GOOD HOPE HOSPITAL NHS TRUST

POLICY: Risk Management Strategy and Policy

HOSPITAL/UNIT/DIRECTORATE/DEPARTMENT
To which the document applies: **All areas**

REFERENCE NUMBER: **52**

THE PURPOSE OF THE POLICY: Outline of the role of the Risk Management Policy and its impact on all staff and its part in the Trust Governance Strategy.

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**

NAME AND TITLE OF ORIGINATOR: **Ruth Gibson, Risk Manager**

REVIEW INTERVAL: 12 months	**Review due by: December 2004**

THE DATE DOCUMENT IS TO BECOME OPERATIONAL: 22 December 2003

DATE DOCUMENT WAS RATIFIED BY: Clinical Governance and Risk Management Committee (Board sub-committee) and Trust Board: 22 December 2003

SIGNATURE OF CHIEF EXECUTIVE:

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Risk Management Strategy

1. Statement of Intent

The Trust recognises that identifying risks and managing these well provides invaluable opportunities to improve patient care.

The Trust will strive to place an active awareness of risk and how to manage it at the core of its activities. The Trust recognises it is vital to develop and maintain systems and procedures which identify and minimise risks to patients, visitors, staff and others if it is to achieve its commitment to providing high quality care.

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.

2. Background/Strategy Objectives

A key objective of the Trust is to provide a responsive, high quality service to patients and their carers. This is achieved by promoting a policy of openness and accountability and by effective communication both within the hospital and with the external community.

The Trust recognises that every event or activity around the hospital involves risks which can or do harm patients, staff and other stakeholders. The Trust further recognises the important part that management of clinical and non-clinical risks plays in helping the Trust meet its objective. If risks are appropriately identified and managed the risks to people and property can be eliminated or minimised.

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.

3. Risk Management Aims

The aim of the Trust's risk management strategy is:

To develop and maintain a clear and effective structure of responsibility and accountability across the whole Trust, together with clear systems for identifying and managing risks, so that all Trust employees will be able to play their part in dealing with risk, leading to measurable improvements in patient and staff safety.

To achieve this aim the Trust has the following 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.

4. What is risk management?

i. Nationally

The NHS Executive defines risk management as:

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. There are a number of external assessment schemes, including controls assurance, CNST and RPST, which require hospitals to put in place robust systems to deal with risks.

Legislation, in particular on Health and Safety, and other external bodies such as CHI, NPSA etc also require Trusts to manage their risks.

ii. At Good Hope

The Trust Board recognises that risk management is a common-sense process which helps us to work better and more safely.

The Trust already has systems in place which allow existing and potential risks to be identified and eliminated or reduced. Further, whether they are aware of it or not, each action by a clinical or non-clinical staff member, involves an analysis of the situation and a weighing up of the risks and benefits of the available solutions. Risk management is already part of the work of the Trust, although this may not be done consistently or generally be recognised.

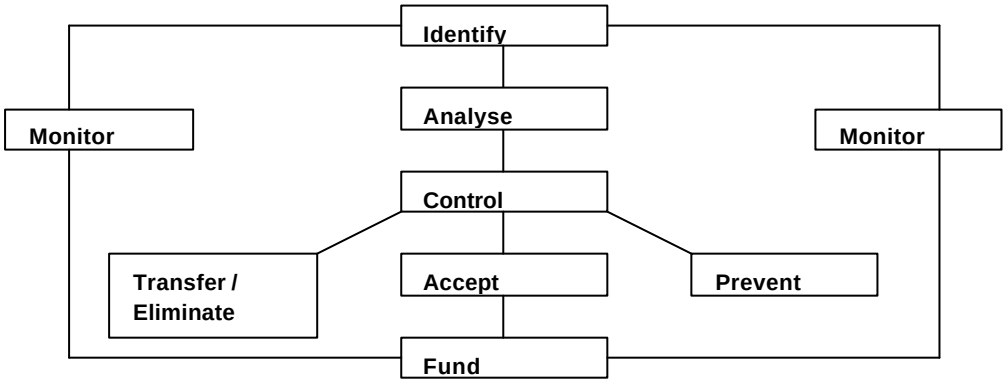
Risks will continue to be identified through the recommendations, comments and guidelines of external bodies and internally through incident forms, complaints, claims, audits, risk assessments and other methods.

To formalise existing practice, this strategy sets out a systematic approach to be adopted across the Trust to identify risks and to manage risks once they have been identified. This will promote certainty at all levels of the Trust that risks are being identified and, once identified, that they are actively dealt with in a consistent and appropriate manner. This strategy will also set out the Trust's structure. This will help ensure that there are clear lines of accountability through which risks can be fed to the correct level, where they will be dealt with and lessons to be learnt will then disseminated back out across the relevant areas.

iii. Risk Management Process

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 1: Risk management process



<u>i. Risk identification and assessment</u>

The first step is to identify a hazard (ie a trailing cable) and from this identify the risks the hazard could present (ie someone could trip). An analysis ("risk ranking" or "risk grading") is then carried out to establish the severity of each risk by assessing the likelihood of the risk occurring and the consequences if it did occur. The Trust has introduced tools for identifying hazards and risks arising from these and for grading risks (See appendices 1 and 2) 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 in section 11 below.

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 - replace a machine prone to break down
- **Transfer** ie avoid the risk by making someone else, say an external contractor, responsible
- **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.

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.

iii. 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, 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.

iv. Risk Monitoring

For each risk, the action to be taken to control the risk should be noted, together with 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. This should all be noted on the risk register. 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.

Policy

5. Who is responsible for which risks?

The Trust is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy. This responsibility is met in a variety of ways:

i. Individual Responsibility for Risk

Trust Board members are accountable for assuring themselves that:

- The Trust's Management Team lead by the Chief Executive is focused on the Key Risks faced by the organisation as identified through external and internal audit processes.

- The Trust's Risk Management Strategy and Policies 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.

Chief Executive

The Chief Executive is personally responsible for corporate governance within the organisation, which includes risk management activities. All of the Trust Board have a role in setting the strategic direction of the Trust and overseeing the implementation of policies and objectives including those relating to risk management.

The Board receive regular reports from key risk management committees. Through these, 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 the Significant Risks of the Trust.

Recommendations of the Clinical Governance and Risk Management Committee are made to the Trust Board where competing risk priorities are debated and agreed or accepted.

Delegation of Risk Responsibility

The Chief Executive has appointed the Medical Director as the accountable executive for implementation of risk management and controls assurance. The Trust has, in accordance with common NHS practice and controls assurance regulations, identified 3 generic risk areas:

Clinical risk
Financial Risk
Organisational Risk

The Medical Director is accountable for implementation of clinical and organisational risk management. The Finance Director is accountable for financial risk. These arrangements are currently under review to ensure the organisation is taking the most appropriate approach to risk responsibility.

Medical Director

- As lead for Clinical Professionals within the Trust, the Medical Director provides a clear focus for the management of Risk.
- The Medical Director has delegated responsibility for managing the strategic direction and implementation of clinical risk management and clinical governance.
- The Medical Director has delegated responsibility for managing the strategic development and implementation of organisational risk management and controls assurance.
- The Medical Director is responsible for:
  - leading the Trust's Corporate Risk Management Activities
  -ensuring that the Trust develops a system to ensure full compliance with the Department of Health Controls Assurance Standards.
- The Medical Director participates on the Clinical Governance and Risk Management Committee. This is a strategic sub-committee of the Trust Board and is responsible for overseeing the work of the Joint Clinical Governance Forum (the operational risk management group) and specialist Risk sub-groups.
- The Medical Director is Chairman of the Joint Clinical Governance Forum, which oversees implementation and development of risk management and controls assurance across the Trust.
- His accountability for Risk Management and Controls Assurance is directly to the Chief Executive and Chairman of the Trust.
- The Director of Finance 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 operational risks are included on the risk register and that these are appropriately monitored.
- Corporate Development and Organisational Risk Management should be informed by the recommendations of the Clinical Governance and Risk Management Committee.
- The Medical Director will seek the Chief Internal Auditor's Opinion on the Effectiveness of the Controls Assurance Programme.

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:
  - o that the Trust carries out its business of providing healthcare within sound Financial Governance arrangements
  - o that those arrangements are controlled and monitored through robust audit and accounting mechanisms
  - o that those mechanisms are open to public scrutiny on an annual basis.
  - o That financial risks are recorded on the risk register and that these are appropriately monitored.

- His 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 in his capacity as lead for clinical risk and for 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 the Clinical Governance and Risk Management Committee.
- The Director of Finance will seek the Chief Internal Auditor's Opinion on the Effectiveness of Internal Financial Control.

Comment: Do we need this as this is MD's strategic role whereas as clinical lead it is strategic and operational?

Health and Safety

Given the importance of having robust Health and Safety Procedures, the Trust Board has also delegated responsibility for Health and Safety activity to the Director of Human Resources. The Director of HR is responsible for ensuring health and safety risks are on the risk register and that these are appropriately monitored.

The Trust Board is assured that appropriate Health and Safety procedures are in place through the Health and Safety Forum, which reports on a quarterly basis to the Joint Clinical Governance Forum, and through this to the Clinical Governance and Risk Management Committee and through this to the Board.

Other specific risk management responsibilities

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

Risk management processes will be overseen by the Trust's risk manager. Additional support will be provided by the health and safety adviser, infection control team, fire safety adviser, security manager and members of the Clinical Governance and Risk Management Committee and Joint Clinical

Governance Forum. Support in implementing risk management processes will also be provided by the Clinical Governance Facilitators, who support clinical areas with development of specialty plans, with investigations of incidents, claims and complaints and identification of trends arising from these and with clinical audit.

Risk Manager

The Risk Manager 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 the Joint Clinical Governance Forum and through identification (from internal and external sources), management and monitoring of risks; providing reports, information and training as appropriate. The Risk Manager 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 Risk Manager is responsible for maintenance and development of the overall risk register. Accountability is through the Clinical Governance Manager to the Director of Nursing.

General risk responsibilities of Senior Trust Staff, Managers and Individual Staff Members

Executive Directors, Clinical Directors and Associate Clinical Directors, Clinical Group Managers, other Senior Managers and Heads of Department are responsible for ensuring that they engage with the Risk Management Objectives in section 2 of this Strategy, in order to ensure that their clinical and managerial responsibilities for risk management are met.

All Directors/Managers are responsible for:

- ensuring that appropriate and effective risk management processes 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.

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 and appropriate risk management control measures within their designated area(s) and scope of responsibility. In situations where significant risks have been identified and where local control measures are

considered to be potentially inadequate directors/managers are responsible for seeking local resolution, and if this cannot be achieved, referring these to the Joint Clinical Governance Forum.

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 are 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.

ii. Committee structure

In addition to the individual responsibilities outlined, there are a number of Trust committees with responsibility for risk management.

- 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 Clinical Governance and Risk Management Committee ensure lines of communication through shared membership (a non-executive Director sits on both committees) and minutes from both committees go to the Board, where members from each committee have the opportunity to consider the minutes.

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

This structure is at present under review to ensure all areas of risk are appropriately incorporated into the overall Trust structure and strategy. It is anticipated that the monitoring work arising as a result of implementation of this strategy will help with development of the committee structure.

Please see appendix 1 – organisational chart

iii. Divisional and Directorate Responsibility

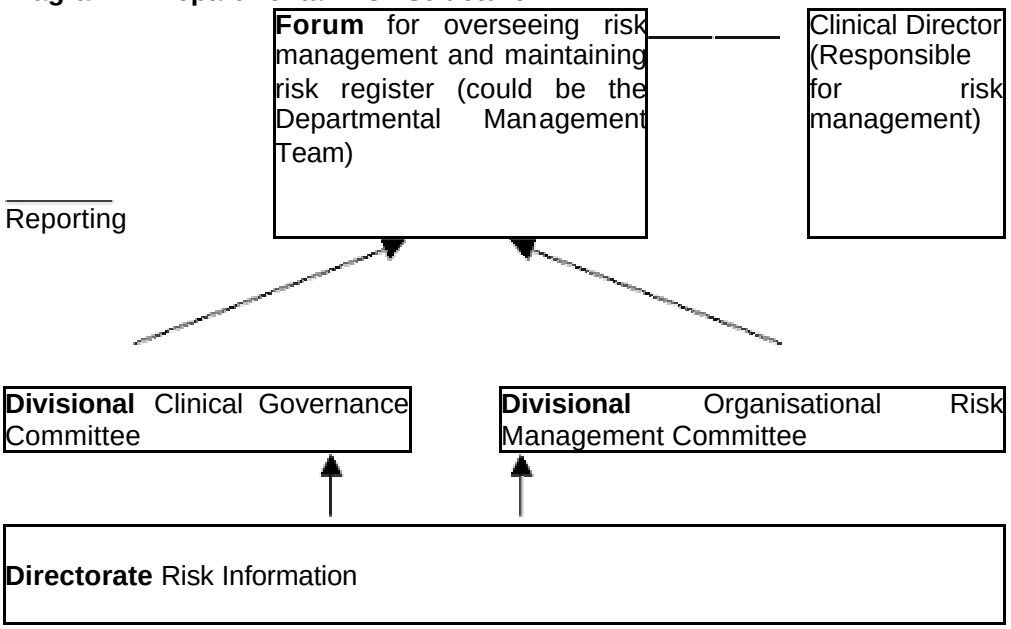
The Trust's **Clinical Governance and Risk Management Committee**, through the **Joint Clinical Governance Forum** is required to be assured that adequate structures and processes to manage risk exist within each department. The committees must be informed of actions undertaken at a departmental level.

? The **Department Clinical Director is accountable** for risk management within the department.

➢ 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. A model structure is described below, however, individual departments may want to implement a structure which is more appropriate to their needs:

Diagram 2: Departmental Risk Structure



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

- The divisional forum should receive reports from within the division, which identify risk management initiatives, incident and complaint trends, lessons to be learned and quality improvements.
- The forum is required to consider amber 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 departmental risk register. The forum will be responsible for ensuring the departmental 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 the Trust's Joint Clinical Governance Forum, as appropriate.

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

Ways of identifying and managing risk

6. 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 ie:

- 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 inform other actions relating to the Trust plan including:
Ensuring that risk assessment and prioritisation is included within the capital spending programme and equipment purchase process.

7. Controls Assurance

Controls Assurance is “a process designed to provide evidence that NHS bodies are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds” (HSC 99/123)

From 1 April 2000, the Trust’s Chief Executive was required to sign a statement of controls assurance that appears in the Trust’s Annual Report. This statement confirms to the public that the Trust Board has in place, and is constantly reviewing, a comprehensive risk management and control framework that is built on sound management practice.

To provide such assurance, the organisation must assess itself against a set of standards covering the areas set out in the table below. The Medical Director has delegated overall responsibility for Controls Assurance. For reasons of operational efficiency the Trust has identified a lead officer for each standard. This lead officer is responsible for ensuring that the assessments are carried out, action plans developed and progress monitored.

Table 1 Leads for Controls Assurance Standards

Standard	**Lead Officer**
Governance	Medical Director
Financial Management	Director of Finance
Risk Management	Medical Director
Buildings, Land, Plant & Non-Medical Equipment	Director of Operations
Catering and Food Hygiene	Director of Operations
Control of Contracts and Contractors	Director of Finance
Decontamination	Director of Operations
Emergency Preparedness	Director of Operations
Environmental Management	Director of Operations
Fire Safety	Director of Operations
Fleet and Transport Management	Director of Operations
Health and Safety	Director of Human Resources
Human Resources	Director of Human Resources
Infection Control	Director of Nursing
Information Management and Technology	Director of Information
Medical Devices Management	Director of Operations
Medicines Management	Director of Operations
Professional and Product Liability	Director of Finance
Records Management	Director of Operations
Security	Director of Operations
Waste Management	Director of Operations

The Governance, Financial Management and Risk Management Standards set out the core requirements for an effective risk management system. The remaining standards are based on the same fundamental principles but go into detailed questioning on each topic.

All the standards relate to statutory and mandatory requirements, and good practice guidance, which the Trust should be following - they serve as a checklist to assess the Trust's compliance.

CONTROL SELF ASSESSMENT

All Departments are required to assess themselves against the controls assurance standards. This should be done as part of the overall risk management process. The standards can be used as a "prompt" to highlight risk areas but should not be relied upon to identify all risks. A questionnaire/audit tool is available which incorporates all relevant aspects of the standards. Advice and support will be provided.

Control self-assessment takes the process one stage further. Having assessed performance against the standards actual evidence is identified which will support the results. This technique can be applied to any of the

many standards with which compliance is required, i.e. CNST, COSHH, etc., thus enabling immediate proof of performance for any external audit.

The Internal Audit Team will work in conjunction with the Trust, carrying out a rolling programme to check compliance with the controls assurance standards in order to assist the Trust in identifying any weaknesses. Their expertise will be used to identify what type of evidence is required under the control self-assessment process.

The Joint Clinical Governance Forum will monitor progress on achievement of Controls Assurance standards and report this, through the Clinical Governance and Risk Management Committee to the Trust Board.

8. Incident reporting - Including Serious Untoward Incident Management

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'. This will be achieved through a review of the current incident reporting system, in particular in defining which incidents are considered serious untoward incidents, and a programme of raising of awareness and education directed at all staff groups. Reporting levels will be monitored regularly and reports provided to the Joint Clinical Governance Forum.

To achieve consistency of reporting and investigation the Trust has introduced a universal tool for grading the severity of incidents. This should be used for grading any risk identified, from a risk assessment, incident form, complaint, claim or other source – see appendix 2.

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.

The Joint Clinical Governance Forum will monitor incident trends and investigations and follow up of incidents and report this, through the Clinical Governance and Risk Management Committee to the Trust Board.

9. Complaints

Patient complaints may be the indicators of risk or adverse outcomes in the delivery of care. It is therefore essential that the complaint management system is integrated with the Trust's other risk management systems.

The Trust has a strategy for devolving the everyday management of complaints to Divisions. At a Corporate level the complaints management process will be reviewed in line with national recommendations and regular reports will be provided to the Joint Clinical Governance Forum and through this to the Clinical Governance and Risk Management Committee and through this to the Trust Board.

10. Claims

Effective management of clinical and non-clinical claims will lead to lessons being learnt within the trust, which in turn, will reduce risk. Good practice standards, which are in line with the National Health Service Litigation Authority, will be introduced. The appropriate risk committees will review analysis of trends and disseminate quality improvement information throughout the trust. A quarterly report on the trends and lessons will be submitted to the Joint Clinical Governance Forum, and through this to the Clinical Governance and Risk Management Committee and through this to the Trust Board.

11. Risk assessments and Risk Register

Clinical and non-clinical inspections will be carried out on at least an annual basis in each area. Any risks identified will be assessed and appropriate controls identified. Tools have been developed which will help people carry out assessments and will help ensure risks are graded consistently across the Trust. This will allow each department to build up a comprehensive picture of all of the risks facing the area and the controls on these risks.

Managers' Level of Responsibility for Managing Risk following assessment.

As a general rule, risks should be noted on the risk register and managed as follows:

Risk score	1-5	managed within department.
	6-12	managed within department, but reported to the specialty forum who will monitor actions.
	13-19	these risks actions will be prioritised by the specialty forum and reported to the clinical governance forum
	20-25	these significant risks must be prioritised through the Clinical Governance forum and action plans developed and reported to the Trust Board.

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 and presented as part of the business planning process. Where urgent action is required out side 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.

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.

The Risk Register

The Risk Register is the main suppository of information relating to risk within the organisation. The register will be reviewed and updated on a continuous basis reflecting all relevant risk assessment activity. The tools the Trust will use to review risk management performance include:

Risk assessments
Local Risk registers
Complaints
Litigation
Incidents and incident trends

National risk alerts / health and safety requirements
Local and national targets and requirements
Clinical Audit
NICE guidance

Their inter-relation is set out at appendix 3. All risks identified in the register will be assessed and prioritised. The risk manager will be responsible for maintaining the risk register and ensuring it is reviewed and kept up to date.

Significant risks

Each specialty in turn 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 which threaten the key objectives of the Trust, generally risks rated at 20 and above, and those where the risk has been deemed as acceptable (ie where adequate controls are not in place). These are identified by each departmental forum from the departmental registers and reported to the Risk Manager for inclusion on the Trust-wide Risk Register.

The Trust Board will receive up to date information on the Risk Register and will be informed of significant risks identified. Such reports of risks will be reported to the Trust Board along with appropriate action plans and confirmation of risk reduction activity.

These will be reviewed on a regular basis by a Risk Register Monitoring Group, which reports to the Clinical Governance and Risk Management Committee and through this to the Board.

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

12.Health & Safety

Requirements for health and safety are governed by statute and associated regulations, and whilst an integral part of risk management, must maintain its separate identity. Accordingly there is a health and safety strategy and action plan as well as policies relevant to specific regulations.

The Director of Human Resources is responsible to the Board for Health & Safety. The Director of Human Resources chairs the Health and Safety Forum. This group meets on a monthly basis and is charged with highlighting operational issues and ensuring these are resolved as far as possible and reported to the Board where appropriate. The Director of Human Resources is also responsible for the Health and Safety Trainer and Adviser. Her responsibilities include identifying new Health and Safety legislation relevant to the work of the Trust and drawing this to the attention of relevant bodies and providing and maintaining a training programme on risk assessments and other Health and Safety issues. The Health and Safety Forum reports to the Joint Clinical Governance Forum and through this to the Trust Board.

13. Major Incident Planning

The Trust has a Major Incident Plan, which has been developed by the Major Incident group and has been circulated to all wards and departments, so that staff are aware of what action to take in the event of a major incident.

A major incident refers to an incident or accident occurring on or off site, *requiring extraordinary measures to be taken within the hospital in order to cope with the situation* and this should be distinguished from a serious untoward incident, referred to in the previous section relating to incident reporting.

14.Clinical Governance

Clinical Governance reflects all the activities within the Trust which aim to strive for continuous quality improvement. Clinical Governance is defined as:

'A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'
HSC 1999/ 065 (March 1999)

Risk Management is a core component of clinical governance particularly in relation to Patient Safety and Clinical risk.

Clinical Governance and Risk Management also share a number of broad principles:

- A focus on continuous quality improvement
- A requirement to demonstrate that structures are in place to lead to improvement
- Active participation of all staff / learning environment / sharing of information

Other components of clinical governance are closely linked to risk management. These include:

Component:	Highlights risk issues	Addresses risk issues
Complaints process	• Identification of risks from patient feedback	• Complaint resolved and action taken to prevent reoccurrence. • evaluation of whether risks reduced
Clinical Audit	• identification of risks from measurement against best practice standards • identification of adverse events	• reduction of risk through implementation of best practice

Information	• Identified potential trends which highlight risks	• Can be used to measure whether risk reduced.
Patient information and involvement	• Identification of risks from patient feedback or viewpoint	• Involvement of patients to reduce risks

External review co-ordination
The Trust is reviewed by a number of external agencies, according to the standards of that agency. These standards often overlap and so co-ordination is required to avoid duplication of work and to ensure the reviews are conducted as effectively as possible. This is co-ordinated in the Clinical Governance Department by the Corporate Governance Co-ordinator.

15. 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.

16. 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

Regional

? Birmingham and Black Country Strategic Health Authority Serious untoward incident policy
? 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
? Serious Clinical Incidents policy
? Major incident plan
? Infection Control policy
? Complaints policy
? Controls Assurance action plan
? Clinical Effectiveness strategy
? Claims Policy

In addition all clinical services will be expected to identify their specific risks taking into account recommendations from external reports such as the confidential enquiries (CEPOD, CESDI and National Audit Reports), findings from local clinical effectiveness audits and recommendations from NICE and the National Service Frameworks.

This strategy sets the strategic direction for Risk Management within the Trust for the next 2 years but will respond to developments and initiatives as required by internal and external forces.

Objectives/Action Plan

17. Risk Management objectives for 2003-2005

Table 3 - Risk Objectives and action plan

Strategic objective:	1 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

Action	Outcome	by	Timescale
1.1 Further develop the Trust Risk Register and ensure business planning priorities identified for 2004 / 05 are reflected within the risk register and vice versa.	Risk register reflects priorities identified within the business plan. Business plan responds top risks identified in the risk register.	RM / Director of Planning.	April 2004

Strategic objective:	2. To promote and support actively the risk management process, procedures and techniques across the Trust, in particular by a vigorous awareness and training programme

Action	Outcome	by	Timescale
2.1 To disseminate the revised risk management strategy and policy.	All staff are aware of the new strategy and policy.	RM	By end Feb 2004
2.2 Initial managers' training session	Introduce all managers to new strategy and policy	RM	January 2004
2.3 Introduce a dedicated training session for Trust Managers.	Training session developed for managers.	RM	Commence April 2004
2.4 Further integrate key elements of risk management within mandatory training sessions.	Key risk issues are included within mandatory training (e.g. incident reporting)	RM	Commence April 2004
2.5 Introduce training on undertaking investigations.	Detailed training is provided on undertaking investigations.	RM / CM / LM	Commence April 2004

Strategic objective:	3. 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

Action	Outcome	by	Timescale
As per 2.1	All staff are aware of their individual responsibilities.	RM	By end Feb 2004
As per 2.2 – 2.3	Appropriate training is	RM / et al.	April 2004

	provided to staff.		

Strategic objective:	4. For there to be a clear and effective structure for active management of both clinical and non-clinical risk across the Trust

Action	Outcome	by	Timescale
4.1 Implement revised structures as outlined in the strategy and policy.	Risk Management structures fully compliant with policy.	RM	December 2003
4.2 Review compliance with CNST and action plan from last assessment. Identify action plan for further improvement to achieve Level 2.	Assured compliance with level 1 and action plan in place for Level 2.	RM	March 2004
4.3 Review compliance with RPST and action plan from last assessment.	Assured compliance with Level 1 RPST.	RM	March 2004
4.4 Review compliance with Controls Assurance standards from self-assessment	Achieve 10% increase on previous scores	RM	March 2004

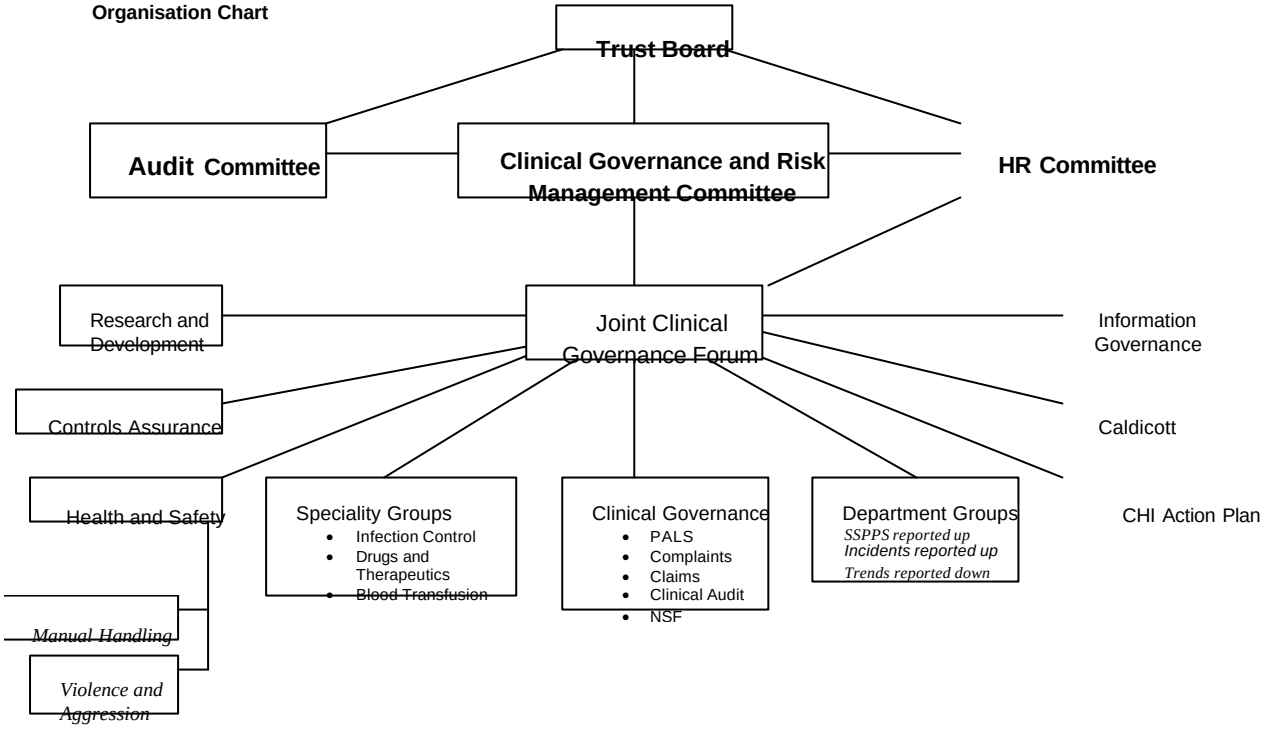
Strategic objective:	**5. To use risk management to learn from our work in a fair way and for us to develop in every area to ensure the best patient care possible.**

Action	Outcome	by	Timescale
5.1 To promote fair culture approach to reporting incidents as identified in the policy.	Increase in incidents as a result of fair blame policy.	RM	Ongoing
5.2 To ensure that improvements to services as a result of risk management are widely reported and celebrated. • Develop Intranet for risk management activity. • Further develop reporting details to CG forum and Specialties. • Consider methods to report back directly to staff reporting incidents.	Improvements demonstrated as a result of risk management.	RM	July 2004 Dec 2004

Achievement of these objectives will require the co-operation and involvement of staff at all levels of the organisation and further information relating to the detail of the above can be obtained from the Risk Manager, ext 1354.

Appendix 1 Organisational Chart
Appendix 2 Universal Grading Matrix
Appendix 3 Risk Management Tools

Organisation Chart



Appendix 2

UNIVERSAL GRADING MATRIX

Use this matrix to assist you in grading the reported incidents in a consistent and systematic way. It is quick and easy to use.

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.

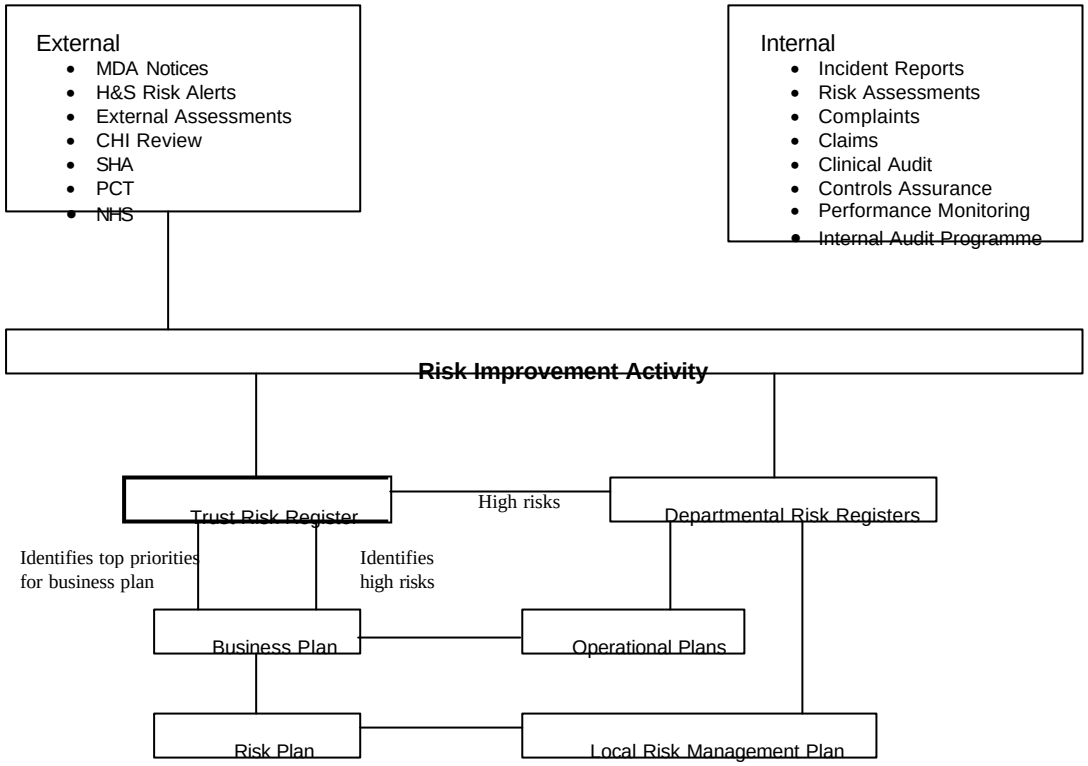
Incident = Probability 3
x Consequence 3
= Risk severity 9 = Amber

	CONSEQUENCE				
LIKELIHOOD	**1**	**2**	**3**	**4**	**5**
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Based on NPSA risk matrix

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

Another way of working out the risk is to look at the number produced when the consequence and likelihood are multiplied. The higher the number the higher this risk. The Trust has decided that risks scoring over 20 need to be recorded on the Trust wide risk register as significant risks.


External
MDA Notices
H&S Risk Alerts
External Assessments
CHI Review
SHA
PCT
NHS
Internal
Incident Reports
Risk Assessments
Complaints
Claims
Clinical Audit
Controls Assurance
Performance Monitoring
Internal Audit Programme
Risk Improvement Activity
Trust Risk Register
High risks
Departmental Risk Registers
Identifies top priorities for business plan
Identifies high risks
Business Plan
Operational Plans
Risk Plan
Local Risk Management Plan