part of the review process the Board will consider the Risk Register. This will ensure that the strategic implications of all risks identified within the Trust are taken into account by the Board when considering the adequacy of its internal controls.

x Business Planning

The success of risk management is dependant on its integration with all key activities of the organisation.

The key driver to this is the business plan / business planning process. The business planning process sets priorities for the organisation and identifies targets for the year. It also ensures that actions to meet the organisation targets are co-ordinated across all departments.

The relationship between the Trust Business Plan / planning process and risk management is a two way relationship i.e.:

- The business plan should be informed by identified risks in order to identify organisational priorities.
- Equally the business planning process will further identify risks through a clear identification of organisation aims by which risks related to these are required to be identified and assessed.

To meet these objectives the business plan should aim to address significant risks identified within the risk register. Furthermore all aims and objectives should be risk assessed and actions prioritised as a result. This process should ensure that risk assessment and prioritisation is included within the capital spending programme and equipment purchase process.

xi. Health Care Standards

From April 2005 the Health Care Commission has introduced a set of national standards for Health Care. These standards will be monitored to inform future performance ratings of all NHS Trusts.
The Trust is required to provide assurances that core standards are being adhered to and that progress is being made against developmental standards. The assessment and review against the Health Care Standards will contribute significantly to the business planning process and the assurances against these standards should identify and risks relating to these.

9. Incident reporting - Including Serious Untoward Incident Management and "Fair Blame" policy

The routine reporting of clinical and non-clinical incidents and 'near misses' is an essential requirement of the Trust's Risk Management Strategy. The Trust recognises that, in line with the Department of Health publication 'Building a safer NHS', measures need to be implemented to further encourage ALL staff to report all relevant incidents and 'near misses' For further details please refer to the Trust's Incident Reporting Policy...

In support of the Trust's commitment for improving incident reporting activity, the Trust endorses the following statement to reassure all staff of the Trust's stance on the management of information obtained through incidents reported:

Staff who make a prompt and honest report of an incident, 'near miss' or error will not be disciplined except under the following circumstances:

- where the member of staff acted in a criminal, deliberate or malicious manner;

- where the member of staff concerned is guilty of gross carelessness with the potential for serious consequences and where a member of staff could reasonably be expected to appreciate the direct consequences of his/her behaviour;
- where an incident follows other incidents of a similar nature and where the Trust has provided all necessary training, counselling and supervision to prevent a reoccurrence.

By adopting this stance the Trust aims to promote an accountability culture which is fair to the staff and enables the hospital to learn and make any necessary changes.

CGOG and RMC will monitor incident trends and investigations and follow up of incidents and report this, through CG&RM, to the Trust Board.

10. Risk Management Training

The Trust recognises the importance of training staff so that they are fully aware of the Trust's risk management procedures and their risk management responsibilities within the Trust's system.

Risk training, including the incident reporting procedure, will form part of the induction training received by all staff. It will also be included within the Trust's mandatory training programme.

Training will also be available for reporting arrangements, risk assessments and investigating incidents, complaints and claims for those staff identified as requiring this training. It is anticipated all staff in a managerial role will require this training.

Training will also be provided for Trust board members so they are able properly to execute their risk responsibilities.

11.Communication

Managers should ensure staff are informed about risks that may directly affect their everyday duties. This includes learning from risk information and from incidents that have occurred. Similarly all staff should have reasonable access to information about risks faced by the organisation. It is expected a variety of means will be used to achieve this, for instance via existing communication channels (Trust newsletters, staff meetings, intranet). All staff and stakeholders should be informed of the key elements of the Risk Register and this strategy/policy.

12. Monitoring and review

The Trust will review whether there is effective implementation of the Risk Management Strategy and Policy through:

- quarterly reviews of the Trust-wide risk register by key Trust committees
- monthly/quarterly reviews of additions to/removals from risk registers at group performance reviews
- Internal Audit reviews of the risk management process

As part of this monitoring process key measurable objectives, to be reviewed through the PSRMC, are:

Objective	To be /monitored/reported by
1. That all groups have 2 trained risk assessors for each local risk register	Head of Risk Management
2. That all groups have a forum at which risk registers are reviewed on at least a quarterly	Clinical/Non-clinical Governance Facilitators
3. That all groups add new risks to/ remove risks from their registers	Head of Risk Management/ Clinical/Non-clinical Governance Facilitators
4. That the risk register is reviewed regularly by key corporate committees	Head of Risk Management
5. That an improvement is demonstrated in the Internal Audit opinion of the Risk Management Process	Head of Risk Management/Internal Audit

13. Associated strategies and guidance

The following National, Regional and Trust strategies and guidance have been identified as having an impact on the Risk Management strategy: -

National

- The NHS Plan, DH August 2000
- A First Class Service: Quality in the new NHS, DH 1998
- "An Organisation with a Memory", DH 2000
- Building a Safer NHS, DH 2001
- Doing Less Harm, DH 2001
- Guidance on the implementation of the NHS Complaints Procedure, NHSE March 1996
- Governance in the new NHS. HSC 1999/123
- Woolf Reforms and the Pre-action Protocol, 1998
- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations, 1999
- Seven Steps to Patient Safety, NPSA 2003
- Building the Assurance Framework: A Practical Guide for Trust Boards DOH 2003

Regional

- Birmingham and Black Country Strategic Health Authority Serious untoward incident policy November 2004
- Organisational Controls Assurance 1999/2000: Regional reporting requirements

Trust

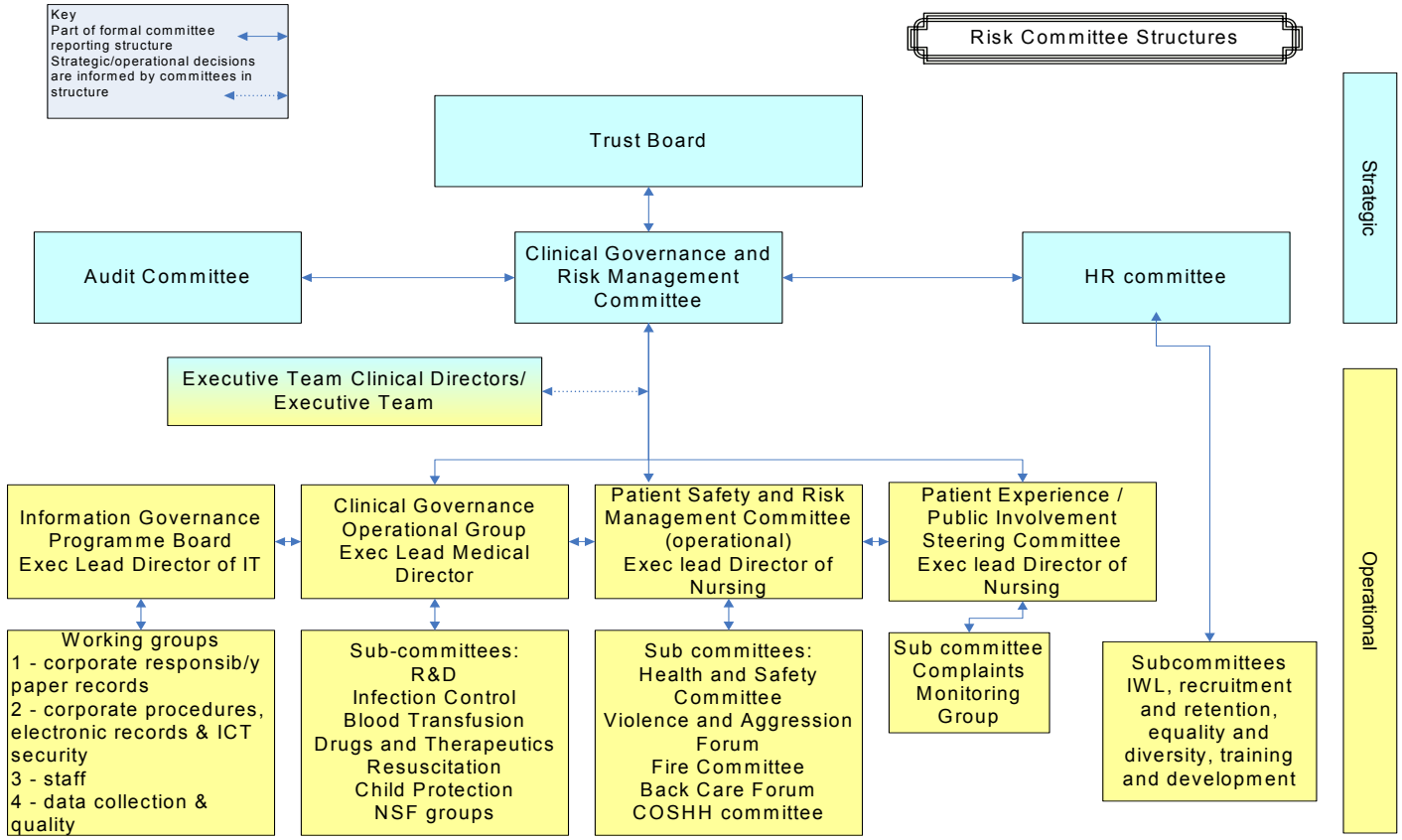
The Trust has the following policies and documents which also relate to risk management and should be referred to for further information:

- Trust Business plan and strategic direction documents
- Clinical Governance Strategy
- Corporate and Financial Governance documents
- Health and Safety Policy
- Incident reporting policy
- Major incident plan
- Infection Control policy
- Complaints policy

- Controls Assurance action plans
- Clinical Effectiveness strategy
- Claims Policy

Appendix 1 Organisational Chart - risk committee structures
Appendix 2 Work programme – hazard/risk identification analysis and assessment
Appendix 3 Universal Grading Matrix
Appendix 4 Risk Assessment Guide
Appendix 5 Risk Register template/standard format
Appendix 6 Flowchart of Risk Management information

Appendix 1
Organisation Chart – Risk Committee Structures



Good Hope Hospital NHS
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Appendix 2

Work Programme – Hazard/Risk Identification, Assessment and Analysis

1. The Trust Risk Management Strategy/Policy as approved by Trust Board sets out a number of ways that hazards and risks can be identified, assessed and analysed. This will allow the Trust to build a profile of risks it faces and how to manage these in the Risk Register.

2. It is important that:

- this work is carried out continuously in a systematic and logical way.
- all staff are aware of responsibilities of both themselves, and others involved in the process.
- relevant information about risks and necessary treatment is communicated to the relevant areas to allow the risks to be managed.
- details of risks and treatments are recorded in the Risk Register so this is continually updated.

3. To support the strategy and ensure this is a continuous process, this work programme action plan sets out requirements for each area that maintains a Risk Register and for Staff with specific risk responsibilities in relation to:

    - Identification of hazards and risks
    - Assessment of risks
    - Analysis of risks

4. Any person identified as having responsibility within the programme for identifying hazards must ensure reviews are carried out as specified and that risks identified are then passed on to be assessed and analysed by the appropriate individuals within the area.

5. It is recommended that the Trust wide tools are used for assessing, analysing and recording risks (grading matrix, Risk Assessment Guide, Risk Register). There are also specific documents available for assessing some risks for example, manual handling – see Trust policy folders for copies.

6. Where the source review is carried out by a specified individual, details of risks identified must be communicated to the relevant area so the area can assess, analyse and record the risk and treatment. If the risk is Trust-wide, the specified individual should identify an appropriate lead to carry out the assessment..

7. Each area is responsible for ensuring that at least two assessors are identified and receive appropriate training and that a suitable person is appointed to maintain the area risk register (usually the area head).

8. The Risk Management Committee will monitor implementation of the programme.

Supporting Documents:

Work Programme matrix
Grading matrix (app 3)
Risk Assessment Guide (app 4)

Flowchart of Risk Management information (app 6)

Work Programme - Risk Identification, Assessment and Analysis

Main Internal/External hazard identification sources	Person responsible for reviewing source	Frequency of review
Analysis of incidents	all area heads/chairs of committees	Monthly
Detailed analysis of frequently occurring incidents	all area heads/chairs of committees	Quarterly
Serious Untoward Incidents/red incidents	Risk Manager	Quarterly
Complaints	all area heads/chairs of committees	Quarterly
Complaints proceeding past local resolution	Complaints Co-ordinator	Quarterly
	Clinical governance facilitators	On receipt of formal response
Claims/inquests	Legal Services Manager	Quarterly
Analysis of claims and staff absence	all area heads/chairs of committees	Quarterly
Audits	Corporate Audit Co-ordinator/ All area heads	Monthly
NICE guidelines	Corporate Audit Co-ordinator	Quarterly
Trust balanced score-card	Head of Performance	Quarterly
Assessments/inspection reports by external bodies	Assessment lead	On receipt of report
Patient satisfaction surveys	PALS manager	Quarterly
National reports and service frameworks	Relevant area lead	Annual
Hazard/safety notices	Corporate Governance Co-ordinator	Monthly
Grapevine/intuition	any member of staff	on receipt
exit interviews with staff	all staff with management responsibilities	Quarterly
public perceptions of NHS/media	Head of Communications	Quarterly
New legislation	Legal Services Manager	Quarterly
Coroner's reports	Legal Services Manager	Quarterly
Patient journeys	PALS Manager	Quarterly
SWOT analysis	Haematology Department	Quarterly
Controls assurance assessments	Controls Assurance leads	Quarterly
Annual Business Plan	Director of Planning	Annual
Risk Assessments	all area heads	Annual
Health and Safety risk assessments	all area heads	Annual
Infection Control incidents	Infection Control Team (through IC committee)	Quarterly

(also see pages 14-21 and appendix 2 RM Strategy, and any local procedures for your area.)

Appendix 3 – Universal Grading Matrix

1. What is the likelihood for re-occurrence of this event? Use the table below to give this incident a value.

Likelihood	Description	Value
Rare	Can't believe that this will ever happen again.	**1**
Unlikely	Do not expect it to happen again but it is possible	**2**
Possible	May re-occur occasionally	**3**
Likely	Will probably re-occur but is not a persistent issue	**4**
Almost certain	Likely to re-occur on many occasions, a persistent issue	**5**

2. Identify the worst consequence of this event? If in doubt grade up not down.

Consequence	Actual or Potential Impact on Individual(s)	Actual or Potential Impact on Organisation	Number of Persons affected at one time	The Potential for complaint/ litigation
Insignificant **1**	• NO INURY OR ADVERSE OUTCOME	No risk at all to organisation	0-1	Unlikely to cause complaint \ litigation
Minor **2**	• SHORT TERM INJURY /DAMAGE • e.g. injury that is likely to be resolved within one month	• Minimal risk to organisation	2-4	Complaint possible Litigation unlikely
Moderate **3**	• SEMI-PERMANENT INJURY/DAMAGE e.g. injury that may take up to 1 year to resolve.	• Needs careful PR • RIDDOR reportable • MHRA reportable • Short term sickness	5-10	Litigation possible but not certain. High potential for complaint.
Major **4**	• PERMANENT INURY • Loss of body part(s) • *Mis-diagnosis – poor prognosis* • RIDDOR reportable injury	• Service closure • RIDDOR reportable • Long term sickness	Moderate number (e.g. loss of specimens vaccination problems)	Litigation expected/certain
Catastrophic **5**	• DEATH • Toxic off site release	• National adverse publicity • HSE investigation	Many e.g. cervical screening disaster, evacuations etc.	Litigation expected/certain

3 Use the matrix below to categorise the severity of the incident.

e.g. A patient ends up anaesthetised with the wrong X-rays in Theatre with the operation about to start.

Incident = Probability 3
x Consequence 3
= Risk severity 9 = Amber

	CONSEQUENCE				
LIKELIHOOD	**1insignifiant**	**2 minor**	**3 moderate**	**4 major**	**5 catastrophic**
1 rare	1	2	3	4	5
2 unlikely	2	4	6	8	10
3 possible	3	6	9	12	15
4 likely	4	8	12	16	20
5 almost certain	5	10	15	20	25

Based on NPSA risk matrix

Green = very low risk
Yellow = low risk
Amber = medium risk
Red = high risk

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Appendix 4

Risk Assessment Guide

For help contact:
Ruth Gibson, Risk Manager,
Good Hope Hospital
0121 378 2211
ext 1354

Assessment by/lead ……

For ……Department/area

Date of assessment ……

Review date ……

Definition of Risk Management

A systematic process to identify and control risks in the activities of the practice/department to the benefit of the patients, staff and the public

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Step 1 Potential risks associated with your area (p3/4)

- List the main activities (both clinical **and** non-clinical) in your working area
- list the potential risks attached to the activities

Step 2 Risk Assessment (p 5)

- Fill in a copy of the risk assessment for each activity. (You may need to prioritise which you look at first).
- For each activity identify what the hazards are, who could be affected and what existing controls are in place.

Step 3 Risk grading (p5/6)

- For each risk, use the matrix and guidance attached to assess the **risk level** for risks identified. Do this twice - p5 – without extra controls, p6 with extra controls

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Step 4 Residual Risk (p6**)**

- Decide if the residual risk is acceptable – if not, list what the risks still are and identify and record the action required to eliminate, reduce or transfer the risk to an acceptable level.

Step 5 Report/review

- Log the risk on your group register (usually by sending completed form to group/dept manager) and review the risk/actions on a regular basis or if the situation changes.

Pages 7/8 – examples of types of risks and sources for identifying risks and aspects to consider during assessment

Clinical/non-clinical Activity	Risks associated with activity

Clinical/Non-clinical Activity	Risks associated with activity

RISK ASSESSMENT FORM (follow numbers to complete for each risk identified) Ward/Area…….

Clinical/Non-clinical Activity (brief description of hazard):

<table>
<tr><td>1.
What is the Risk:</td><td></td><td colspan="2">4. Use matrix and circle number to record risk score with current controls ((ie assess current position):
<table><tr><th>Conseq</th><th>Likelihood</th><th>Risk Score</th></tr><tr><td>1 2 3
4 5</td><td>1 2 3
4 5</td><td>Green / yellow / amber / red</td></tr></table></td></tr>
<tr><td>2.
Who is at risk:</td><td colspan="3"></td></tr>
<tr><td colspan="4">3.What control measures are already in place? (include an assessment of whether current controls are working as well as they should):</td></tr>
</table>

<table>
<tr><td colspan="3">5.Set out residual risks: (ie risks left with current controls in place)</td></tr>
<tr><td colspan="2">6. Action plan to address residual risk (include timescales, leads and cost implications)</td><td>7. Give score from matrix for level of risk once action plan in 6 complete:

<table>
<tr><th>Conseq</th><th>Likelihood</th><th>Risk Score</th></tr>
<tr><td>1 2 3
4 5</td><td>1 2 3
4 5</td><td>Green / yellow / amber / red</td></tr>
</table>

8. Is this level of risk acceptable (circle yes/no)?
<table>
<tr><td>Yes</td><td>No</td></tr>
</table>
</td></tr>
<tr><td>9. Review date (at least quarterly):</td><td>10. Person responsible for review:</td><td>11. Date of assessment:

12. Assessment by:</td></tr>
</table>

Date agreed by specialty risk group…….Date entered on specialty risk register…….
Date agreed by General Manager……Date entered on group risk register……..

Ensure results of assessment are included in risk register and are reported to your manager.

Clinical/Non-clinical Risks - examples

Consent and information giving

- Consent Policy- are staff fully aware, using correct methods?
- Leaflets-do they give risks benefits and alternatives
- Forms-is the national form used

Record Keeping/Communication

- When was the last audit of record keeping
- Are there record keeping standards
- Storage
- Links between records

Training and competence

- Can you demonstrate competencies or training to carry out Procedures particularly those you do not carry out regularly
- Have all staff attended mandatory training?

Use of equipment IV & Syringe pumps

- Is there an Equipment inventory
- Has a training needs analysis been carried out
- Are the training records/competencies complete

CPR

- Is there a policy on who does what? (call alert team etc)

Infection control including Hand Hygiene

- Is there a policy, are staff aware of it
- Is there annual training

Registration

- How do you ensure that all professional registration is up to date

Health and Safety –

- Are all assessments up to date?
- Are staff aware of Health and Safety requirements?

Staffing/Communication

- Are there issues with absenteeism/covering shifts
- How do you ensure good customer care with patients, relatives and other staff groups?

Tasks

- What tasks do staff perform either routinely or occasionally?
- Are there any particular concerns relating to these?

Sources for identifying hazards/risks

Incident, complaints & claims reporting
Analysis of incidents, complaints, claims & staff absence
Risk assessments
Audits
Reports from assessments/inspections by external bodies
Patient satisfaction surveys
National reports and Service frameworks
Hazard/safety notices
Grapevine
Exit interviews with staff
Public perceptions of the NHS
New legislation
Coroner reports
Patient journeys
SWOT analysis
Process analysis
Intuition

Appendix 5 Risk Register template/standard format

The agreed Trust Risk Register format is set out below, with brief explanations of each column. All risk assessments should contain this information as a minimum. The format is based on a template produced by Willis Risk Assessors, who carry out CNST/RPST assessments for the NHSLA.

Source of Risk (eg , Incident, NICE guideline, etc)	Areas concerned	Summary description of risk and persons affected	Original risk score or score on last review	Current Risk Score	Control measures already in place	Summary of action plan	Who is responsible for implementing plan?	Cost	Target date for completion	Date of Review	Residual risk rating
Source hazard identified from – ie source from work programme at app 2	Areas affected by the risk identified (ie ward 14/ T&O / Group 2 / Trust wide)	Description of hazard and nature and extent of risk All areas should: 1 carry out a comprehensive proactive risk assessment 2 identify risks on on-going basis from incidents, complaints, claims etc. 3 review risks identified at least quarterly	Consequence X likelihood from trust matrix (app 3). Score assessed or approved by: 1. local lead/group 2. General Manager (and added to the Group register) 3. Group register signed off by the relevant Executive Director	Revised score following review of register by local lead/group	A description of measures currently in place to deal with the risk (ie regular training)	A description of additional action to reduce the level of risk. This action should be assessed to ensure it does not introduce additional risks.(ie recruit additional staff)	Lead executive director for Corporate Risk Register/ operational lead for local registers – "all staff" not acceptable	Actual/ estimated cost of taking action identified		Review date to ensure risks and actions identified are monitored for progress	The score for the level of risk remaining when the action plan is in place. This should reduce the level of risk to an acceptable level

Appendix 6

Flowchart of Risk Management information