University Hospitals of Leicester NHS
NHS Trust

RISK MANAGEMENT UHL POLICY

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REVIEW DATE AND DETAILS OF CHANGES MADE DURING REVIEW

January 2023: Change to the BAF and risk register reporting arrangements to Trust Board and Audit Committee to quarterly in line with the agreed work programmes. Updated risk assessment form with updated impact matrix. Updated Datix user guide instructions.

Keywords: risk, risk management, risk assessment, strategic risks, operational risks, risk register, Board Assurance Framework, BAF, Quality Impact.

1 INTRODUCTION

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust (hereafter referred to as "the trust") policy to manage risks arising from all types of activity including clinical, governance (incorporating information governance and research governance), finance and mandatory services, human resource, safety, environmental, service development and business. The document also sets out the Trust's procedure for risk assessment to comply with the general duties of the Health and Safety at Work etc Act and more specific duties in various Acts and Regulations, including the Management Regulations.

1.2 Effective risk management requires a culture where all staff are involved in reducing risks and improving quality and safety. Risk management is a responsibility for all members of staff and must be part of objective setting in every business and management planning cycle and of every service development. It relies on all members of staff identifying and minimising risks within a progressive, honest, learning and open environment.

1.3 It is important that risk management is a systematic process, using existing expertise and structures along with clear direction, guidance and support from the Trust's senior management teams. This policy and its supporting documents set out the Trust's framework for risk management.

1.4 The policy recognises that there is a requirement for an Annual Governance Statement, informed by an embedded system of assurance via the Board Assurance Framework (BAF) and joined by a clear public declaration on compliance with the Care Quality Commission's (CQC) registration standards, which require the Trust Board and nominated committees to consider the whole system of internal control.

2 POLICY AIMS / STATEMENT OF INTENT

2.1 The Trust Board of Directors (hereafter known as the 'TB') is committed to the implementation of risk management and ensuring that risk management is embedded into the culture of the organisation to foster an environment which minimises risks and promotes the health, safety and wellbeing of all those who enter or use the premises whether as staff, patients or visitors.

To that end this policy shall ensure:

a. Compliance with all appropriate legislative and statutory requirements.
b. That risk management is embedded in the Trust's business processes.
c. Selective, regular and systematic audit/ review of activities is undertaken in order to identify and, minimise risk in line with statutory requirements as far as is reasonably practicable.
d. Action is taken on recommendations from inspecting bodies.
e. Co-operation of all Trust staff in identifying and managing risk.
f. Business and financial opportunities are pursued within a managed, risk-based framework.
g. An environment where all members of staff are encouraged to report risks, incidents and 'near misses' and raise concerns about matters that affect the quality of care.

2.2 The aim of this document is to ensure that all risks associated with the delivery of the Trust's objectives and the provision of the Trust's services are minimised in line with statutory requirements and as far as is reasonably practicable. The broad objectives of this policy are to:

a. Describe a co-ordinated approach for the management of risk across all Trust activities;
b. Promote safe working practices aimed at the reduction of risk, as far as is reasonably practicable;
c. Describe responsibilities and accountabilities for risk management at every level of the Trust;
d. Raise awareness of risk management through a programme of communication, education and training;
e. Promote continuous improvement through internal and external audit and assessment;
f. Maintain a pro-active, forward-looking approach;
g. Ensure a systematic and consistent approach to risk assessments;
h. Manage risks to an acceptable level ensuring action plans are fully completed;

i. Integrate risk management with quality and performance management arrangements to become an integral part of the business planning and objective setting processes of CMGs and corporate directorates and the Trust as a whole;
j. Enable staff to be empowered to report risks and register concerns about unsafe practice;
k. Enable all aspects of risk management to be approached in a structured manner, in line with the CQC registration standards and NHS Compliance framework;
l. Provide guidance on the risk management process and the benefits of how effective risk management will enable the Trust to contribute to a wider risk network within the health community.

3 POLICY SCOPE

3.1 This policy applies to members of staff directly employed by the Trust for whom the Trust has legal responsibility. For those staff covered by a letter of authority / honorary contract or work experience, this policy is also applicable whilst undertaking duties on behalf of the Trust or working on Trust premises including those covered by the Research Passport Scheme.

3.2 This policy forms an integral part of the Trust's Safety process.

4 DEFINITIONS

Board Assurance Framework (BAF): A Board developed and managed document that brings together all the relevant information on the risks to the board's strategic objectives.

Cause (Hazard): The base reason that needs to be present (or is present) for a risk event to happen.

Consequence or impact: The outcome experienced as a result of the event enabled by the cause.

Control: An act, object, a system or process that actively maintains and/or modifies a risk.

Event: The most significant thing (in the context of achieving the relevant objective) that might happen (if the cause is present).

Operational Risk: Risks to the delivery of business-as-usual activities identified at CMG/ corporate directorate or specialty/ department level.

Risk: The chance that something will happen to have an impact on achievement of the Trust's aims and objectives or exposure to a chance of loss or damage. It is usually measured in terms of likelihood (frequency or probability of the risk occurring) and impact (on the organisation if the risk occurs).

Risk Appetite: The amount, and type, of risk that an organisation is willing to pursue to secure the achievement of its objectives.

Risk Assessment: The systematic collection of information to determine the likelihood and severity of harm and identify where additional controls are needed to reduce the risk to as low as reasonably practicable.

Risk Register (Datix): The Trust's database of CMG, specialty, corporate directorate and department risks.

Risk management: The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

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

Strategic Risk: Risks to the achievement of the Trust's strategic objectives. They are contained within the Trust's Board Assurance Framework (BAF).

5 ROLES AND RESPONSIBILITIES

5.1.1 **Trust Board**
The TB holds ultimate responsibility for ensuring that the Trust has effective risk management processes in place.

5.1.2 **Chief Executive**
Is responsible for establishing and maintaining an effective risk management system within the Trust to meet all statutory requirements and adhere to national guidance in respect of governance. The Chief Executive is the Accountable Officer responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's annual priorities and strategic objectives. This will include the identification and management of operational and strategic risk and oversight of progress against the BAF. The Chief Executive is supported in the role by the executive and corporate directors below:

5.1.3 **Executive and Corporate Directors:**
Executive Directors are collectively and individually responsible for the management of risk, and for the areas included in their portfolios and as reflected in their individual job descriptions. They must ensure that staff are familiar with this policy and aware of their responsibility for risk management. The discharge of these responsibilities is overseen and supported by Trust committees that are ultimately accountable to the TB (see section 5.2). Each committee is formally constituted and has approved terms of reference.

5.1.4 **Director of Corporate and Legal Affairs**
Is executive lead for maintaining the Risk Management Framework including the Board Assurance Framework and its supporting processes. Is responsible for minimising risks to corporate governance.

5.1.5 **Clinical Directors** shall discharge their responsibilities for clinical risk management by:

a. Agreeing levels of competence with medical/dental staff in line with national and professional guidelines;
b. Ensuring induction and on-going training of medical staff to the desired levels of competence;
c. Ensuring monitoring and maintenance of the quality of clinical records;
d. Ensuring planned introduction of new clinical procedures;
e. Ensuring the development, dissemination, implementation and review of local clinical policies, procedures and guidelines;
f. Ensuring local dissemination and implementation of Trust wide clinical policies;
g. Actively managing clinical risk;
h. Ensuring evidence exists for all clinical risk management activity;
i. Implementing, supporting and co-ordinating risk management processes in line with this policy;
j Ensuring new risk assessments are considered by CMG/ directorate boards and appropriately endorsed prior to entry onto the risk register.

5.1.6 **Corporate Directors / Managers, CMG Heads of Operations and Heads of Nursing** shall discharge their responsibilities for risk management by:

a. Ensuring risks to the achievement of CMG/ directorate objectives are identified, assessed and effectively managed to minimise those risks as low as reasonably practicable;
b. Ensuring adequate resources and expertise are made available to effectively manage risks within their areas of responsibility;
c. Ensuring risk management is incorporated into all clinical and non-clinical processes (including business processes);
d. Ensuring that this policy and other information related to risk management is disseminated to and upheld by all staff;

e. Identifying staff responsible for championing risk management and making their roles, responsibilities and accountabilities clear to them and to other staff;
f. Identifying the risk management training needs of CMG/ directorate managers and ensuring their attendance at relevant training events;
g. Ensuring all Trust / local policies are implemented and that compliance with these policies is regularly reviewed/ audited;
h. Ensuring all staff have received corporate induction and specific local induction and are aware of their personal responsibility within the risk management process;
i. Act upon aggregated information from incident reports, complaints and claims to identify risks, and, where necessary, update working practice;
j. Providing feedback from Trust committees and/or CMG/ directorate boards to staff on the outcome of incidents, complaints, claims and risks;
k Ensuring new risk assessments are considered by CMG Quality and Safety boards (Q&S)/ equivalent directorate boards and appropriately endorsed prior to entry onto the risk register;
l. Ensuring that existing risks are reviewed by CMG Q&S boards/ equivalent directorate boards;
m. Ensuring that evidence exists for all risk management activity to demonstrate that Trust standards and legal and statutory requirements are being met;
n. Being accountable for the CMG or corporate directorate management of the Central Alerting System (CAS) broadcasts.

5.1.7 **Specialty Managers (including Service and General Managers)** shall discharge their responsibilities for risk management by:
a. Ensuring that risks to the achievement of specialty, service or department objectives and all significant hazards inherent within work processes are identified, assessed, effectively managed and risk assessments submitted to CMG Q&S boards/ equivalent directorate boards for approval prior to entry onto the risk register.
b. Analysing and investigating incidents, near misses, complaints, risks and claims and subsequent implementation of improvement strategies.
c. Ensuring accurate risk register entries are maintained and that risks and mitigating actions are implemented and regularly reviewed in line with this document.
d. Ensuring risk management processes are embedded within specialties / departments.
f. Ensuring that the results of risk assessments are brought to the attention of their staff group.
g. Seeking advice and guidance from the corporate risk team on any aspects of risk management beyond their knowledge and skills.
h. Identifying the risk assessment and management training needs of staff, monitoring and ensuring their attendance at relevant training events.
i. Providing advice and support to staff in relation to risks.
j. Ensuring that there are suitable arrangements in place for the review and control of serious and imminent danger, where this potential is identified during the risk assessment process.

5.1.8 **All Staff** are accountable for their own working practice and behaviour and this shall be implicit in contracts of employment and reflected in individual job descriptions, objective setting and performance review.

All staff must:-
a. Be aware of risk assessment findings and control measures appropriate to their work area.
b. Co-operate with and engage in the risk assessment process including using and complying with control measures implemented to ensure the health and safety of themselves and others.
c. Understand their accountability for individual risks and how their actions can enable continuous improvement of risk management.
d. Report systematically and promptly any perceived hazards, new risks, or failures of existing control measures to their line manager.
e. Comply with any measures in place for dealing with a situation of serious and imminent danger.
f. Understand that risk management and risk awareness are a key part of the organisation's culture.

5.1.9 **Risk Assessors.** Any member of staff may be designated as a 'risk assessor'. Risk assessors will:

a. Carry out risk assessments, within the context of their own competency and in consultation with others, as situations arise and seek advice where unforeseen situations arise.
b. Attend appropriate risk assessment training programmes led by the Corporate Risk Team and contribute to CMG / directorate risk awareness.
c. Support managers in the identification, assessment and administration of risks.
d. Ensure new risk assessments are 'signed off' by their line manager, reviewed by specialty/ department managers and presented at CMG (Q&S) Boards/ equivalent directorate boards for confirm/challenge and approval prior to entry onto the risk register.

5.1.10 **Corporate Risk Management Team.** The Corporate Risk Team will: -

- Develop the risk management policy and keep it up to date.
- Facilitate a risk aware culture within the Trust (providing advice and challenge to ensure risks are kept under prudent control - effective systems are in place to identify, report, and act upon themes and trends and accumulated risk across the Trust).
- Establish risk tools and risk reporting structures.
- Compile risk information and participate in the activities of Trust committees / groups as required.
- Oversee the effective operation of risk management systems including maintenance, development, and day-to-day administrative responsibility of Datix risk register.
- Develop risk education programmes and guidance material.
- Provide CMGs and directorates with relevant advice, guidance, and information.
- Advise the Trust on risk management strategies.
- Produce reports on risk management activities for relevant Trust committees and CMGs
- Regularly audit compliance against relevant policies.

5.1.11 In addition to the roles listed in the previous sections there are other specialist personnel and groups within the Trust, who play a role in risk management, who have formal links with, and reporting systems to, the corporate risk team and committees with risk management responsibilities.

5.2 Committee Structures and Reporting Arrangements

5.2.1 The risk reporting framework shall integrate across all established committees within the Trust that have responsibility for risk to create a culture of risk reporting and feedback. Trust committees will report on the BAF as part of their usual reporting processes to the Trust Board. Reporting frameworks in relation to the BAF and the organisational risk register are attached at appendix one and two.

5.2.2 **Trust Board (TB)**

Will seek assurance of the implementation of risk management processes within the Trust and will be responsible for the identification of the Trust's strategic objectives, strategic risks, and the assessment and subsequent review of the Trust's BAF.

An updated BAF will be presented on a quarterly basis to the TB.

The function of the TB within the risk management process is to;

a. Develop, review and comment upon the BAF, as it deems appropriate;
b. Note the actions identified within the BAF to address any gaps in either controls or assurances (or both);
c. Identify any areas in respect of which it feels that the Trust's controls are inadequate and do not effectively manage the risks to the organisation meeting its objectives;
d. Identify any gaps in assurances or the effectiveness of the controls in place to manage the risks; and consider the nature of, and timescale for, any further assurances to be obtained;
e. Identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance that the Trust is meeting its strategic objectives.
f. Be aware of risk trends developing within the organisation and the strategies adopted for their control.

g. Agree the levels of risk appetite and tolerance that the Trust is prepared to accept in the pursuit of its strategic objectives.

5.2.3 **Audit Committee (AC)**

Is a committee of the TB and has responsibility for monitoring implementation of the risk framework. Its duties include:

a. Reviewing risk management, to ensure that there is an appropriate range of strategic objectives and that the risks to these objectives have been identified.
b. Seeking assurance that the process undertaken to populate the BAF is appropriate, in that the necessary directors and managers have been involved and take responsibility for their entries, and that there are no major omissions from the list of controls and assurance sources.
c. Seeking assurance that actions have been identified and are being implemented to address gaps in controls and assurances in the BAF.
d. Considering the "audit needs" of the organisation in terms of the sources of assurance, both independent and from line management, and ensure that there is a plan for these assurances to be received in the BAF.
e. Reviewing the risk process to monitor that the assurance framework is effective and there is a robust system in place for the identification, assessment and prioritisation of risk including a means of escalating risks to relevant Trust committees and providing a line of sight for operational risks from 'ward to Board'.
g. Using the BAF to inform future strategies and audit work programmes.

The Committee will receive an updated BAF at least quarterly. This report will support the AC to be able to provide assurance to the TB regarding its controls systems and support the Annual Governance Statement.

5.2.4 **Risk Committee**

This is an executive level group led by the Chief Executive; Membership includes executive and corporate directors, and CMG clinical directors.

The purpose of the Risk Committee is to support the Audit Committee, by obtaining objective assurance that the framework and systems for risk management are robust and effective. The Risk Committee has overall responsibility for establishing a pro-active approach to risk management across the various CMGs and directorates across the Trust.

CMGs/Directorates will be expected to present new risks with a current (residual) rating of 15 and above, to allow for constructive challenge, and provide assurance(s) that effective control(s) to mitigate the risk are in place.

In addition, CMGs/Directorates will be expected to report to the Risk Committee on their risks rated 15 and above at least twice yearly according to the Risk Committee's agreed Work Programme. This process is designed to enable the Risk Committee to take assurance as to the effectiveness of risk management within the Trust and to intervene to support the management of specific risks where necessary.

5.2.5 **UHL Performance Review Meetings**

The group comprises of executive directors. It meets CMGs/Directorates monthly and part of its remit will be:

a. To confirm and challenge for effective management of their risks.
b. To identify operational risks that cannot be adequately managed/ treated within the CMG and to agree appropriate escalation process for these risks.
c. Ensure that clinical directors, corporate directors and the triumvirates are supported in relation to the effective management of risks and their mitigations. This will include monitoring of risks scoring 15 or above on the risk register where there is a risk with one or more elapsed action due date and / or elapsed risk review date.

5.2.6 **CMG Q&S boards/ equivalent directorate Boards**

On a monthly basis will review a risk register report describing all open risks.

On a monthly basis will receive new risk assessments from their specialties for consideration and approval prior to entry on the risk register. There may be instances where a new risk needs to be entered on the risk register immediately and, in these cases, rather than wait for the next meeting the assessment must be endorsed either by chairs actions or by the CMG Triumvirate.

The function of the CMG **Q&S Boards** / equivalent directorate boards will be to:-

i. Approve risks for entry onto CMG/ directorate risk registers.
ii. Ensure relevant personnel are accountable for risks within CMGs / directorates.
iii. Ensure appropriate quality in relation to the content of the risk register.
iv. Analyse risk themes across the CMG/ directorate to identify trends.

The review of risk assessments and the risk register must be a standing agenda item at each CMG Q&S/ equivalent directorate board and the notes of the meeting shall evidence involvement in approving assessments and reviewing open risk register entries including scrutiny of risk ratings, effectiveness of controls in place and monitoring progress of action plans to treat risks.

5.2.7 **Specialty boards (where applicable)**

Will be responsible for:-

a. Submitting new risk assessments to the CMG/ directorate board for consideration and approval.
b. Monitoring that all actions to reduce risks are being implemented in line with the specified timeframes.

6 POLICY STATEMENTS AND ASSOCIATED DOCUMENTS

6.1 Risk Appetite and Tolerance

6.1.1 The Board of Directors is responsible for determining the extent of risk it is willing to take in achieving its strategic objectives. The Trust recognises that its long-term sustainability depends upon the delivery of its objectives and its relationships with its patients, staff, the public and strategic partners. The Trust's "risk appetite" line is set at 15; any risks rated at or above this level are reported to the Risk Committee and where necessary to the Board. A risk score of 15 or above should therefore be treated as a trigger for a discussion as to whether the trust is willing to accept this level of risk.

6.1.2 The Trust has a low appetite for undue risks to the health and/or safety of its staff and others and for risks that may compromise safety and the achievement of better outcomes for patients i.e. a level of risk that is greater than that accepted as consistent with safe clinical practice.

6.1.3 The Trust has a zero appetite for undue risks relating to failure to meet national targets and /or registration requirements from regulators, except where this would conflict with 6.1.1 and/or 6.1.2 above.

6.1.4 The Trust may decide to accept risks in developing innovative pathways to improve patient care where this is in line with its clinical strategy. This level of risk will be no more than accepted as consistent with safe clinical practice.

6.1.5 The Trust may decide to accept financial risks and will use its financial capabilities to enable change in support of its ambitions.

6.1.6 The Trust may decide to take calculated reputational risks where it deems the outcomes will be beneficial to its stakeholders.

6.1.7 Target risk ratings should be set for all risks. This risk rating is a means of expressing a target for the highest acceptable (tolerated) level for that risk. When setting target risk ratings, risk leads should consider what level of tolerated risk they are willing to retain. For some risks, the target risk

rating could be high, especially where the impacts are potentially severe, or some elements of the risk lie outside the direct control of the Trust.

6.2 Risk Identification

6.2.1 The Trust is committed to managing risks by undertaking risk assessments at every level of the organisation.

6.2.2 An important part of minimising risk involves reporting incidents. Any incident that *'has given or may result in actual or possible personal injury; to patient dissatisfaction; or to property loss or damage'* must be reported following the UHL incident, complaint or claim procedures. A robust system of reporting allows the Trust to monitor incidents, complaints and claims; to review practice; and to identify trends and patterns. It also allows for the quick detection and resolution of any problems resulting from inadequate procedures, lack of training, or pressure of work.

6.2.3 Risk identification and assessment systems are vital to the success of the Trust's risk management process and there are several internal and external sources of risk identification that can be used. Risks from the sources listed in sections 6.4.2 and 6.4.3 must be assessed.

6.3 The Process for Assessing Risk:

6.3.1 This provides a systematic examination of clinical and non-clinical processes and allows a trust-wide risk profile to be developed subsequently enabling informed decisions to be taken about the management of the risks. Responsibility for ensuring suitable and sufficient risk assessments lies with managers with support as necessary from the specialists within the Trust. It is expected that all risks will be reduced to the level required by law and/or as low as is reasonably practicable.

6.3.2 Risk assessments are essential components of the risk management programme and must not be solely an annual 'snapshot' but rather an embedded and cyclic process to ensure that risks are properly managed. Assessments must take account of all types of risk and select what type of risk it is. For example, there may be a risk which is a staffing risk (Cause i.e. not enough RGNs on a particular ward) but has a patient safety and/or a financial impact; this should be categorised as a staffing risk and not a patient safety and/or financial risk, despite the impacts the risk may have. It is the very essence of its character which determines what the type is rather than its effect.

6.3.3 All aspects of a risk must be considered, and some risks may cross more than one impact domain (e.g. Quality & Safety impact; Compliance & reputation; Finance & resources) and, in those instances, all relevant domains must be assigned a separate risk score. The domain with the highest risk score should be selected when entering the risk on to the risk register. Risks should link to Trust or CMG/ directorate objectives.

6.3.4 Risk assessments are performed using a standard UHL risk management assessment form (appendix three and up to date version is available on Insite) and all fields of the form must be completed to ensure a minimum dataset for entry onto the risk register. As part of the risk assessment each risk identified must be scored using the Trust's risk scoring matrix.

6.3.5 The risk assessment must be approved by the appropriate CMG Q&S board/ equivalent directorate board prior to entry onto the risk register. Evidence of approval /authorisation must be attached to the risk register entry. There may be cases where a new risk needs to be entered on the risk register immediately and in these cases rather than wait for the next meeting the assessment may be endorsed either by chairs actions or by the clinical / corporate director, head of operations or head of nursing and some form of correspondence to demonstrate that the risk has been approved must be attached to the risk register entry (i.e. an email, a scanned signed copy of the assessment form, a copy of minutes/notes etc).

6.3.6 Each risk must be reviewed at a frequency based on the severity of the risk score (see section 6.7.3 to 6.7.6). The risk owner must perform the review along with others who were involved in the initial assessment to provide consistency with risk scoring. Following review, the owner must ensure the risk register is updated to reflect any changes to the assessment.

6.4. Requirements of a Risk Assessment

6.4.1 Identify the cause(s) of the risk (i.e. something with the potential to cause harm that needs to be present (or is present) for a risk event to happen). This involves examining all causes of risk from the perspective of all stakeholders, both internal and external. Causes of risks (hazards) can be systematically identified from a number of proactive and reactive processes/sources including but not limited to:-

6.4.2 **Internal Sources**

- Organisational key performance indicators (e.g. Quality and Performance reports, etc)
- Risk, incident, complaints and claims reporting and analysis
- Work activities/ processes
- Internal audits/ reviews
- Self-assessments
- Process analysis, including compliance with Trust / dept strategies, policies, plans & procedures
- Internal safety alerts
- Post event analysis
- Surveys (e.g. patient and staff satisfaction surveys)
- Training evaluations
- Unions
- Whistle blowing

6.4.3 **External Sources**

- Coroner reports
- Media
- National standards, guidance, and new/updated legislation
- Horizon scanning of the external healthcare environment and learning from others
- Working partnerships with other local and national healthcare organisations
- National Central Alerting System broadcasts
- External Audits
- Membership of professional body
- Reports from assessments, inspections from external bodies, e.g., CQC, Health and Safety Executive, External Audit, etc.

It is important to concentrate on the significant risks that could result in harm to individuals or the organisation.

6.4.4 **Decide What or Who may be Harmed and How (i.e. the consequences or impacts of the risk)**
Describe the outcome (potential harm or loss) that will be experienced as a result of the event enabled by the cause. Patients, staff, and others must be considered and the impact scoring table in appendix three should be used to consider the level of harm. Consideration must also be given to risks affecting the business of the Trust, for example risks to quality, finance, business objectives, reputation of the Trust, service, etc.

6.4.5 **Identify Current Controls in Place**
Consider how the causes are already being controlled by preventive methods to reduce the likelihood of the risk occurring and how impacts are being mitigated by corrective methods to reduce the effect should the risk event occur.

6.4.6 **Evaluate the Risk**
Consider the likelihood of the risk event occurring and the impact should the risk event occur.

6.4.7 In this context, impact is defined as the potential harm or loss if the risk occurs and must be scored using the risk impact matrix in appendix three. Score the risk against the most appropriate domain(s) from the left-hand column of the table and work along the appropriate row until the most relevant definition of the risk impact is found. The impact score is assigned a number from 1 – 5 dependent upon the severity and can be found at the top of the columns.

6.4.8 The likelihood score reflects how likely it is that the risk event will occur with the current controls in place and can be identified by using the likelihood scoring table included within appendix three where definitions of descriptors used to score the likelihood of a risk being realised are provided. The likelihood is assigned a number from '1' to '5': the higher the number the more likely it is the risk event will occur. Frequency may not be useful in scoring certain risks associated with time-limited or one-off projects and for these risks the likelihood score must be based on the probability of the risk occurring in a given time period.

6.5 Risk Scoring

6.5.1 Once a cause (hazard) is identified the severity of risk is measured using a matrix giving a numerical value to the impact and the likelihood of the risk event occurring to produce a single risk rating. The risk rating is calculated by multiplying the impact score by the likelihood score. The risk scoring matrix is included in appendix three.

6.5.2 When assessing a risk there are two risk severity scores that need to be recorded, these are:

- Current score – i.e. the level of the risk at present time taking into account any current controls in place and working effectively. The current score will alter following periodic review of the risk as actions to treat them are put into place (i.e. actions to mitigate the risk have been implemented) or withdrawn and this must be reflected in an updated current risk score within the risk register entry.
- Target score – i.e. the level of the risk expected following the implementation of actions to treat the risk.

NB: Where the current risk score equals or is less than the target risk score this demonstrates that the risk has been treated to a tolerable level, as agreed by the risk owner and CMG / corporate leadership team. The risk should be subsequently reviewed at least quarterly for a period of 6 months, following the achievement of the target risk score, prior to being closed, to monitor the detective control sources are on trajectory. The risk register should be a repository of managing all significant risks with a treatment plan.

6.6 Risk Treatment

Risks may be:-

6.6.1 ***Tolerated (accepted):*** Low risks can normally be accepted as requiring no further action, however, always consider whether further action is appropriate to control low scoring risks that have a consequence / impact score of 4 or 5.

6.6.2 ***Transferred:*** The Trust is a member of the Liabilities to Third Parties Scheme (LTPS), Property Expenses Scheme (PES), and the National Health Service Litigation Authority (NHSLA) risk pooling schemes. This membership transfers some financial risk to these scheme providers.

6.6.3 ***Treated***: In many cases further controls can be implemented to reduce the risks. If so, these should be recorded on the risk assessment document as future actions and should include timescales for completion and details of the individual accountable for implementing the actions.

6.6.4 ***Terminated:*** In some cases risks cannot be tolerated, transferred or treated. In these cases the Trust may decide a particular risk should be avoided altogether and this may involve ceasing the activity that gives rise to the risk.

6.7 Local Accountability for Risk, Review & Escalation

6.7.1 Risk assessments must be reviewed by the risk owner at a frequency determined by the risk score. Regular review will ensure that when actions have been implemented, they are reassigned as control measures with a subsequent revision of the current risk score in the risk register entry (until the target risk score is achieved). The CMG Q&S board/ equivalent directorate board will confirm and challenge individual risk owners for the effective management of their risks. When the implementation of risk control measures is beyond the authority or resources available to the CMG/ corporate directorates then the Clinical Director/ Head of Operations are responsible for escalating this to the relevant executive director and / or trust committee via the Quality and Performance

review group meetings so a decision can be reached as to whether the risk will be accepted at this level or whether the risk is to be escalated to the executive boards or TB.

6.7.2 Line managers are responsible for agreeing, implementing, and monitoring appropriate risk control measures within their designated areas. Where the implementation of risk control measures is beyond the authority or resources available to the manager then this should be brought to the attention of the CMG Q&S board/ equivalent directorate board so a decision can be reached as to whether the risk will be accepted at this level or whether additional resources can be made available to treat the risk.

6.7.3 Risk Score 1 – 6 (Low Risks)
Can be accepted without further treatment and in these instances the risk does not need to be entered on to the risk register, however a copy of the assessment must be maintained at local level. Always consider whether further action is required to control any low risks with an impact score of 4 or 5. Where it is decided to treat a low risk the risk shall be entered onto the risk register and reviewed at least annually until the target risk score is achieved.

6.7.4 Risk Score 8 - 12 (Moderate Risks)
Risk assessment details must be entered onto the risk register along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG Q&S board/ equivalent directorate board at least quarterly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed on the risk register.

6.7.5 Risk Score 15 – 20 (High / Significant Risks)
Risk assessment details must be entered onto the risk register, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG Q&S board/ equivalent directorate board at least monthly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed on the risk register. The Trust's "risk appetite" line is set at 15; any risks rated at or above this level are reported to the Risk Committee and as required to the Board. A risk score of 15 or above should therefore be treated as a trigger for a discussion as to whether the trust is willing to accept this level of risk.

6.7.6 Risk Score 25 (Extreme Risks)
Must be brought to the immediate attention of the Clinical Director /Manager, or corporate director as appropriate who will subsequently contact the corporate risk management team to provide independent advice in relation to the accuracy of scoring. Risks that are downgraded following this exercise shall follow the process outlined in sections 6.7.3 – 6.7.5. Risk assessment details must be entered onto the risk register along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG Q&S board/ equivalent directorate board at least weekly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. All risks scoring 25 will be reported at the earliest opportunity to the next available Risk Committee meeting by the relevant director.

6.7.7 All risk management assessments must be 'signed-off' prior to entry on the risk register and will normally follow consideration and approval of the risk by the CMG Q&S board/ equivalent directorate board and must include the signature of the Corporate/ Clinical Director, CMG Head of Operations or Head of Nursing. In circumstances where a risk needs to be entered onto the risk register as a matter of urgency then the risk assessment must be considered, approved and 'signed-off' by the Corporate/ Clinical Director, CMG Head of Operations or Head of Nursing..

Risk Escalation

Risk Rating / Score	**Reported to/ Monitored by**

1 – 6 (Low)	Dept manager. CMG Q&S/ equivalent directorate board when there are actions to treat the risk
8 – 12 (Moderate)	CMG Q&S/ equivalent directorate board
15 – 20 (High)	CMG Q&S/ equivalent directorate board (monthly), Risk register summary to Risk Committee (monthly) and TB (Quarterly)
25 (Extreme)	Risk Committee and TB (monthly)

6.8 Risk Recording:

6.8.1 **BAF**

NHS Chief Executive Officers are required to sign an Annual Governance Statement as part of the statutory accounts and annual report. The TB must be able to demonstrate they have been properly informed about the totality of risks within the Trust, both clinical and non-clinical. The TB shall assure itself that strategic objectives have been systematically identified and the risks to achieving them are adequately managed. The BAF fulfils this purpose.

The application of the Trust's risk scoring criteria shall assist in the rating of these risks.

The minutes of the TB shall evidence that it identifies, records, assesses and analyses the Trust's risks via the BAF and that it is involved in taking decisions on risk treatment options.

6.8.2 **Risk Register**

The risk register is an electronic database and provides a dynamic operational risk profile of the Trust. It is used in conjunction with the BAF to provide an overall view of the Trust's risk profile.

The register provides a mechanism for risks and risk treatments to be recorded and accessed by individuals, teams, and CMGs/ directorates to assist in informing clinical, non-clinical and business decisions.

As a minimum the risk register will hold details as specified in the *'UHL Datix Risk Register User Guide'* (appendix four).

CMGs and directorates shall maintain accurate risk register entries and risks shall be entered in line with the process described section 6.7 of this document.

The Trust's corporate risk management team is responsible for producing regular and ad-hoc risk reports for Trust committees and CMG Q&S boards/ equivalent directorate boards.

6.9 Learning

6.9.1 Learning from incidents, complaints and claims and other such events is key to developing a culture within the Trust that welcomes investigation of such cases to provide opportunities to improve patient care, the services offered within the Trust, the working environment and the safety of staff, visitors and contractors.

6.9.2 A well established and active internal reporting culture provides the Trust with detail about actual and potential harm and associated risks for incidents, complaints and claims. Data from incidents, complaints, claims, and inquest activity, are managed, monitored and investigated in conjunction with CMGs and directorates by Specialist personnel.

6.9.3 Clinical incident data is uploaded to the National Reporting and Learning System (NRLS) as part of the external reporting requirement.

6.9.4 Learning lessons from internal incidents, complaints, claims and inquests is an important factor in the Trust's approach to managing risk. Following investigation, presentation of the final report and action plan will be monitored via the appropriate CMG and relevant Trust-wide groups.

6.9.5 More detailed information regarding the management of incidents, complaints and claims can be found in the following Trust guidance:

- Guidance for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims.
- Incident and accident reporting policy. A10/2002.
- Claims Handling Policy and Procedure. B24/2008
- Management of Complaints Policy. A11/2002

7 EDUCATION AND TRAINING REQUIREMENTS

7.1 Risk Management Training

7.1.1 The Trust is committed to the provision of training and education to ensure the workforce is informed, competent, prepared and possesses the necessary skills and knowledge to perform and respond appropriately to the demands of clinical care and service delivery.

7.1.2 Staff will be offered risk management awareness training commensurate with their duties and responsibilities.

7.1.3 TB members will receive risk management awareness training, commensurate with their roles and responsibilities.

8 PROCESS FOR MONITORING COMPLIANCE

8.1 Systems for Monitoring the Effectiveness of the Policy

8.1.1 An annual report on risk management in the Trust, based on all available relevant information, shall be included in the Trust's Annual Report. To ensure compliance with this policy the report, together with performance against the key performance indicators (KPIs), shall be reviewed by the AC and used to inform the development of action plans to remedy deficiencies and to inform future strategies. Existing audit / review mechanisms shall be used wherever possible to avoid duplication.

8.1.2 Regular self-assessment of compliance against the CQC 'essential standards' of quality and safety' is a requirement of registration and the Trust must demonstrate that it meets these across all its services.

8.1.3 Systematic review of the risk management process is a key responsibility of the AC.

8.1.4 Other internal and external audits shall take place as required by inspecting bodies.

8.2 Key Performance Indicators

8.2.1 KPIs and audit requirements are described in appendix five.

9 EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

10.1 References

[1] Australian/New Zealand standard AS/NZS 4360:2004.

[2] ISO 31000 – Guide 73

10.2 **Related Policies**

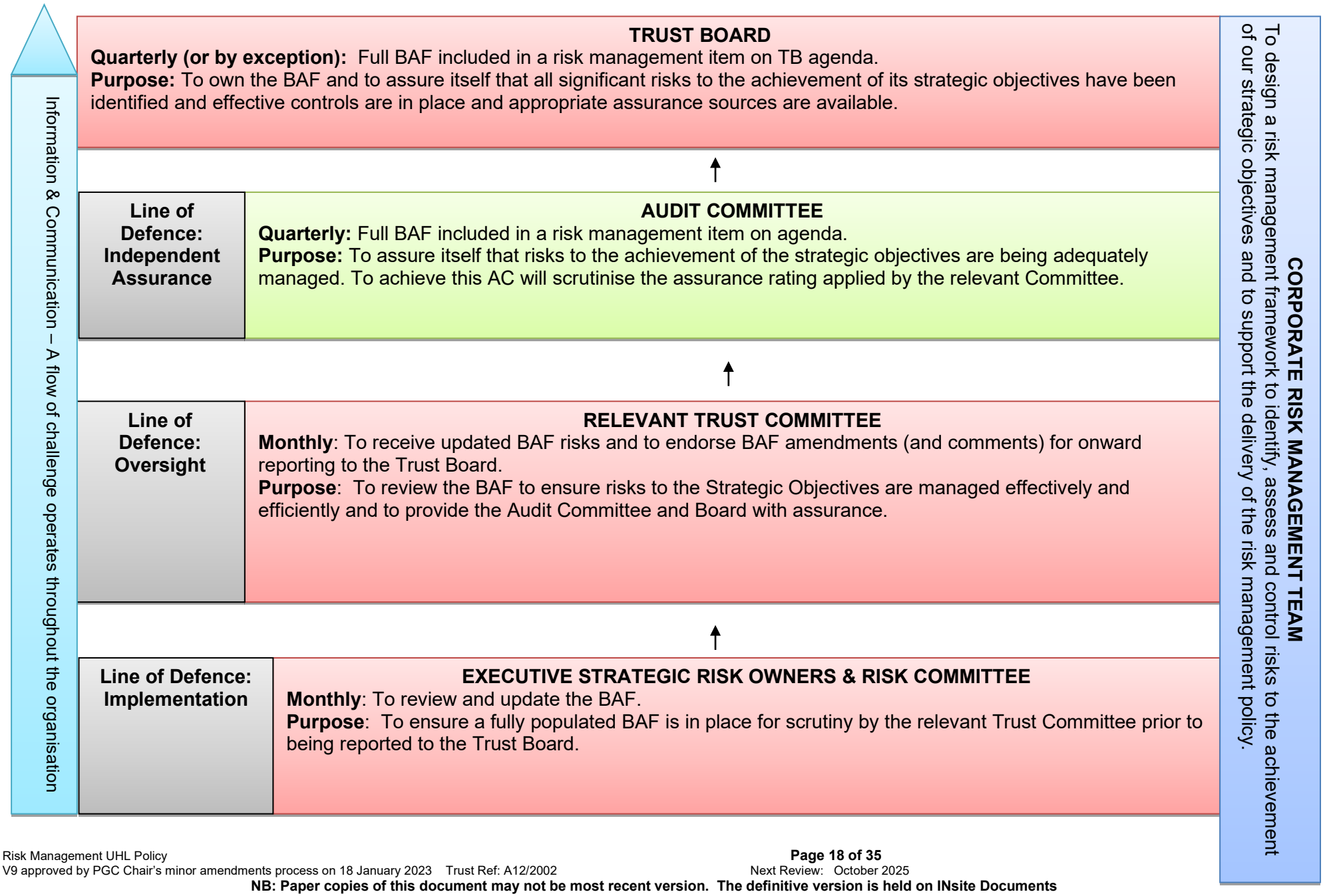
- UHL Health and Safety Policy. A17/2002
- UHL Safer Handling Policy – Risk Assessment. B65/2011
- UHL Incident and Accident Reporting Policy. A10/2002
- UHL Information Governance Policy. B4/2004
- UHL Statutory and Mandatory Training Policy. B21/2005
- UHL Corporate and Local Induction Policy for Permanent Staff. B4/2003
- Management of Complaints Policy. A11/2002
- UHL Claims Handling Policy and Procedure. B24/2008
- UHL Central Alerting System (CAS) Policy. B1/2005
- Guidance for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims. B28/2007.

11 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

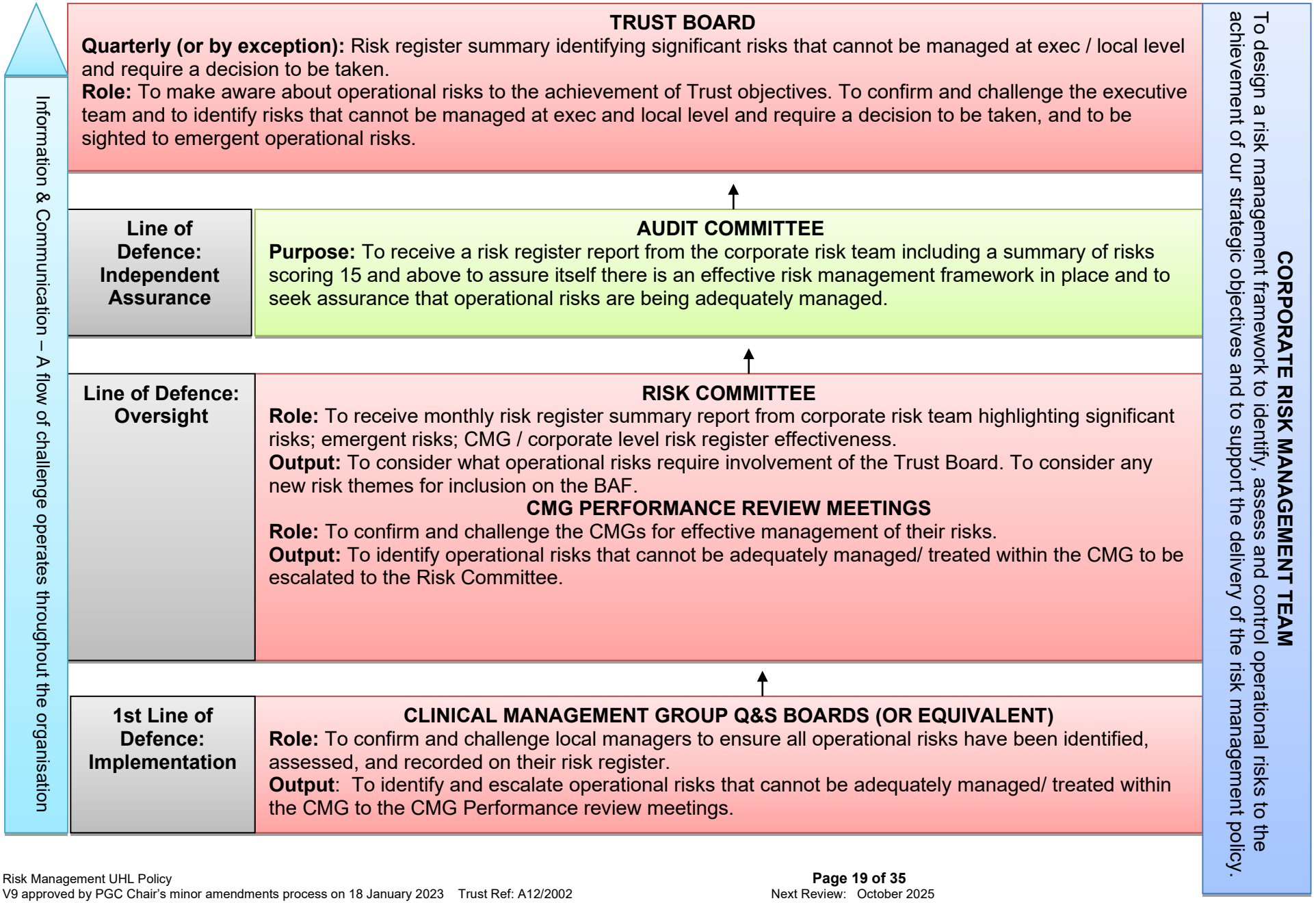
11.1 Following ratification by the AC and UHL Policy and Guidelines Committee new versions of this document will be uploaded onto SharePoint by Trust Administration and previous versions will be archived automatically through this system. Access for staff to this document is available through UHL 'InSite'.

11.2 This document will be reviewed in line with the Policy Guidelines unless earlier revision is required following internal audits and/ or external guidance.

Appendix one – BAF reporting framework



Appendix two – Risk register reporting framework



Appendix three – UHL Risk Management Assessment Form

UHL RISK MANAGEMENT ASSESSMENT FORM			Local Ref. No.	
CMG/Corporate Directorate		Service / Specialty		
Date of Assessment		Assurance Source ***(How was this risk identified)***		

Risk Description: Risks should be described as - **If (cause)… then it may result in (event)… leading to (Impact)**

Example: If Staffing levels are below establishment in X service, then it may result in widespread delays with patient diagnosis and /or treatment, leading to patient harm

CAUSE – Describe a single cause of the risk event happening. Guidance: *What needs to be present or is present for the risk event to happen? There should only be one cause per risk. Controls should map back to controlling the one cause. The cause is the base reason for the risk event to happen. There are several ways to identify the cause for something, but fundamentally, it consists of asking 'why' until you get to the bottom of it.*
If (this is the main CAUSAL FACTOR) …

EVENT – Describe the risk event (the thing) that might happen (or has already happened but could happen again). Guidance: *What's the most significant thing that you are concerned about? A good rule of thumb to use is that if the risk event could not have a post event analysis conducted should it happen – then it is probably not a risk! Although succinctness is important using a single word is not helpful in describing an event. When scoring the risk, you must rate the likelihood of this event occurring by using the scoring descriptors.*
Then it may result in (this is the EVENT)…

IMPACT – Describe the typical impacts if the risk event happened. Guidance: *If the risk event happened what would be the impact(s) – see impact matrix for guidance:*
Leading to (these are the IMPACT(S) if the event has happened)…

-

Controls & Assurances: (Describe any systems and processes that are already in place to control the likelihood of the risk event happening or to control the risk event if it happened. There should be evidence (for assurance purposes) that these controls are working effectively.)

Preventive: *(***Guidance**: *What preventive systems and processes are already in place to control the risk. These should reduce the likelihood that the risk event may happen. If there are no controls, state none)*

-

Corrective: *(***Guidance***:What corrective systems and processes are already in place to control the risk. These should control the impact if the risk event happened. There should be evidence (for assurance purposes) that these controls are working effectively.* If there are no controls, state none)

-

Assurances: (**Guidance**: *Sources of assurance: consider what reports, audits, checks, reviews are in place to provide evidence the risk is being managed well or, if not, where there are gaps and what forums - both internal and external - they are reported*

-

Current Risk Rating: (Describe the current risk rating)

Guidance:
Impact if the risk event has happened (managed by corrective controls)
Likelihood of the risk event happening (managed by preventive controls)
Select the highest risk rating category to enter on Datix risk register

Risk categories: *NOTE - Delete risk categories if not applicable to the risk being assessed*	Impact *(the impact should be for the worst credible outcome rather*	x	Likelihood *(enter a single score based on the likelihood of risk event occurring*	=	Current Risk Rating

	than the worst conceivable) (I)		*managed by the current controls)* (L)		
Quality & Safety		x		=	
Compliance & Reputation		x		=	
Finance & Resources		x		=	

Action Plan: (Ensure the actions address gaps in control. *Copy & paste to add more rows as required)*

Guidance: *What actions will address the impact(s) gaps in control or the likelihood gaps in control. Actions must be SMART (specific, measurable, achievable, realistic and timebound) and action owners signed up.*

Action Plan	Assigned to	Start date	Due date	Completed date	Cost £

Target Risk Rating: (Describe the target risk rating)

Guidance:
Impact if the risk event happened (managed following additional actions identified)
Likelihood of the risk event happening (managed following additional actions identified)
Select the highest risk rating category to enter on Datix risk register

Risk categories: *NOTE - Delete risk categories if not applicable to the risk being assessed*	Impact *(the impact should be for the worst credible outcome rather than the worst conceivable)* (I)	x	Likelihood *(enter a single score based on the likelihood of risk event occurring managed by the current controls)* (L)	=	Target Risk Rating
Quality & Safety		x		=	
Compliance & Reputation		x		=	
Finance & Resources		x		=	

Risk Assessment Approval: (All risk assessments must be approved prior to being entered on to Datix)

Risk Assessor name		Line Manager name		Date approved by Line Manager	
NOTE: This Risk Assessment form must be approved by the CMG / corporate directorate Management Team prior to being entered on to the Datix risk register. If there is no signature the risk will be suspended on Datix.					
Approved by CMG / Director: name		Signature		Date	

Note: The Risk Register is a publicly accessible document and published on the Trust's external website (within the Trust Board papers and reports).

UHL Impact Scoring Guidance:

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Safe **By safe, we mean people are protected from abuse and avoidable harm. e.g.** • Hospital acquired infection / pressure ulcers (+ / -) • Slips, trips & falls (+ / -) • Abuse* (physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory • Medication error (+ / -) • Surgical error (+ / -) • Timely & accurate patient information (+ / -)	No harm / no abuse No hospital acquired infections Near miss Prevented patient safety incident	Minimal harm e.g. requires first aid treatment Non-permanent harm Missed or incorrect dose of non-critical medicine / administration error not resulting in harm Grade 1 pressure ulcer Staff member requiring time off work <7 days Patient sent for invasive procedure without proper prep or notes (Angios/ Cath Labs/ Theatres/Vascular access)	Significant but not permanent harm Slips, trips and falls leading to e.g. fractured clavicle, laceration requiring suturing Hospital acquired infection Missed or incorrect doses of critical medication or treatment / administration error resulting in moderate harm / adverse reaction to medication Grade 2 - 3 pressure ulcer Staff member requiring time off work 7-14 days	Long term or permanent harm Chronic pain (continuous, long term pain of more than 12 weeks as a result of the incident) Slips, trips and falls leading to e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence Psychological harm, impaired or sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days) Infection outbreak Multiple missed or incorrect doses of critical medication or treatment / administration error resulting in severe permanent harm / long term harm / severe allergic reaction Grade 4 pressure ulcer Staff member requiring time off work >14 days	Death, irreversible health effect or life changing effect Systematic failure to provide an acceptable standard of safe care to multiple patients (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services) Multiple / ongoing infection outbreaks Multiple missed or incorrect doses of critical medication or treatment /administration error resulting in fatalities / permanent harm or irreversible health effects Systematic treatment errors affecting multiple patients resulting from miscalibration of equipment e.g. Radiotherapy Reportable radiation incidents. RPA involved.

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Caring **By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.** **e.g.** • Single sex accommodation (+ / -) • DOLS / DNACPR / Consent (+/-) • Patient satisfaction (+ / -)	N/A	N/A	Single sex accommodation breach	Inappropriate enforcement /care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS) Repeated single sex accommodation breach	Systematic failure to provide an acceptable standard of safe care to multiple patients Systematic failure to provide Single sex accommodation affecting multiple patients
Responsive **By responsive, we mean that services meet people's needs.** e.g. • Backlogs (+ / -) • WLIs (+ / -) • End of Life Care plans (+ / -) • Interpreters (+ / -) • Patient choice (+ / -) • Patient satisfaction (+ / -) • Patient pathways	Negligible disruption Zero patients waiting 52+ weeks No ambulance handovers >30 mins No ED waits >4hours	Minor disruption to the delivery of the service/activity. No stoppage of activities as a result. Recovery will be swift. Patients Follow up Clinic rebooked later due to a Diagnostics Reporting delay Patients waiting between 52-78 weeks No ambulance handovers >60 mins	Moderate disruption to the delivery of the service/activity. Any stoppage to activities not breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may take time Single instance of a cancelled operation or operation cancelled on the day Patients not re-booked within 28 days following cancellation of surgery Whole patient cohorts delayed due to systematic Diagnostic reporting delays Appointment cancelled due to lack of interpreter	Major disruption to the delivery of the service/activity. Stoppage to activities breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may take significant time Multiple patients not re-booked within 28 days following cancellation of surgery Repeated cancelled operations or multiple operations cancelled on the day Failure to appropriately prioritise patients on a waiting list / failure to appropriately manage long term follow ups Multiple clinically	Extreme disruption to the delivery of the service/activity. Stoppage to activities breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may not be possible Growing backlog of patients waiting 104+ weeks Growing % of ambulance handovers >60 mins Growing number of ED waits >12hours

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
			Clinically inappropriate bed move(s) for a patient in the last stages of life Patients waiting between 78-104 weeks Single instance of ED wait >12hours Single instance of a 12 hour trolley wait	inappropriate bed moves for a patient in the last stages of life Patients waiting 104+ weeks (inc patient choice, capacity breaches and complex cases) Ambulance handovers >60 mins Multiple ED waits >12hours Multiple 12 hour trolley waits	
Effective **By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.** **e.g.** • Compliance with NICE guidance (+ / -) • Extend LoS or increased readmissions • Out of date / lack of / non-compliance with SOPs • Staff training & education required to undertake their roles & responsibilities (+ / -) • Clinical supervision (+ / -) • Benchmarking against comparable peers (+ / -)	N/A	Single breach of NICE guidelines (or where derogation agreed , breach of Trust policy) Increase in length of stay by 1-3 days	Out of date / lack of / non-compliance with SOP Failure to complete essential to role training Increase in length of stay by 4-15 days External review or assessment of a clinical service resulting in immediate actions and recommendations	Multiple breaches of NICE guidelines (or where derogation agreed, breach of Trust policy) Increase in length of stay by >15 days Failure to address or resolve immediate actions and recommendations from an external review or assessment of a clinical service	N/A
Well led **By well-led, we mean that the**	Inspection or audit resulting in a small	Inspection or audit resulting in recommendations made	Inspection or audit resulting in challenging	Inspection or audit resulting in enforcement / prohibition	Inspection or audit resulting in prosecution,

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture **e.g.** • Capacity & capability (+ / -) • Strategy & planning (+ / -) • Succession planning & business continuity (+ / -) • Wellbeing (+ / -) • Stress (+ / -) • Staff satisfaction (+ / -) • Assessment and accreditation • Statutory duties (+ / -)	number of recommendations which focus on minor quality improvement issues Rumours	which can be addressed by low level of management action Minor, short term reduction in public, commissioner and regulator confidence Multiple deceased patients included in survey mailing Single breach of regulatory duty Adverse local media coverage <3 days Staff member requiring time off work <7 days	recommendations that can be addressed with appropriate action plan or an Improvement Notice Significant, medium term reduction in public, commissioner and regulator confidence Single breach of regulatory duty with Improvement or Warning Notice Adverse local media coverage >3 days Staff member requiring time off work 7-14 days	action, low rating or Critical report Widespread reduction in public, commissioner and regulator confidence Large volumes of patient activity (a whole weekly clinic) not recorded on systems that support business decision-making and payment Multiple breaches in regulatory duty with subsequent Improvement or Warning Notices and enforcement action Adverse national media coverage <3 days Activation of Major Incident Plan (by provider, commissioner or relevant agency) Staff member requiring time off work >14 days	zero rating or severely critical report Total loss of public, commissioner and regulator confidence External submission of data leading to a False or Misleading Information Offence Multiple breaches in regulatory duty with subsequent Special Administration or Suspension of registration / prosecution Adverse national media coverage >3 days

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Use of resources **By use of resources we mean delivering value for money, evidencing both efficiency and effectiveness. e.g.** • Fraud (+ / -) • Breach of Data protection & data security (+ / -) • External review (+ / -) • Peer review (e.g. GIRFT) (+ / -) • Environment • Research and innovation • IM&T	0 - £50K annual impact	£50k - £100K annual impact Single data breach; internal dissemination of data without appropriate consent Minor onsite release of substance	£100k – £1m annual impact External review or assessment resulting in immediate actions and recommendations Single data breach; external dissemination of data without appropriate consent + ICO reportable Co-morbidities to describe patient complexity frequently omitted from clinical documentation Onsite release of substance contained with potential contact with patients, staff or members of the public.	£1m - £5m annual impact Failure to address or resolve immediate actions and recommendations from an external review or assessment Multiple data breaches / data breach; dissemination of large scale data at department level externally / deliberate (when proved); breach of data for personal gain; potential media involvement; ICO reportable Special Measures (finance or quality) On-site release with potential for detrimental effect leading to off-site release with potential for detrimental effect. Involvement by the Environmental Agency	Annual loss > £5 million impact Extreme data breach of total data held by the Trust sent externally either through accident or deliberate means; wide scale reputational damage / media involvement; ICO reportable Sustained Special Measures (finance & quality) Onsite/Offsite release with realised detrimental/ catastrophic effects Suspension of activity by Environmental Agency

How to assess likelihood: The likelihood reflects how likely it is the risk event described will occur with the current controls and / or further actions in place.

Likelihood score	1	2	3	4	5
Descriptor	**Extremely unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Qualitatively:	Will probably never happen/recur. Unlikely to happen except in very rare circumstances.	Do not expect it to happen/recur. Unlikely to happen except in specific circumstances.	Might happen or recur occasionally. Likely to happen in a relatively small number of circumstances.	Will happen/recur but it is not a persisting issue. Likely to happen in many but not most circumstances.	Will happen/recur frequently. More likely to happen than not.
Probability:	Less than 1 chance in 1,000 (< 0.1% probability).	Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability).	Between 1 chance in 100 & 1 in 10 (1- 10% probability).	Between 1 chance in 10 & 1 in 2 (10 - 50% probability).	Greater than 1 chance in 2 (>50% probability).

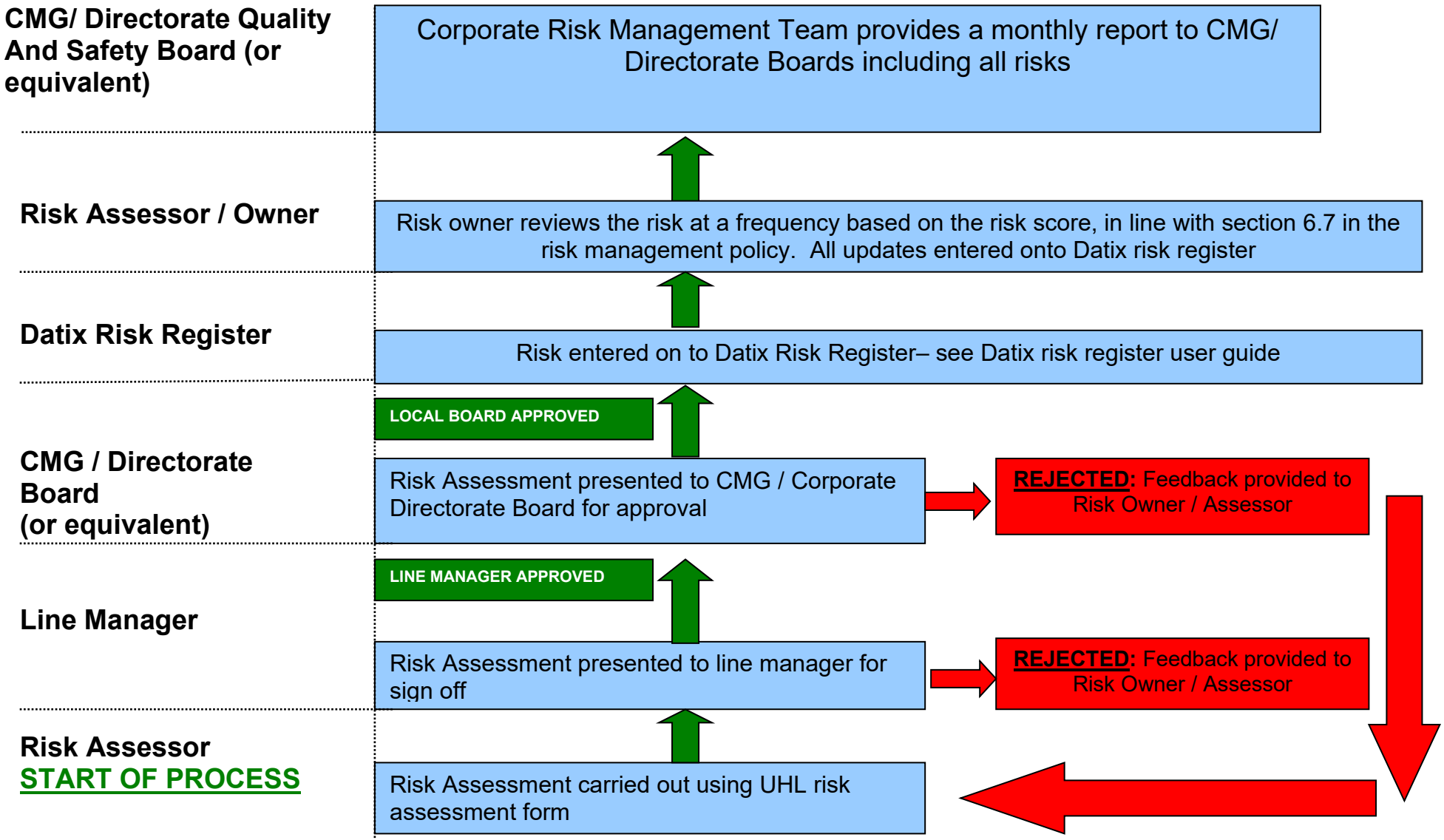
Risk matrix: The risk score is calculated by multiplying the impact score by the likelihood score.

	← Impact →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Extremely unlikely	**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**

SUGGESTED ACTION REVIEW PERIODS	
Low (1 – 4)	Acceptable risk requiring no immediate action. Review annually.
Moderate (8 – 12)	Review at least quarterly. Place on risk register.
High (15 – 20)	Review at least monthly. Place on risk register.
Extreme (25)	Review weekly. Place on risk register.

Note: The Risk Register is a publicly accessible document and published on the Trust's external website (within the Trust Board papers).

RISK MANAGEMENT ASSESSMENT ESCALATION PROCESS (included as part of Risk Management Assessment form)



Appendix four – Datix Risk Register User Guide

UHL Datix Risk Register User Guide	University Hospitals of Leicester NHS NHS Trust

1. Introduction

1.1 This guidance is intended to provide support to Datix users in relation to data entry and searching for risks on the UHL risk register. Access to the Datix risk register should be via the VM Ware Horizon Client on the desktop screen.

2. Scope

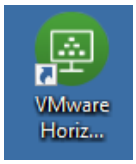
2.1 All staff having responsibility for data entry and searching for data within the UHL risk register.

3. Recommendations, Standards and Procedural Statements

3.1 When risk assessments have been performed the information must be transferred to the 'Datix' Risk Register in line with the Trust's Risk Management Policy. A fully completed action plan to reduce the risk must accompany each risk register entry (see section 3.3). Actions must be specific, measurable, achievable, realistic and timely (SMART).

3.2 Adding a Risk to the Risk Register

3.2.1 You must access Datix Risk Management V14 Rich Client version via the 'Vmware Horizon Client' icon (1) on your Desktop. Then select the UHL Desktop Anywhere icon (2).

(1) 

(2) 

3.2.2 Log into the virtual desktop by using the username and password you use to login to your PC. Select the UHL Staff Desktop Tool then access Datix (Rich Client version) via the Windows Start Menu.

3.2.3 Open the Datix Risk Management Folder and click on the Datix Risk Management icon. Enter your Datix username and password to login.

3.2.4 If you don't have a Datix risk register login, complete the registration form: http://datix.xuhl-tr.nhs.uk/datix/live/index.php?action=register

3.2.5 Following login to Datix click on the yellow risk triangle at the top of the screen, ⚠ then click on the '***NEW'*** tab (symbolised by a pencil and paper along the same tab/row).

3.2.6 Complete the risk register fields as required. A number of these are mandatory (identified by a red outline) and must be completed to allow the record to be saved. Many fields incorporate drop down menus that can be accessed by using the arrow at the right hand side of the field. The following table provides further detail on how to complete the risk register module. **Please note that fields indicated by an asterisk (*) are mandatory.**

Field	Information required
Title	**The title should be included as a statement in the 'description' section.**
Ref No	This field can be left blank, unless you have a local referencing system within your department that you wish to refer to.
ID	A Datix generated reference number. Users cannot enter data into this field.
Site*	Select from the drop-down list the site or sites that are affected by the risk.
CMG*	Select from the drop-down list the CMG or directorate affected by the risk.
Specialty	Select from the drop-down list the specialties within specific directorates

	affected by the risk (**NB:** if you require additional specialties to be added please contact the Datix Manager on ext. 18562).
Location (type)	Select the type of location affected by the risk (if applicable) (**NB:** if you require additional specialties to be added please contact the Datix Manager on ext. 18562).
Location (exact)	Select the exact location that is affected by the risk (if applicable).
Risk Type	**THIS FIELD IS NOT CURRENTLY USED**
Risk Subtype*	Select from the drop-down list the risk subtype (domain) that scores highest on the risk assessment.
Objectives	Users need not enter data into this field. The corporate risk team will link risks to the Trust's objectives.
Assurance Sources*	Identify either **Internal** or **External** sources of risk information (i.e. how have you identified that a risk is evident). This may relate to inspections / reports from sources such as HSE, Care Quality Commission, internal /external audits, internal policies and procedures, etc. Select from the multi-pick field.
Handler	This field is populated automatically with the name of the person who is logged in to record the risk. (Please note if you require additional names to be added to this list, please contact the Datix Manager on ext. 18562).
Manager*	Select a name from the drop-down list of the person that will be responsible for managing the risk. (Please note if you require additional names to be added to this list, please contact the Datix Manager on ext. 18562).
Description*	**NB: The field can be expanded for easier viewing by pressing 'Ctrl' and 'E'.** Risks must be described as a statement using the **If … caused by… then…** approach. Descriptions should avoid abbreviations that may not be understood by people external to the organisation.
Controls in place*	**NB: The field can be expanded for easier viewing by pressing 'Ctrl' and 'E'.** Describe the measures that are already in place to control the risk under the heading's 'preventive', 'detective' and 'corrective'.
Approval Status	**THIS FIELD IS NOT CURRENTLY USED.**
Risk rating*	Enter the impact and likelihood descriptors from the drop-down menus The risk rating will be entered in three fields as follows: - **Initial*:** The impact and likelihood descriptors at the time of assessment with no controls in place. **Current***:At first this field will reflect the 'initial' impact and likelihood descriptors however this field should be revised following periodic reviews of the risk action plan to reflect the level of risk at the time of the review. When all actions have been implemented it is expected that the rating will be the same as the 'target'. **Target*:** The impact and likelihood descriptors applicable if the actions to mitigate the risk are fully implemented**.**
Rating	Automatically populated by Datix once the risk impact and likelihood descriptors have been entered.
Level	As above.
Cost of risk	An estimate of costs to the Trust if the risk came to fruition (if known)
Investment	Automatically populated from any figures entered in the 'Cost' column of the action plan.
Type	If costs have been identified, please specify whether the costs are actual or estimated.
Adequacy of Controls	Specify whether these are Adequate, Inadequate or Uncontrolled.
Field	**Information required**
Cost/Benefit	Automatically populated by Datix if costs are entered on the action plan. The cost benefit is the cost per risk point between the initial and target score and is calculated by dividing the investment cost by the difference between the initial score and the target score.
Review Date*	A future date must be entered when the risk will be reviewed (in line with

	review frequency outlined in the UHL Risk Management Policy). **NB:** When an action has been completed it should be entered as a 'control' and the current score revised if appropriate to reflect the lower risk.

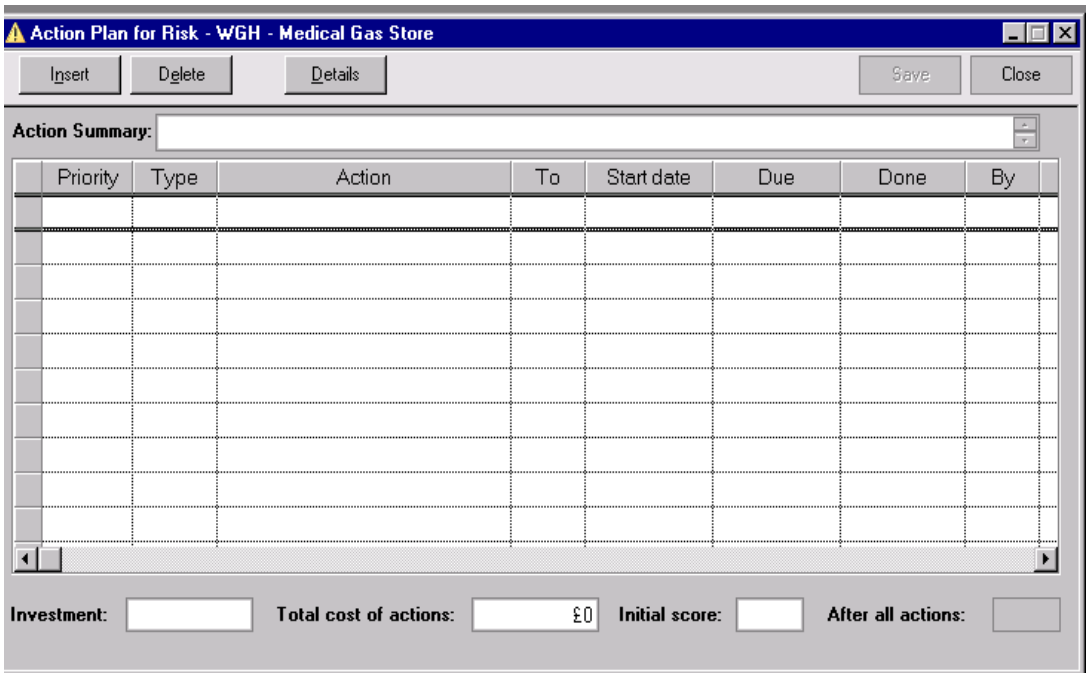
3.2.7 When all information is entered, click '***SAVE'***. This will generate a risk ID reference.

3.2.8 A scanned copy of the risk assessment form, signed off by the CMG / Directorate Board, must be attached to the entry on the risk register. See section 3.4 for attaching documents.

3.3 Completing a Risk Action Plan

3.3.1 After saving the risk the ***'ACTION'*** function button (tab) at the right of the risk register screen will become active (i.e. not greyed out).

3.3.2 Click on the ***ACTIONS*** tab, located on the right hand side of the main risk register screen and you will be presented with this screen:



3.3.3 Fields within the action plan must be completed as follows:

3.3.4 **Action Summary**

NB: To more easily visualise content this field can be expanded by pressing 'Ctrl' and 'E'.

A list of actions to further control (reduce) the risk must be added in this section. An estimated completion date must be entered alongside each action in the ***'Due'*** field. Actions listed in the ***'ACTION'*** field in the main body of the screen must also be copied into the ***'ACTION SUMMARY'*** above.

3.3.5 Complete the Action summary with a brief description of your open actions and their due dates/owners as per the actions in your Action Log; Note, you can copy the 'short descriptions' and paste in the Action summary section. Then click on '***D*ONE'**.

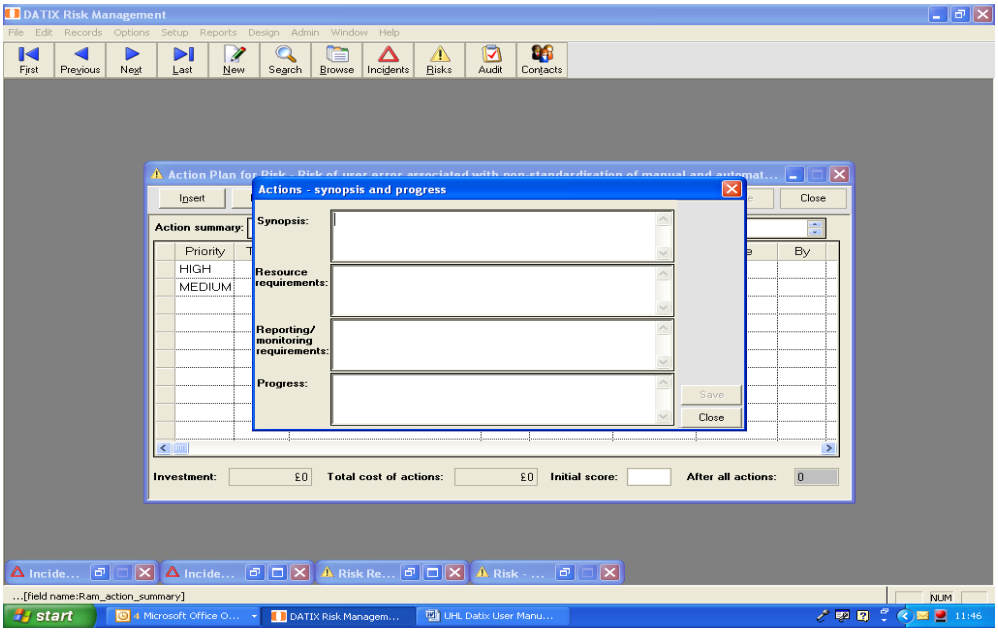
3.3.6 Below the action summary field is the main body of the action screen. This allows further details about the actions to be entered (e.g. date that action is due to start, date the action is due to be completed, accountable person/s, etc). Click '***INSERT'*** and a single line will be highlighted in the screen. For the highlighted line the following information is required.

Field	Information required

Priority (optional)	Assign a priority of high, medium or low if relevant.
Type	**Field not currently in use.**
Action (mandatory)	Copy each action from the *'Action Summary'* field using a separate line for each action.
To (mandatory)	Insert the initials of the person the action is assigned to.
Start (mandatory)	Insert the date the action is due to start.
Due (mandatory)	Insert the date the action is due to be completed. This field must be updated when necessary to reflect any changes to timescales.
Done (mandatory)	Insert the date the action is completed.
By (mandatory)	Insert the initials of the person who has completed the action(s).
Cost (optional)	Insert any cost associated with each action (if known). These will automatically populate the 'investment' field and will enable Datix to calculate a cost/ benefit analysis
Cost Type (optional)	Specify whether the costs are capital or revenue or charitable funds (i.e. non-exchequer funded).

3.3.6 In instances where multiple actions are required, click ***INSERT*** to highlight a specific line for each of the actions. **IMPORTANT:** When an action is complete the ***'Done'*** field within the action plan must have a date inserted and in addition the word *'COMPLETED'* must replace the date alongside the relevant action in the *'ACTION SUMMARY'* field.

3.3.7 Additional information can be added to each action (if required) by accessing the fields shown below.



3.3.8 The fields shown in the screen shot above are accessed by clicking on '***DETAILS'*** (above the action summary field). If information has been entered, click '***SAVE'*** then '***CLOSE'*** **to** return to the action plan screen.

3.3.9 Following completion of the action plan click '***SAVE' then 'CLOSE'*** and you will return to the main risk screen.

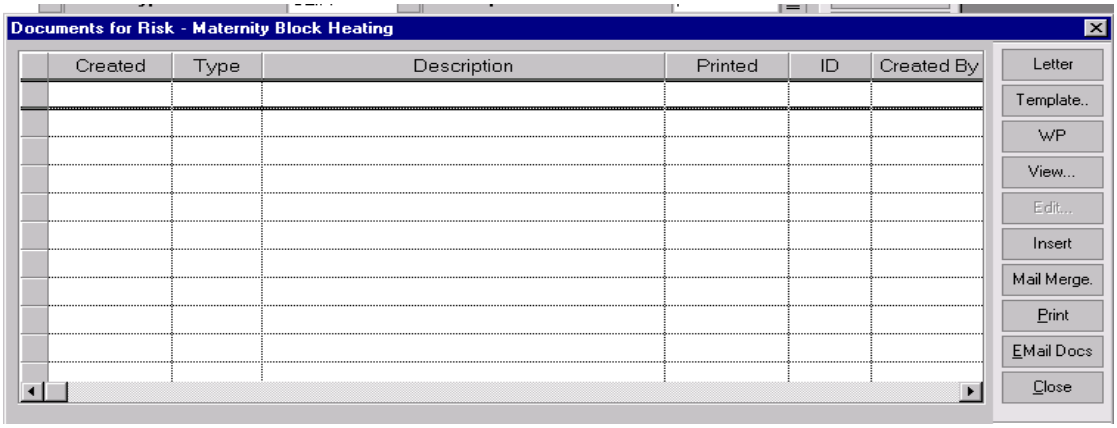
3.3.10 To update an existing action; please select the field requiring update and type in your update e.g., revised due date. Please note updating the **Actions** and their due dates in the **Action Log** does not update the ***'ACTION SUMMARY'*** field as this is a separate field. The detail about open actions in the Action Log and Action Summary field should mirror each other. Click in the ***'ACTION SUMMARY'*** field and press ***Ctrl and E*** to expand the box to update the information as per the detail in the Action Log. Then click on ***'DONE' and 'SAVE'***.

3.3.11 Note: If you have completed an action to treat a risk down you may need to change the current risk score on the home screen. The current score may change if an action can't be taken and a risk score may need to increase.

3.3.12 Select '***SAVE' then 'CLOSE'*** to return to the front screen of the risk record. Select ***'FILE then EXIT'*** to leave Datix.

3.4 Attaching Documents

3.4.1 To attach documents (e.g. an electronic copy of the original risk assessment form, etc) click on the '***DOCUMENTS'*** tab, located to the right of the main risk screen and the screen below will be displayed.



3.4.2 Click '***INSERT'*** and double click the required document from your PC drive(s). Once selected a ***'DOCUMENT EDIT'*** screen will appear. Within this screen enter the item description. Please ensure this is a clear identifier for the document.

As a minimum a copy of the completed risk assessment form must be attached or where the assessment has been entered directly on to the risk register there should be some form of correspondence to demonstrate approval of the risk assessment.

Click '***SAVE'*** and the document will now be attached to the risk entry.
Repeat the process for any additional documents.

3.5 Using Notepad

This facility can be used to make short notes (e.g. notes of discussions, telephone calls, etc) and is accessed by clicking 'NOTEPAD' on the main risk register screen.

Note: Details entered in the ***NOTEPAD*** field will not be included within Datix generated reports.

4. Searching for a Risk on the Risk Register

4.1 Following login to Datix click on the yellow risk triangle at the top of the screen, ⚠ then click on the '***SEARCH'*** tab (symbolised by a magnifying glass along the same tab/row).

4.2 If the risk register reference number is known then this should be input in to the ***'ID'*** box on the main risk assessment (NEW QUERY) screen. Click ***'START'*** to search for the risk.

4.3 If the risk register reference number is not known, the table below describes how to perform a new search:

Search symbol	Fields to search	Information required
*	Title / description / controls	The asterisk is used to tell Datix that your search criteria include a number of unknown characters. e.g. A search under BROWN* will retrieve all risks beginning with BROWN,

		i.e. BROWN, BROWNE, BROWNING etc. The asterisk can also be used for key word or phrase searches, e.g. *infusion* will retrieve all risks with the word infusion in the specific search field chosen. Type the 'word' with the asterisk/s and then select the Start button.
:	Opened date / reviewed date / closed date	The colon allows you to search for a range of variables by specifying start and end dates. e.g. 01/01/XX:31/03/XX will retrieve risks for the first quarter of 20XX.
<	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'less than' symbol enables you to search for value less than a specified amount, or dates before a specified date. e.g. <01/01/XX will retrieve risks for before 1st January 20XX.
>	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'more than' symbol enables you to search for values greater than a specified amount, or dates after a specified date. e.g. >01/01/XX will retrieve risks after 1st January 20XX.
Search code	**Fields to be used**	**Information required**
'Is null' or '=0'	Closed date	If this is entered in the closed date field, it will retrieve all records which do not have data entered in that field. For example if 'is null' is entered in the 'Closed date' field, only cases where there is no date in this field will be identified, i.e. records that are 'open'. This can be entered in upper or lower case.

5. Closing a risk on the Risk Register

5.1 Once a risk has been treated to its target risk score (which should have been endorsed by the CMG Q&S boards/ equivalent directorate boards as the score which is as low as reasonably practicable) the risk should be subsequently reviewed for a period of 6 months, prior to being closed on Datix risk register by entering the date when final action was treated in the closed date field. The risk will then not feature in the risk register reports generated (however it should be remembered that the risk is unlikely to have been eliminated, rather treated to as low as reasonably practicable and the detective control measures should continue to be monitored to ensure the risk does not increase in rating).

6. Running a report from the Risk Register

6.1 Following login to Datix, Select Risk Module  and click Search (symbolised by a magnifying glass along the same tab/row as the risk module). Search using the CMG drop-down field or by the risk ID (if known). Enter '=' into the Closed Date field to ensure the search if for only open risks. Click start to run the report.

Click on reports (on the very top row of the screen), select Custom Reports, scroll down to the bottom and select report: 'Trust Board / Executive Team' – whilst highlighted, double click or click on Run – and chose Excel. This will now export the report to Microsoft Excel.

Format the spread sheet including changing the font size to Ariel 8 and removing the bold font. It is recommended to format certain columns to change the alignment to -90 degrees and centre the data in these columns for improved presentation.

Report complete

Appendix: Five – KPIs and Audit Requirements

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
Effectiveness of UHL Risk Management Structure	Head of Risk and Assurance	Risk register review Observation of CMG Q and S Boards Observation/ feedback from exec boards and TB	Monthly Annually Annually	Risk management report to Risk Committee. Reports will identify deficiencies in the risk management system and make recommendations for improvement	Action plans will be developed by UHL corporate risk management team and implemented at a corporate or local level as necessary	Required changes will be actioned within time frame and lessons learned will be shared with all relevant stakeholders via executive boards, AC and CMG/ directorate boards.
Effectiveness of risk register	Head of Risk and Assurance	Risk register	Monthly	Risk management report to Risk Committee.	As above	As above
Board Assurance Framework	Head of Risk and Assurance	BAF reports to TB, Executive meetings, and AC in line with reporting framework	Monthly	Risk management report to Risk Committee. BAF report to TB and AC	As above	As above
Local management of risk	Head of Risk and Assurance	Risk reports to CMG/ directorate Q and S boards in line with reporting framework	Monthly	Report to AC	As above	As above
	Head of Risk and Assurance	Actions to mitigate risks being taken within timescales	Monthly	Monthly to CMG Q and S boards Monthly to Risk Committee Report AC	As above	As above
	CMG/ Corporate Directors and Managers	Risks being reviewed at local level at the frequencies defined within Risk Management Policy	Monthly	As above	As above	As above