To:	**Trust Board**
From:	**Medical Director**
Date:	**30 May 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL Risk Management Policy**

Author/Responsible Director: Medical Director

Purpose of the Report:
The report provides the Board with a summary of changes to the revised UHL Risk Management Policy.

The Report is provided to the Board for:

Decision		Discussion	**X**
Assurance	**X**	Endorsement	**X**

Summary :

- The draft policy was subject to a consultation exercise during April and May 2013 with divisions, corporate directorates and members of the UHL Policy and Guidelines Committee having the opportunity to comment on the content. Following this consultation the draft was endorsed by the UHL ET at the meeting on 7 May 2013 and was presented to the Audit Committee on 28 May 2013 for consideration prior to final ratification by the Board.
- **Changes of particular note include:**

a. The requirement for risk assessments to be approved by local boards prior to risk register entry.
b. The corporate risk team to provide local management teams with monthly risk reports.
c. Trust Board to receive a twice-yearly report of all risks scoring 15 and above.
d. Executive Team to receive twice-yearly reports showing all risks scoring from 8 – 12.
e. Updated risk reporting/ escalation framework.

- **Further points for consideration:**

a. A proposal to provide the Board with a monthly report of all new high risks opened in month supplemented by a quarterly report of all high risks (as opposed to a twice yearly report previously described in the policy).
b. Acknowledgement that the policy has been revised to help close the gaps identified in reviews and that following implementation a period of time will be required for the new processes to be fully embedded at all levels of the organisation (approximately 3 months).

- It is proposed that following a period of implementation for the new processes outlined in the policy that further reports are provided to the Audit Committee to provide assurance of improvement and effectiveness of processes.

Recommendations:
The Board is invited to:

a. Receive and note this report;
b. Consider and advise in relation to the proposal for monthly reporting of new high risks to the Board:

c. Consider the proposal to monitor the effective implementation of the RMP by regular assurance reporting to the Audit Committee: d. Recognise the need for a period of stability in relation to risk management processes in order to enable the Trust to embed current processes: e. Endorse the RMP subject to any amendments agreed by the Board.	
Strategic Risk Register No	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? No	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 MAY 2013**

REPORT BY: **MEDICAL DIRECTOR**

SUBJECT: **UHL RISK MANAGEMENT POLICY**

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1 INTRODUCTION

1.1 During the last 12 months the UHL risk management framework has been a subject of review by a number of agencies including Ernst and Young, RSM Tenon, the National Health Service Litigation Authority (NHSLA) and our internal auditors Price Waterhouse Cooper (PWC). Recommendations from these reviews have identified changes to improve risk management processes at UHL; furthermore our own internal assurance mechanisms have also highlighted deficiencies within existing processes. This does not mean that our current risk management processes are not fit for purpose but rather that there is scope for improvement to reflect best practice and to ensure that risk management adds value to the organisation.

1.2 The risk management framework has previously been described in two documents these being the UHL Risk Management Strategy and the UHL Risk Assessment Policy and it appeared sensible to attempt to amalgamate the two documents into a single policy renamed the UHL Risk Management Policy (RMP) and to ensure that the relevant changes to address recommendations from reviews are included.

1.3 The UHL RMP (attached at appendix one) has been developed over a number of months and was originally intended to be launched at the end of 2012, however in light of the outcome of reviews described above and ongoing organisational changes, including those listed below, it was felt best to postpone the original launch to ensure that all items were captured in the new document. Organisational changes were as follows:

- Changes of Chief Executive Officer
- Changes to Executive Director portfolios
- Changes to UHL committees and reporting lines
- Changes divisional structure

1.4 The draft RMP was subject to a consultation exercise during April and May 2013 with divisions, corporate directorates and members of the UHL Policy and Guidelines Committee having the opportunity to comment on the content. Following this consultation the draft was endorsed by the UHL ET at the meeting on 7 May 2013 and will be presented to the Audit Committee (AC) on 28 May 2013 for consideration prior to final ratification by the Board.

1.5 This report provides the Board with a summary of changes to the RMP and the Board is asked to consider and endorse the new policy.

2. SUMMARY OF CHANGES

2.1 Appendix two provides a summary of the changes to the RMP and the rationale for their inclusion. Appendix three provides a summary of recommendations from reviews/ audits and each change in appendix two is cross referenced to the relevant recommendation(s) in appendix three.

2.2 Of particular note is:

a. **The requirement for risk assessments to be approved by local boards prior to the risk being entered on to the risk register.**
This is intended to improve risk data quality by ensuring that risks are accurately portrayed along with SMART actions to reduce the level of risk. It will avoid the situation where senior management teams are unaware of the risks at an operational level until they have already been entered on the risk register. This is not anticipated to significantly increase the administrative burden of local teams as a recent review of the risk register has shown a total of 33 risks opened across the Trust during a 16 week period (1 January – 21 April 2013) therefore averaging two per month.

b. **The corporate risk management team to provide local management teams with monthly risk register reports**.
These reports will contain:
- All open risks with a score from 8 – 25 (moderate to extreme).
- Risks with an overdue review date.
- Risk with a review date during the current month.
- A list of risk action plans with an elapsed 'action due' date.

This is intended to enable more consistent risk reporting and risk review by local boards and will significantly reduce the administrative burden of report production at local levels. Local Boards will be able to sort and filter this data to provide specific information in relation to their risks.

c. **Trust Board to receive a twice-yearly report of all risks scoring 15 and above (high and extreme).**
This will provide the Board with:
a. An opportunity to scrutinise the detail of risks at an operational level;
b. To provide assurance of the effective management of risks;
c. Enable a line of sight from 'ward to Board';

d. **Executive Team to receive a twice-yearly report showing all risks scoring from 8 – 12 (moderate).**
This will provide ET with the opportunity to scrutinise the detail of risks at an operational level and hold divisions and directorates to account for the effective management of their risks, including challenge around risk reduction actions not completed within timescale.

e**. Updated risk reporting/ escalation framework**
In order to achieve the effective escalation of relevant risks, thereby ensuring line of sight from 'ward to Board', it is important that local boards and senior Trust committees understand their accountabilities and discharge their responsibilities as outlined in the Risk Management Policy and in particular, the role of the ET in holding to account divisions and directorates for the effective management of their risks and identifying those risks for onward reporting to the Board.

f. Updated flowcharts for the risk escalation process (appendix 1, pages 27 and 40 of the policy) are included to provide staff with an 'at a glance' description of the process.

3. POINTS FOR CONSIDERATION

3.1 Following endorsement of the policy at ET, and subsequent discussions, it has been noted that even with twice yearly reporting of high risks to the Board there is a risk that there may be a 'blind-spot' due to lack of real-time reporting. To help bridge this gap the Board is asked to consider a proposal to receive a monthly report of all new high risks opened in that reporting period and supplemented by a quarterly report of all high risks open within the Trust. This is not anticipated to significantly increase the Board agenda time as the average number of high risks opened per month (based on the period April 2012 – March 2013) is two.

3.2 Whilst the processes are described to improve the escalation and accountability for risk it is incumbent upon the Board, other Trust committees and in particular local boards to understand their accountabilities and responsibilities in relation to risk management and to discharge them accordingly. Weaknesses in challenge at divisional / directorate board level could have more significant repercussions further on in the risk management chain.

3.3 The previous 12 months have seen almost constant incremental changes to risk management processes in response to organisational changes, reviews and audits and the Trust would now benefit greatly from a period of stability in relation to this. There needs to be acknowledgement that the RMP has been revised to help close the gaps previously identified and following implementation a period of time will be required for the new processes to be fully embedded at all levels of the organisation. It is proposed that the UHL Audit Committee continue to receive regular risk reports to provide assurance of improvement and effectiveness of risk management processes.

4. RECOMMENDATIONS

4.1 The Board is invited to:

a. Receive and note this report;
b. Consider and advise in relation to the proposal for monthly reporting of new high risks to the Board;
c. Consider the proposal to monitor the effective implementation of the RMP by regular assurance reporting to the Audit Committee;
d. Recognise the need for a period of stability in relation to risk management processes in order to enable the Trust to embed current processes;
e. Endorse the RMP subject to any amendments agreed by the Board

P Cleaver
Risk and Assurance Manager
18 May 2013

University Hospitals of Leicester NHS
NHS Trust

RISK MANAGEMENT POLICY

Approved By:	**Policy and Guidelines Committee**
Date Approved:	
Trust Reference:	**A12/2002**
Version:	**4.0 (May 2013)**
Supersedes:	**October 2011 version**
Author / Originator(s):	**Corporate Risk Management Team**
Name of Responsible Committee/Individual:	**Peter Cleaver**
Review Date:	

CONTENTS

REVIEW DATE AND DETAILS OF CHANGES MADE DURING REVIEW

Document reviewed and revised April 2013 to combine the previous UHL Risk Management Strategy and UHL Risk Assessment Policy.

Section 4
4.1: Definitions for strategic risks, operational risks, risk register, risk appetite, and Board Assurance Framework (BAF) are now included.

Section 5
5.2.1 – 5.2.3: Update to roles and responsibilities including changes to director portfolios.
5.2.4: Addition to include risk assessments must be approved by divisional / directorate Boards prior to entry onto the risk register.
5.2.10: Addition of Occupational Health Physicians and Nurses, Infection Prevention Team, Research & Development Manager.
5.3.2: Update to include the Trust Board will also receive a twice yearly report to show risks scoring 15 or above on the risk register from the corporate risk management team.
5.3.3: Update to role of Audit Committee to receive at each meeting a report comprising the BAF and high risks in addition to any further ad-hoc reports requested to provide assurance.
5.3.4: Removal of regular reporting to QAC (formerly GRMC).
5.3.4: Update to role of ET to receive a monthly update of the BAF and a report showing risks scoring 15 or above and a twice yearly report showing risks scoring between 8 and 12 (moderate risks). Update to function of ET to ensure that Divisional Directors are held to account in relation to the effective management of high risks and their mitigations.
5.3.5: Update to role and function of QPMG to receive risk report on quarterly basis instead of monthly.
5.3.6: Update to include divisional and directorate Boards will receive monthly and quarterly risk register reports from the corporate risk management team. Also, on a monthly basis will receive new risk assessments from their CBUs for approval prior to entry on the risk register and an update to the function of this confirm and challenge exercise. Also, clarification that risk register review must be a standing agenda item at each local board and adequate notes must be recorded and retained to reflect the risk discussions.
5.3.7: Update to role of CBUs to submit new risk assessments to the divisional / directorate Boards.

Section 6
6.7.3: Clarification that low risks do not need to be added to the risk register.
6.7.4 – 6.7.6: Clarification that new risks must be approved by divisional and directorate Boards prior to risk assessment details being transferred on to the risk register and a scanned copy of the approved risk assessment form attached on to the risk register.
6.8.1: Updated to title of BAF to remove SRR element.

Appendices
Appendix one: Job descriptions for key personnel removed from appendices and replaced with role summaries.
Appendix two: Risk reporting framework updated to reflect updates to roles of executive and assurance functions.
Appendix three: Datix risk register user guide included in prescribed UHL format.
Appendix four: Key performance indicators included in prescribed UHL format.
Appendix five: Includes redesigned risk assessment form to capture minimum risk dataset and to include new approval process. Consequence table and likelihood scores now integrated in the risk scoring matrix.
Appendix six: New risk assessment escalation process included in a flowchart.
Terms of reference for Trust committees removed from appendices.

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 governance (incorporating Information Governance and Research Governance), finance and mandatory services, clinical, 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 not solely the responsibility of the Trust's Risk and Safety Managers but 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 a Statement on Internal Control, 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 'Trust Board') is committed to ensuring the implementation of risk management and ensuring that risk management is embedded into the culture of the organisation to enable an environment which minimises risks and promotes the health, safety and well being 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 and as far as is reasonably practicable.
d. Action is taken on recommendations from inspecting bodies.
e. Full 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. Evidence based practice in all aspects of care and treatment.
h. All Trust staff are trained and competent in their roles.
i. Senior Trust staff (for the purpose of this policy defined as band 7 and above, including Trust Board members) receive risk awareness training commensurate with their role.
j. 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.
k. To secure optimum levels of investment (staffing and other resources) in the management of risk.
l. Strategic and operational objectives (i.e. organisational, divisional / directorate and CBU/ department) and the risks to their achievement are described.

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 including risks arising from significant partnerships and other external factors.
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 for further controls are fully completed. Acceptable level is reached where risks are reduced in line with statutory requirements and/or so far as is reasonably practicable.
i. Integrate risk management with quality and performance management arrangements to become an integral part of the business planning and objective setting processes of clinical divisions 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 Care Quality Commission registration standards, Foundation Trust Compliance framework, and the NHS Litigation Authority (NHSLA) risk management frameworks.
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 Health and Safety process.

4 DEFINITIONS

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 severity (impact or consequence on the organisation if the risk occurs).

Cause (Hazard): Something with the potential to cause harm.

Consequence (harm / loss event): The harm or loss event caused by the hazard.

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.

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 an acceptable level.

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

Operational Risks: Risks identified at divisional/ directorate or Clinical Business Unit (CBU)/ department level.

Risk Register (Datix): The Trust's database of divisional/ CBU/ directorate/ department risks.

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

Board Assurance Framework (BAF): A document identifying the Trust's strategic objectives, the key risks to the achievement of these, the controls required to mitigate these risks, the assurance sources to prove that controls are effective, gaps in controls and assurances, and actions to remedy these.

5 ROLES AND RESPONSIBILITIES

5.1 Organisational Structure

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

5.1.2 The Chief Executive has overall responsibility for risk management and discharges this through the designated accountability of other Executive Directors for different aspects of risk management.

5.1.3 Executive and Corporate Directors are collectively and individually responsible for the management of risk, and in particular for the areas included in their portfolios and as reflected in their individual job descriptions. These responsibilities will be discharged through Divisional Directors and Managers and Directorate Managers.

5.1.4 The discharge of these responsibilities is overseen and supported by a number of Trust committees that are ultimately accountable to the TB (see section 5.3). Each committee is formally constituted, and has approved terms of reference.

5.2 Roles and Responsibilities

5.2.1 Chief Executive

Is responsible for establishing and maintaining an effective risk management system within the Trust to meet all statutory requirements and adhere to guidance issued by Monitor and the Department of Health 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 strategic goals and objectives. The Chief Executive is supported in the role by the Executive and Corporate Directors below:

5.2.2 **Executive Board Directors:**

Chief Nurse

Is responsible for driving the quality, safety and risk agenda in the Trust. This will include being accountable for the processes to enable the Trust to achieve compliance with the CQC registration standards and the NHSLA Acute Risk Management Standards (ARMS) and Clinical Negligence Scheme for Trust (CNST) maternity standards; leads on the Trust's fulfilment of its clinical governance and clinical risk management responsibilities; and also leads on health and safety management, patient safety and complaints management, Infection Prevention, safeguarding adults

and children, Information Governance, maintenance and development of the Trust's Central Alerting System (CAS) and risk registers.

Medical Director
Is responsible for the revalidation process of a doctor's licence to practise in the UK. This role will also lead on research and innovation and will have responsibilities around medical risk management.

Director of Finance and Business Services
Is responsible for financial risk management. The Director of Finance and Business Services is the Trust's Senior Information Risk Owner (SIRO).

Director of Human Resources
Is responsible for workforce risk management and service equality.

5.2.3 **Corporate Directors:**

Director of Communications and External Relations
Is responsible for minimising risks to UHL reputation.

Director of Nursing (Accountable to the Chief Nurse)
Is responsible for minimising operational risks in relation to to 'Safeguarding' issues.

Director of Corporate and Legal Affairs
Is responsible for corporate governance.

Director of Research and Development
Is responsible for minimising risks to research and development governance.

Director of Strategy
Is responsible for minimising risks to business development, and IM&T.

Director of Safety and Risk (Accountable to the Chief Nurse)
Is responsible for corporate risk and safety; including development and maintenance of the Trust's risk management and assurance framework. This role also incorporates that of Patient and Employee Safety Lead reporting to the Chief Nurse and with a direct link to the Chief Executive.

Director of Clinical Quality (Accountable to the Chief Nurse)
Is responsible for minimising risks in relation to compliance and external accreditation.

Director of Operations
Is responsible for the delivery of all operational targets, the line management of the clinical divisions (including Pathology) and any subsequent risks. This role is the lead for emergency preparedness including business continuity.

Director of Estates & Facilities
Is responsible for minimising risks to the estate, environment, security, water quality and fire.

Director of IM&T
Is the Trust's Chief Information Officer with responsibility for controlling risks to information, management and technology within the Trust.

Assistant Medical Director (Accountable to the Medical Director)
Is responsible for minimising risks to clinical education and training activities.

5.2.4 **Corporate Directors** / **Managers, Divisional Managers and Heads of Nursing** shall discharge their responsibilities for risk management by:

a. Ensuring adequate resources are made available to effectively manage risks within their areas of responsibility.
b. Ensuring risks to the achievement of divisional / directorate objectives are identified, assessed and effectively managed to minimise those risks as far as practicable.
c. Ensuring risk management is incorporated into all clinical and non-clinical processes (including divisional business processes).
d. Ensuring that this policy and other information related to risk management processes is disseminated 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 divisional / directorate managers and ensuring their attendance at relevant training events.
g. Ensuring Trust policies and other relevant national policies / strategies are translated into local procedures applicable to the work of the division or directorate.
h. Ensuring all Trust / local policies are implemented and that compliance with these policies is regularly reviewed/ audited.
i. Ensuring all staff have received corporate induction and specific local induction and are aware of their personal responsibility within the risk management process.
j. Act upon aggregated information from incident reports, complaints and claims to review and, where necessary, update working practice;
k. Providing feedback from Trust committees and/or divisional / directorate Boards to staff on the outcome of incidents, complaints, claims and risk reporting.
l. Ensuring new risks are approved by divisional / directorate Boards prior to entry onto the risk register.
m. Ensuring that risks are reviewed by divisional / directorate Boards.
n. Ensuring that evidence exists for all risk management activity to demonstrate that Trust standards and legal and statutory requirements are being met.

5.2.5 **Divisional 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 ongoing 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.

5.2.6 **CBU Medical Leads, CBU Managers**/ **Quality and Safety Managers** (or directorate equivalent) shall discharge their responsibilities for risk management by:

a. Ensuring that risks to the achievement of CBU or department objectives and all significant hazards inherent within work processes are identified, assessed, effectively managed and risk assessments submitted to divisional / directorate Boards for approval prior to entry onto the risk register.
b. Analysis and investigation of incidents, complaints, risks and claims and subsequent implementation of improvement strategies.
c. Ensuring accurate risk registers are maintained and that risks and mitigating actions are implemented and regularly reviewed in line with this document.
e. Ensuring health and safety, incidents, complaints, claims and risk management processes are embedded within CBUs / departments.

f. Ensuring there are sufficient competent people to perform risk assessments.
g. Ensuring that the results of risk assessments are brought to the attention of their staff group.
h. Seeking advice and guidance from the corporate risk team on any aspects of risk management that are beyond their knowledge and skills.
i. Identifying the risk management training needs of staff, and monitoring and ensuring their attendance at relevant training events.
j. Being accountable for the clinical division or corporate directorate management of the Central Alerting System (CAS) broadcasts.
k. Providing advice and support to staff in relation to incidents, inquests, claims, and complaints.
l. 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.

5.2.7 **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.

5.2.8 **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. Identify and attend appropriate risk assessment training programmes.
c. Support managers in the identification and assessment of risks.
d. Ensure new risk assessments are reviewed by CBU/Department Managers and Quality and Safety Managers (or directorate equivalent) at CBU Boards and presented at divisional / directorate Boards for approval prior to entry onto the risk register as part of the review and approval process.
e. Contribute to divisional / directorate training programmes for risk assessment and awareness.

5.2.9 **Corporate Safety and Risk Management Team**

There are specialist officers within this team with Trust wide roles relative to specific risk areas. These are: -

- Director of Safety and Risk
- Risk and Assurance Manager (corporate risk management team leader)
- Senior Safety Manager (clinical risk and complaints)
- Senior Health and Safety Manager
- Manual Handling Service Leader
- Head of Privacy (Information Governance)
- Local Security Management Specialist (LSMS)

Role summaries for the above posts are attached at appendix one.

5.2.10 The Trust employs other **specialist advisors** as listed below:

- Claims & Inquest Advisers

- Fire Safety Advisers
- Security Officers
- Radiation Protection Officer
- Occupational Health Physicians and Nurses
- Infection Prevention Team.
- Research & Development Manager

5.2.11 Roles described in sections 5.2.9 and 5.2.10 shall co-ordinate and support risk management activity within the Trust by:

a. Providing divisions and directorates with relevant advice, guidance and information.
b. Participating in the activities of Trust risk committees / groups as required.
c. Facilitating corporate risk management training and contributing where required to clinical division and corporate directorate risk management training programmes.
d. Providing risk assessment training for Trust staff.
e. Producing information materials on risk management within the Trust for staff, patients, stakeholders and the public.
f. Maintaining and developing the Trust risk register.
g. Advising the TB on risk management strategies for the Trust and clinical divisions / corporate directorates; auditing achievement in line with those objectives.
h. Developing corporate risk management tools.
i. Producing reports on risk management activities for relevant Trust committees.
j. Regularly auditing compliance against relevant policies.

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

5.3 Committee Structures and Reporting Arrangements

5.3.1 The risk reporting framework shall integrate across all established committees within the Trust that have responsibility for risk in order to create a culture of risk reporting and feedback. A reporting framework is attached at appendix two. Overarching committees with responsibility for risk are the Board Committees listed in 5.3.3 and 5.3.4 below, which report directly into the TB.

5.3.2 **Trust Board (TB)**

Will seek assurance of the implementation of risk management processes within the Trust and will be responsible for the identification of strategic risks, assessment and subsequent review of the Trust's BAF. On a day-to-day basis executive responsibility for clinical and non-clinical risk management shall be delegated in accordance with the portfolios set out in sections 5.2.2 and 5.2.3.

No less than four times per year the TB will receive an updated integrated BAF compiled by the corporate risk management team following discussions with the relevant Executive Directors.

Extreme risks (i.e. those scoring 25) identified as a direct threat to achieving strategic objectives will be reported to the TB from the UHL Executive Team as and when necessary.

The TB will also receive from the corporate risk management team a twice yearly report to show risks scoring 15 or above on the risk register.

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

a. 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 strategic risks to the organisation meeting its objectives;

d. Identify any gaps in assurances of the effectiveness of the controls in place to manage the strategic 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.

5.3.3 **Audit Committee (AC)**

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

a. Reviewing the BAF at each meeting, 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.
c. Seeking assurance that actions have been identified and implemented to address gaps in controls and assurances in the BAF.
d. Considering, in particular, 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.
e. Reviewing the results of assurances, either in whole or specific to a risk or objective, and the implications that these have on the achievement of objectives.
f. Reviewing the high risk register entries at each meeting 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 significant risks to relevant Trust committees and providing a line of sight for risks from 'ward to Board'.

In this way the AC provides assurance to the TB regarding its controls systems and supports the Statement on Internal Controls (SIC).

5.3.4 **Executive Team (ET)**

This is an Executive level group led by the Chief Executive that meets weekly. Membership includes Chief Executive, Executive and Corporate Directors, and Divisional Directors. It will receive notification of any risk with a score of 25 (extreme).

The ET will receive a monthly update of the BAF and a report showing risks scoring 15 or above (high risks). In addition the ET will receive a twice yearly report of all risks scoring from 8 to 12 (moderate risks).

The function of the ET is to;

a. Review and update the contents of the BAF prior to submission to the TB.
b. Identify any high /extreme risks from the risk register of strategic significance and decide whether the risk(s) are already inked to themes within the BAF or whether there is a requirement for a new strategic risk to be entered.
c. Ensure that Divisional Directors are held to account in relation to the effective management of risks and their mitigations. This will include monitoring of high and extreme risks on the risk register where there is one or more elapsed action due dates in order to ensure that risks are being effectively managed.

5.3.5 **Quality and Performance Management Group (Q&PMG)**

The Q&PMG is a sub-committee of the UHL ET and on a quarterly basis will receive:

a. A risk report detailing recent amendments to the risk register for risks scoring 15 or above.
b. An overview of developments within the risk management agenda.

The function of the Q&PMG will be to receive and note the content of the risk report.

5.3.6 **Divisional / Directorate Boards**

On a monthly basis will receive a report from the corporate risk management team identifying divisional/ directorate risks scoring from 8 to 25.

On a monthly basis will receive new risk assessments from their CBUs for approval prior to entry on the risk register (see appendix six).

The function of the divisional / directorate Boards will be to:-

i. Approve risks for entry onto divisional/directorate risk registers.
ii. Ensure relevant personnel are held to account for those risks within divisions / directorates.
iii. Ensure appropriate data quality in relation to the content of the risk register. This will include challenge and confirm to assure:
    a. The risk has a descriptive title.
    b. The risk description lists the causes and consequences of the risk.
    c. The documented controls are currently in place and are not future actions.
    d. The risk rating scores are accurate (current and target).
    e. The risk review date is current.
    f. Where a risk can be treated an action plan is included with explicit actions, realistic and achievable timeframes and responsible persons identified. As part of the review process, where an action due date has elapsed challenge is made to the risk owner about the reason why.
    g. The risk manager details are correct.
iv. Monitor action plans to ensure that actions are completed within specified timeframes.
v. Analyse risk themes across the division/ directorate in order to identify trends.
vi. Report any confirmed risks scoring 25 to the ET and corporate risk management team at the earliest possible opportunity.

The review of risk assessments and risk register entries must be a standing agenda item at each divisional/ directorate Board and the notes of the meeting shall evidence involvement in approving assessments and reviewing open risk register entries including monitoring control measures, and challenging risk ratings and action plans.

5.3.7 **Clinical Business Unit (CBU) Boards**

Will be responsible for:-

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

5.3.8 **Reporting to Commissioners**

All new high and extreme risks are reported to Commissioners each week as a requirement of the Quality Schedule.

6 POLICY STATEMENTS AND ASSOCIATED DOCUMENTS

6.1 Risk Appetite

6.1.1 The Trust will aim for a zero appetite for undue risks to the health and/or safety of its staff and others.

6.1.2 The Trust will aim for a zero appetite for undue clinical risks, 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 quality 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.

6.2 Risk Identification

6.2.1 The Trust is committed to reducing healthcare risks by undertaking risk management 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 Identification and assessment systems are vital to the success of the Trust's risk management process. There are a number of internal and external sources of risk identification that can be used and these are listed in sections 6.4.2 and 6.4.3.

6.2.4 Risks identified from these sources must be assessed to predict their likelihood to affect the organisation and the consequences on the organisation should they occur.

6.3 The Process for Assessing Risk:

6.3.1 The risk assessment process 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 identified. The responsibility for ensuring suitable and sufficient risk assessments lies with managers with support as necessary from the specialists within the Trust who can advise on health and safety, clinical risk, business risks, etc. It is expected that all risks will be reduced to the level required by law and/or as far as is reasonably practicable.

6.3.2 Risk assessment and the maintenance of risk registers are essential components of the Trust's risk management programme and must not be solely an annual 'snapshot' but rather an embedded cyclic process to ensure that risks are regularly identified, assessed, managed, monitored and reviewed. Assessments should take account of all types of risk and the following list illustrates the risk domains that are of key importance to the Trust and must form the basis of the risk identification and assessment process:

- Safety and health of patients (physical / psychological harm) – Patient domain
- Safety and health of staff, public or others (physical / psychological harm) – Injury domain
- Business objectives, targets, projects, etc – Business domain
- Quality / complaints / audit – Quality domain
- Human resources (e.g. organisational development, staffing levels, competence to practice, etc) – Human resources domain
- Statutory duty/ inspections – Statutory domain
- Adverse publicity/ reputation – Reputation domain
- Finance (including claims), organisational economy, property loss, etc – Economic domain
- Service / business interruption – Target domain
- Environment – damage to the environment – Environmental domain

6.3.3 All aspects of a risk must be considered. Some risks may cross more than one domain and in those instances all relevant domains should be assigned a separate risk score. The domain with the highest risk score should be selected when inputting the risk on to the risk register. Risks should link to the Trust's or local objectives.

6.3.4 As part of a risk assessment each risk identified must be graded using the Trust's risk scoring matrix. Risk assessments are performed using a standard UHL risk assessment form (see appendix five) and all fields of the form must be completed to ensure a minimum dataset.

6.3.5 Following assessment the findings must be approved by the appropriate divisional / directorate Board prior to entry onto the risk register. A scanned copy of the original risk assessment form with approval authorisation must be attached to the risk register entry.

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 manager responsible for managing the risk should perform the review along with others who were involved in the initial assessment in order to provide consistency in risk scoring. Following review or if conditions change the manager must ensure the risk register is updated to reflect any changes to the assessment.

6.3.7 Managers will set out a programme for risk assessments to be performed by identifying the various work processes and producing a prioritised list based on information from sources listed in sections 6.4.2 and 6.4.3.

6.4. Requirements of a Risk Assessment

6.4.1 **Hazard Identification (i.e. cause of risks)**

Hazard identification involves examining all causes of risk from the perspective of all stakeholders, both internal and external. Hazards (causes) 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 report, etc)
- Risk, incident, complaints and claims reporting and analysis
- Work activities
- 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
- Department of Health/ NHS Safety alerts
- External Audits
- Corporate Health and Safety Performance Index (CHaSPI) score
- Reports from assessments, inspections from external bodies, e.g., Care Quality Commission (CQC), NHSLA, Health and Safety Executive, External Audit, etc.

When assessing risks evidence must be examined from internal and external sources and processes within the organisation to identify what could reasonably be expected to cause harm. It

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

6.4.4 **Decide What or Who may be Harmed and How**
Health and Safety and organisational issues must always be considered e.g. are there risks to the safety and well-being of patients, staff and others? Consider people who might not be in the workplace all the time for example, cleaners, contractors, delivery persons, etc. especially if there is a chance that they could be injured by work activities. Consideration must also be given to risks affecting the reputation of the Trust, business objectives or continuity of service.

6.4.5 **Identify Current Controls in Place**
Consider how the risks/ hazards (causes) are already being controlled within the organisation.

6.4.6 **Evaluate the Risks Arising from the Hazards (Causes)**
When undertaking a risk assessment, the consequence or severity of the risk being assessed must be measured. In this context, consequence is defined as: the outcome or potential outcome of an event. Consequences must be scored using the risk consequence table in appendix five.

6.4.7 Choose the most appropriate domain(s) (remember there may be more than one domain for a risk) from the left hand column of the table. Work along the appropriate row until the most relevant definition of the risk consequence is found. The consequence score is the number at the top of the column.

6.4.8 Once a specific area of risk and its consequence score is agreed, the likelihood of the risk occurring can be identified by using the likelihood and risk scoring table included within appendix five. 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 will occur. Frequency may not be useful in scoring certain risks associated with the success of 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. The likelihood score is a reflection of how likely it is that the risk will occur with the current controls in place.

6.5 Risk Scoring

6.5.1 Once a hazard (cause) is identified the severity of risk is measured using a matrix giving a numerical value to the consequence (impact) and the likelihood (probability) of the risk occurring to produce a single risk severity score. The Trust uses a 5 x 5 risk scoring matrix to assign a risk rating (i.e. a level of low to extreme) dependent upon the risk score (i.e. 1 – 25). The risk score is calculated by multiplying the consequence score by the likelihood score. The risk scoring matrix is included in appendix five.

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 time of assessment taking into account any current controls. The current score may alter following periodic review of the risk if further controls have since been put into place (i.e. actions to mitigate risk have been implemented) and this must be reflected in an altered score within the risk register entry.
- Target score – i.e. the level of the risk expected following the implementation of an action plan.

NB: If the current risk score equals or is lower than the target risk score the risk will have been treated and should be closed.

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 required to control low scoring risks that have an extreme consequence score.

6.6.2 ***Transferred:*** The Trust is a member of the Liabilities to Third Parties Scheme (LTPS), Property Expenses Scheme (PES), and the 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, Risk Review & Escalation

6.7.1 Risk assessments must be reviewed by the divisional / directorate Board 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 risk score in the risk register entry.

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 divisional / directorate Board.

6.7.3 Low Risks (Risk Score 1 – 6)

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 a consequence score of 4 or 5. Where it is decided to treat a low risk the risk shall be entered onto the risk register following approval by the appropriate divisional / directorate Board and reviewed on an annual basis until the target risk score is achieved.

6.7.4 Moderate Risks (Risk Score 8 -12)

Risk assessment details must be entered onto the risk register following approval by the appropriate divisional / directorate Board, along with a scanned copy of the original risk assessment form. Where possible an action plan to reduce the risk must be developed and implemented within six months. The action plan must be reviewed by the relevant manager and monitored by CBU/ divisional / directorate boards on a quarterly basis to ensure implementation of actions within timescales until such time as the target risk score is achieved. In instances where the risk is accepted at a moderate level (i.e. no actions can be taken to reduce risk) then it must still be recorded on the risk register.

6.7.5 High Risks (Risk Score 15 – 20)

Risk assessment details must be entered onto the risk register following approval by the appropriate divisional / directorate Board, along with a scanned copy of the original risk assessment form. Where possible an action plan to reduce the risks must be developed and implemented within three months. The action plan must be reviewed by the relevant manager and monitored by CBU/ divisional/ directorate boards on a monthly basis to ensure implementation of actions within timescales until such time as the target risk score is achieved. In instances where the risk is accepted at its current level (i.e. no actions can be taken to reduce risk) then it must still be recorded on the risk register.

6.7.6 Extreme Risks (Risk Score 25)

Must be brought to the immediate attention of the Divisional 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 following approval by the appropriate divisional / directorate Board, along with a scanned copy of the original risk assessment form. The action plan must be developed as soon as possible and reviewed / monitored by the divisional/ directorate manager on a weekly basis. All extreme risks will be reported at the earliest opportunity to the ET meeting by the relevant Director. The table below summarises the risk escalation process described in sections 6.7.3 to 6.7.6.

Risk Escalation

Risk Rating / Score	Risk Owned by	Reviewed by	Reported to/ Monitored by
Low (1 – 6)	Dept Manager	Dept Manager	Dept Manager
Moderate (8 – 12)	Dept Manager	Dept Manager	Divisional / Directorate Board (Quarterly), ET (Twice yearly)
High (15 – 20)	Dept Manager	Dept Manager	Divisional/ Directorate Board, ET (monthly), TB (Quarterly), AC, QPMG (Quarterly)
Extreme (25)	Dept Manager	CBU/Dept Manager, Divisional/ Directorate Board, Relevant Exec Director, Exec Team, TB	Exec Team (ASAP), TB (monthly), AC, Q&PMG (Quarterly)

6.7.7 Where the risk rating for an open risk has either increased or reduced the risk must be presented to the divisional / directorate Board for approval. This process should provide either assurance that actions have been taken to control the risk or identify where there are gaps in control and the proposed action plan including due date and responsible person.

6.8 Risk Recording:

6.8.1 BAF

NHS Chief Executive Officers are required to sign a Statement on Internal Control (SIC) 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 (including business risks). The TB shall assure itself that strategic objectives have been systematically identified and the key strategic risks to achieving them are adequately managed. The BAF fulfils this purpose.

The BAF shall be received and monitored no less than four times per year at the TB and at each Audit Committee.

Key strategic risks are defined as those potentially damaging to the achievement of the Trust's strategic objectives. The application of the Trust's Risk Management Policy 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 strategic risks via the BAF and that it is involved in taking decisions on risk treatment options.

6.8.2 Risk Register (Datix)

The risk register is an electronic database (Datix) and provides a dynamic risk profile of the Trust. It is used in conjunction with the Trust's 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 divisions/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 three).

Divisions and directorates shall maintain accurate risk registers and risks shall be entered in line with section 6.7 of this document.

The Trust's corporate risk management team is responsible for reviewing the risk register on a monthly basis and producing regular and ad-hoc reports for Trust committees and divisional / 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 divisions and directorates by the:-

- Patient Safety/ Patient Information and Liaison (PILS)Team
- Litigation (Claims)Team
- Health and Safety Team (including Manual Handling)

6.9.3 Clinical incident data is uploaded to the NHS Commissioning Board (NCB) as part of the external reporting requirement.

6.9.4 The responsibility for investigating incidents will be undertaken by designated individuals within clinical divisions and corporate directorates with support from the Trust's Safety and Risk Team according to the nature, severity and outcome of the incident.

6.9.5 Learning the 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 division or directorate and relevant Trust-wide groups.

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

- Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims.
- Reporting and Management of Incidents Policy Including Serious Incidents.
- Claims Handling Policy and Procedure.
- Management of Complaints Policy

6.10 Embedding Risk Management

6.10.1 The effective implementation of this risk management policy will facilitate the delivery of a quality service and alongside staff training and support will provide an improved awareness of the measures needed to prevent, control and contain risks. To this end the Trust will:

a. Ensure appropriate levels of resources are available to develop and maintain effective risk management processes;
b. Ensure all staff have access to a copy of this policy;
c. Maintain a risk register that is subject to regular review;
d. Communicate to staff any actions to be taken in respect of risk issues;
e. Deliver risk management training and evaluate and monitor its effectiveness;

f. Ensure that training programmes raise and sustain awareness throughout the Trust about the importance of managing risk;
g. Monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

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 training (including risk awareness training for senior managers) commensurate with their duties and responsibilities. This will be provided in line with the Trust's Statutory and Mandatory Training Policy (document ID 0691583737).

7.1.3 Trust Board members will receive risk awareness training, commensurate with their roles and responsibilities.

7.1.4 The Trust employs advisers in specialist areas (see section 5.2.9 and 5.2.10) to ensure that a link is provided for information, advice and training in these specialist areas.

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 produced in the first quarter following the end of the financial year. To ensure compliance with this policy the report, together with performance against the Key Performance Indicators (KPIs), shall be reviewed annually by the ET 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 The Trust is a member of the NHSLA risk pooling schemes. And as a requirement of this membership the Trust will be regularly assessed for compliance with the NHSLA Acute Risk Management Standards and CNST Maternity Standards.

8.1.3 Regular self assessment of compliance against the Care Quality Commission is a requirement of registration and the Trust must demonstrate that it meets the essential standards of quality and safety across all its services.

8.1.4 Systematic review of the risk management process is a key responsibility of the AC and the ET.

8.1.5 Other internal and external audits shall take place as required by the Department of Health, Monitor, Audit Commission and other bodies.

8.2 Key Performance Indicators

8.2.1 Systems shall be in place to monitor and report performance against KPIs with findings reported to the AC, ET and other Trust committees as required.

8.2.2 KPIs and audit requirements are described in appendix four.

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 LEGAL LIABILITY

10.1 The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Division/ Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

10.2 It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

10.3 Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

For advice please contact: Assistant Director - Head of Legal Services on Ext 8585.

11 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

11.1 References

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

[2] ISO 31000 – Guide 73

11.2 Related Policies

- UHL Health and Safety Policy
- UHL Safer Handling Policy – Risk Assessment
- UHL Reporting and Management of Incidents Policy Including the Investigation of Serious Incidents
- UHL Information Governance Policy
- UHL Statutory and Mandatory Training Policy
- UHL Corporate and Local Induction Policy for Permanent Staff
- Management of Complaints Policy
- UHL Claims Handling Policy and Procedure
- UHL Central Alerting System (CAS)Policy
- Datix Risk Register User Guide
- UHL Maternity Risk Management Strategy

12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

12.1 Following ratification by the TB 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'.

12.2 This document will be reviewed on a three yearly basis unless earlier revision is required following internal audits and/ or external guidance. The UHL Risk and Assurance Manager will be responsible for initiating the regular review of this policy.

Appendix: One

ROLE SUMMARIES FOR KEY INDIVIDUALS

Director of Safety and Risk:
The Director of Safety and Risk will be the UHL Patient Safety Lead, with direct access to the Chief Executive and the Trust Board. This post will encompass the "suitably qualified person" role for safety and reporting directly to the Chief Executive, and will have the authority to act and make decisions that improve safety.

The Director of Safety and Risk will lead the patient safety and clinical risk agenda, developing a strategic safety plan, policies and processes to reduce clinical risk and error, and improve patient safety.

The Director of Safety and Risk will manage the Patient Safety and Complaints Team, including the PILS Service and ensure that all safety legislation and compliance requirements are met.

The role of Director of Safety and Risk is to manage the risk and assurance manager, the health and safety department (including the manual handling service), the information governance department and, in conjunction with the Medical Director and the Director of Corporate and Legal Affairs, develop and implement a risk management policy (both clinical and non-clinical and encompassing IRMER and safety requirements) throughout the Trust, supporting other Directors and managers in meeting their objectives across the full range of risk areas.

The Director of Safety and Risk will deputise for the Medical Director or other Directors as directed from time to time. The Director of Safety and Risk will undertake the third tier on call manager function on an on call rota basis, and at those times has the full operational authority of the Chief Operating Officer to act and make decisions as appropriate to ensure the Trust continues to function properly.

The Director of Safety and Risk will provide out of hours safety/legal advice and information as directed by the Director of Corporate and Legal Affairs.

Risk and Assurance Manager:
The Risk & Assurance Manager will provide risk management leadership across the Trust including:-

- Development and implementation of the Trust's risk management policies and processes in order to facilitate an internal control environment that will enable risks arising from all types of activity to be effectively managed.

- Development and maintenance of a Trust-wide risk register and coordination of the Trust's risk management activity including provision of risk management education & training, risk assessment support and guidance.

- Manage the Trust's National Health Service Litigation Authority (NHSLA) Acute Risk Management Standards (ARMS) project ensuring continued progress is made to comply with the standards.

- Act as the Trust's Central Alerting System (CAS) Liaison Officer and Medical Device Liaison Officer (MDLO). This will include developing, implementing, and reviewing processes to ensure that patient safety notices, alerts and other communications concerning patient safety are acted upon within required timescales. This will involve close liaison with division/ directorate senior management teams, medical staff and external agencies including Medicines and Healthcare products Regulatory Agency (MHRA), National Patient Safety Agency, (NPSA), Department of Health Estates and Facilities division.

- To act as line manager to the Risk and Safety Manager.

- To project lead on the Trust's agenda to achieve, maintain and monitor compliance with the Clinical Negligence Scheme for Trusts (CNST) standards, both acute and maternity. To chair the NHSLA Operational Groups which are Trust-wide forums.

Senior Safety Manager (Clinical Risk and Complaints):
The Senior Safety Manager (Clinical Risk and Complaints) will promote a safety culture that is open and fair for sharing information and ensuring lessons are learned throughout the organisation, including:-

- To deputise for the Director of Safety and Risk on a regular basis covering annual leave, study leave, sickness, etc.

- To assist in the investigation of clinical adverse events and their proactive and appropriate management so that the Trust learns lessons and takes the appropriate preventative/remedial action.

- To assist the Director of Safety and Risk in the implementation of all aspects of the Trust's clinical risk management strategy and to foster constructive relationships with clinical staff to ensure effective communication of all issues related to clinical risk.

- To act as line manager to the clinical risk managers, the Datix administrator and the team secretary.

- To manage all inquests relating to UHL NHS Trust, identifying risk management issues through the application of clinical acumen and knowledge.

- To assist the Senior Claims Adviser and his/her team in aspects of clinical negligence claims management, investigation and remedial action, as appropriate.

- To assist the PILS team in aspects of complaints management, investigation and remedial action, as necessary.

Senior Health and Safety Manager:
The Senior Health and Safety Manager will:-

- Provide competent advice, guidance and support to all levels of the organisation and promote the effective development, implementation and monitoring of health and safety management systems and arrangements in the work place.

- Establish and maintain systems which encourage managers and employees to treat safety as an integral element of the day to day operation of the Trust.

- Seek and use the advice of appropriate safety advisory bodies.

- Liaise with the Trust's Insurers, Government Inspectors and other enforcing authorities.

- Keep up-to-date with new developments and, in particular, be fully aware of regulations, approved codes of practice and advice issued by the authorities in order to advise on their implications for the Trust.

- Assess the likely effectiveness of any proposed action by Line Managers / supervisors to prevent the recurrence of danger, injury or ill health.

- Set and monitor annual safety objectives against timescales.

- Monitor Trust arrangements to verify that safety legislation is being followed and that the statutory requirements are being maintained.

- Produce and implement safety training programmes.

- Monitor all internal information concerning 'RIDDOR reportable' accidents and dangerous occurrences, maintaining and using appropriate statistics.

- Co-operate with employee safety representatives and participate in the work of the Health and Safety Committee with a view to maximising its usefulness.

- Co-ordinate health and safety within and between Clinical Divisions and Corporate Directorates across all sites.

Manual Handling Service Leader:
The Manual Handling Service Leader will:-

- Advise the Trust on measures necessary to reduce the risk of musculo-skeletal injury to staff in the workplace, in compliance with the Manual Handling Operations Regulations (1992).

- Advise the Learning and Development Strategy Group on Manual Handling Training including provision, content, and delivery.

- Liaise with Divisional/Directorate Managers and Manual Handling Advisors to act as a resource for advice on Risk Assessment and Risk Reduction.

- Advise on appropriate methods of reducing the risk of manual handling to the lowest level reasonably practical.

- Manage the personal and professional development of the UHL trust's manual handling service personnel.

- Communicate Manual Handling/ergonomic related information to senior managers and Staff in the Trust.

- Develop and maintain up-to-date manual handling training for UHL staff in partnership with the Manual Handling Service and ensure the provision and recording of training programmes.

- Manage the "Training for Trainers" Programme, training sufficiently qualified personnel to deliver ward\dept. based training.

- Provide highly specialised advice concerning the care/treatment of all patients. (E.g. Bariatric Care).

- Establish and maintain audits of manual handling practice in the workplace, and report the findings to the appropriate managers.

- Analyse trends and prevalence in manual handling related accidents and incidents within the trust and advise accordingly.

- Advise on the purchase of manual handling and associated equipment to eliminate or reduce the risk to the lowest reasonably achievable level.

- Keep up to date on developments in the fields of Back Injury Prevention, Risk Management and Legislation.

Head of Privacy (Information Governance Management):
The Head of Privacy has the following responsibilities:

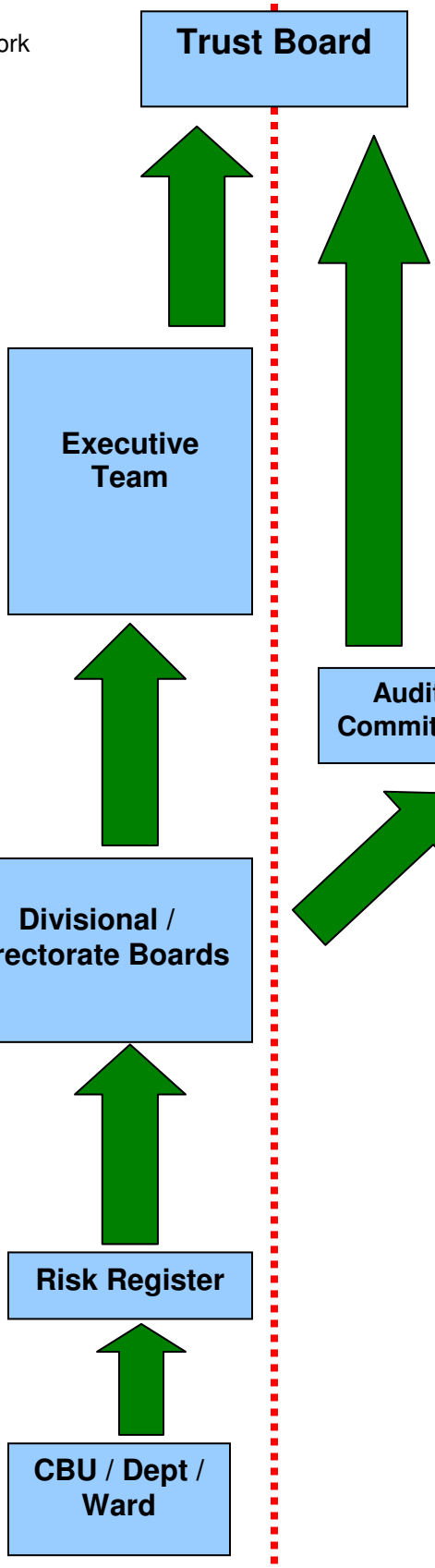
- Lead for the Trust on the Data Protection Act and confidentiality;
- Ensure staff have access to the up to date guidance on keeping personal information secure;
- Lead for the IGT within the Trust, including liaison with Internal Audit on IGT matters;
- Ensuring that evidence is made available to support the attainment levels reported to Connecting for Health;
- Review and evaluate IG arrangements & communicate changes in assessment/guidance across all functional areas;
- Supporting managers through assisting in progressing specific areas of compliance/advancement;
- Co-ordination of activity across groups to ensure that issues are appropriately addressed and avoiding duplication;
- Developing and supporting information risk assessment which integrates into the Trust's risk management framework.

Appendix: Two

UHL RISK REPORTING FRAMEWORK: WARD TO BOARD

Executive Function

Assurance Function



- Will review the Board Assurance Framework (BAF) no less then 4 times per year.
- Will receive a twice yearly report showing risks scoring 15 or above.

- Will receive notification from Divisions / Directorates of risks scoring 25.
- Will confirm & challenge risks scoring 25 for potential inclusion in BAF.
- Will receive monthly update of the BAF.
- Will receive a monthly report from the UHL corporate risk management team showing risks scoring 15 or above and associated mitigating actions not completed within agreed timescales.
- Will receive a twice yearly report showing risks scoring from 8 to 12 (moderate risks).

- Will receive an update of the Trust's BAF and a report showing risks scoring 15 or above (high and extreme) at each meeting

- Will receive a monthly report from corporate risk management team showing divisional or directorate risks scoring from 8 to 25.

- Approved risks entered on to risk register. See process at appendix six.

- Identify risks of all types/scores.
- Will provide monthly notification to divisional or directorate boards of new risk assessments for approval prior to entry on to the risk register.

1. Introduction

1.1 This guidance is intended to provide support to Datix users in relation to data entry onto the UHL operational risk register (i.e. divisional/ directorate risk registers).

2. Scope

2.1 All staff having responsibility for data entry onto the UHL operational 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 time-bound (SMART).

3.2 Adding a Risk to the Risk Register

3.2.1 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).

3.2.2 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*	Provide a clear and concise description of the risk issue. Consider prefacing the risk title with '*there is a risk of* 'or *'there is a risk to'* in order to try and ensure a descriptive title (e.g. '*There is a risk of unavailability of syringe pumps, there is a risk to the achievement of CIP, etc).*
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.
Site*	Select from the drop-down list the site or sites that are affected by the risk.
Division*	Select from the drop-down list the division affected by the risk.
Business Unit	Select from the drop-down list the Clinical business Unit (CBU) 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 Administration Manager on ext 8562).
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 Administration Manager on ext 8562).
Location (exact)	Select the exact location that is affected by the risk (if applicable).
Risk Type	Enables the selection of *'divisional'* or *'directorate'* to signify that the risk is across one or more CBUs / departments.

Risk Subtype*	Select from the drop-down list the risk subtype (domain) that scores highest on the risk assessment.
Objectives	**THIS FIELD IS NOT CURRENTLY USED**
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 NHSLA, 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 Administration Manager on ext 8562)
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 Administration Manager on ext 8562).
Description*	**NB: The field can be expanded by pressing 'Ctrl' and 'E'.** Enter a concise description of the risk, outlining in brief both the **causes** and the **consequences** of the risk. Descriptions should avoid abbreviations that may not be understood by people external to the organisation. The use of bullet points is encouraged wherever possible to avoid lengthy narrative.
Controls in place*	**NB: The field can be expanded by pressing 'Ctrl' and 'E'.** Describe the measures that are already in place to control the risk.
Risk rating*	Enter the consequence and likelihood descriptors from the drop-down menus The risk rating will be entered in three fields as follows: - **Initial:** The consequence and likelihood descriptors at the time of assessment. **Current**: This field should be revised following periodic reviews of the risk action plan and will, at first reflect the initial rating. In time the consequence and likelihood descriptors will start to reduce towards the target as actions are taken to further control the risk. **Target:** The consequence and likelihood descriptors applicable if the actions to mitigate the risk are fully implemented**.**
Rating	Automatically populated by Datix once the risk consequence and likelihood has 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	Specify whether the costs are actual or estimated
Adequacy of Controls	Specify whether these are Adequate, Inadequate or Uncontrolled.
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). The review must reflect any changes to the risk description, controls, scores and actions. **NB:** When an action has been completed it should be entered as a 'control' and the current score should be revised if appropriate to reflect the lower risk.

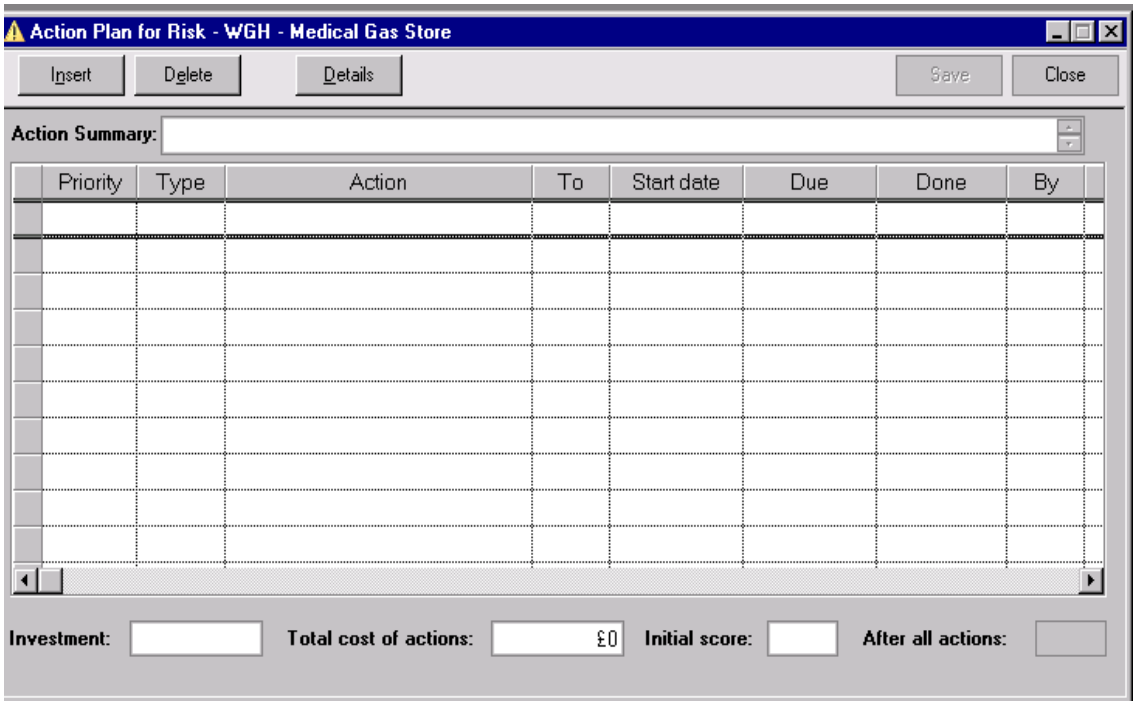
3.2.3 When all information is entered, click '***SAVE'***. This will generate a risk ID.

3.2.4 A scanned copy of the risk assessment form signed off by the Divisional / 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.

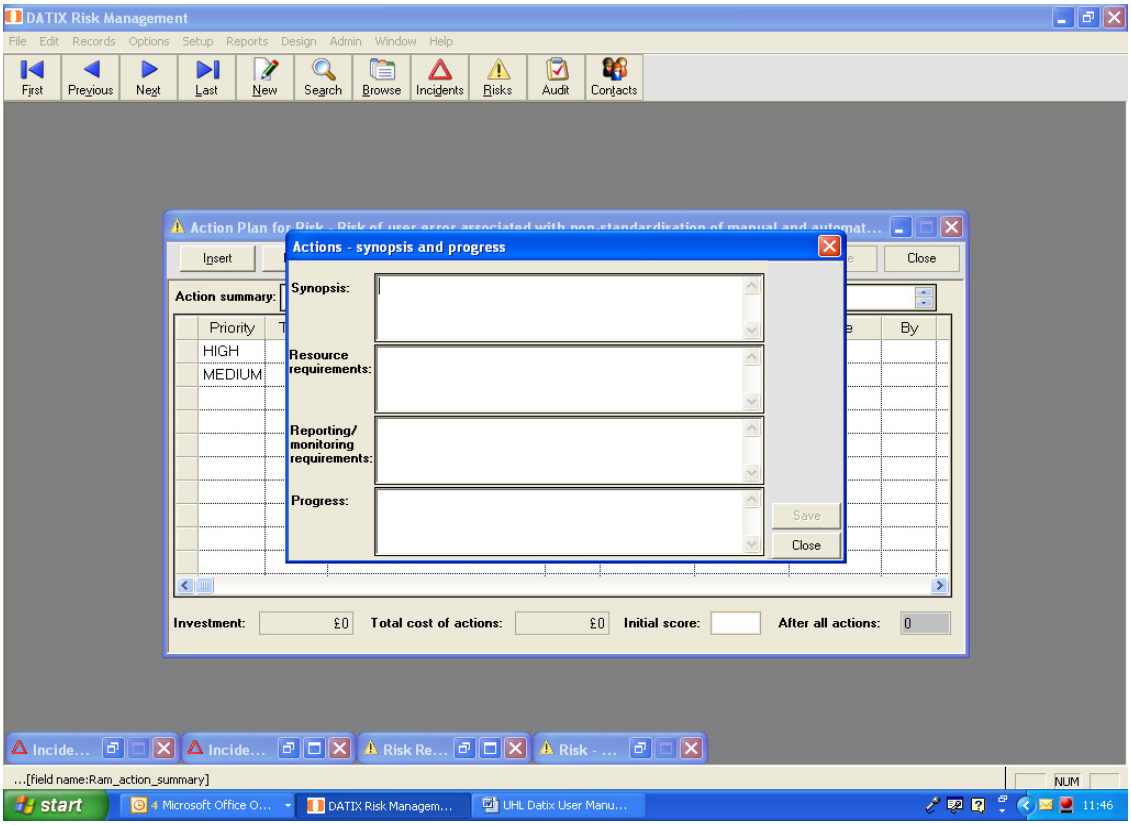
3.3.5 Below the action summary field is the main body of the action screen. This allows further details about the actions to be entered (e.g. date that action is due to start, date the action is due to be completed, accountable person/s, etc). Click '***INSERT'*** and a single line will be highlighted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

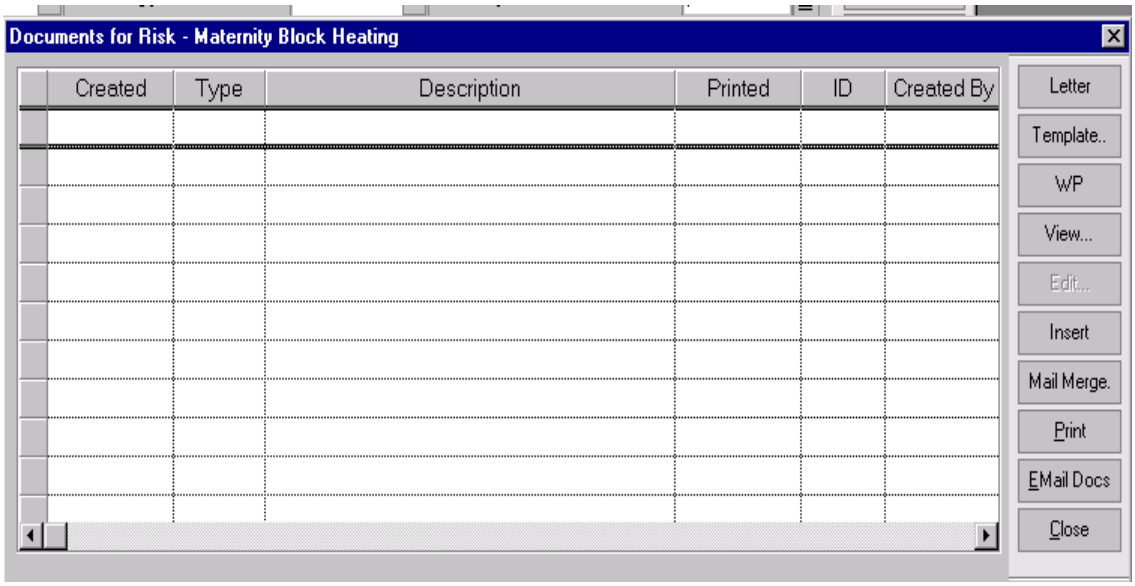


3.3.8 The fields shown in the screen shot above are accessed by clicking on '***DETAILS'*** (above the action summary field). If information has been entered, click '***SAVE'*** then '***CLOSE'*** **to** return to the action plan screen.

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

3.4 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 risk assessment form must be attached.

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. Education and Training

4.1 Datix risk register training is strongly recommended prior to entering data onto the risk register. This training can be accessed by contacting the UHL Corporate Risk Management Team for further detail (ext 3479 or 3441).

5. Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Correct completion of risk register entries	Risk register review of: • Extreme/ high risks • Moderate risks	• Monthly. • Twice per year	Corporate Risk Management Team

6. Legal Liability Guideline Statement

Guidelines or Procedures issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines or Procedures and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

7. Supporting Documents and Key References

UHL Risk Management Policy.

8. Key Words

Datix, risk register, guidelines, user guide

This line signifies the end of the document

This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT			
Author / Lead Officer:	Peter Cleaver		**Job Title:** Risk and Assurance Manager
Reviewed by:	Richard Manton		
Approved by:	**PGC**		**Date Approved:**
REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
8/8/12	1	P Cleaver	Transfer of content of previous version to UHL guidance template
DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**

Appendix: Four

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
UHL Risk Management Structure	Risk and Assurance Manager	Risk reports to TB, ET QPMG, and ACin line with reporting framework	Annually	Risk management annual report to ET and AC. Report will be scrutinised to 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 stakeholder via ET, QPMG, AC and divisional / directorate boards.
	Risk and Assurance Manager	Risk reports to divisional/ directorate boards in line with reporting framework	Annually	As above	As above	As above
	Risk and Assurance Manager	Review of risk register to show risk movement.	Annually	As above	As above	As above
	Health and Safety Manager	No. of risk assessors per division /directorate	Annually	As above	As above	As above
High level review of risk register	Risk and Assurance Manager	Risk reports to ET, AC and QPMG in line with reporting framework.	Annually	As above	As above	As above
Board Assurance framework	Risk and Assurance Manager	BAF reports to TB, ET, QPMG, and AC in line with reporting framework	Annually	As above	As above	As above
Local management of risk	Divisional/ Corporate Directors and Managers	Risk reports to divisional/ directorate boards in line with reporting framework	Annually	As above	As above	As above

	Divisional/ Corporate Directors and Managers	Actions to mitigate risks being taken within timescales	Annually	As above	As above	As above
	Divisional/ Corporate Directors and Managers	Risks being reviewed at local level at the frequencies defined within Risk Management Policy	Annually	As above	As above	As above
Duties of key individuals	Divisional/ Corporate Directors and Managers	Job descriptions	Annually	As above	As above	As above
Risk Reports	Risk and Assurance Manager	Risk reports showing involvement of key individuals in risk management	Annually	As above	As above	As above

Appendix Five

UHL RISK ASSESSMENT FORM				**Local Ref. No.**	
Title of risk (i.e. There is a risk of/that… resulting in…)					
Division/Directorate		Unit		Site	
Department/Ward		Date of Assessment		Assurance Source (Refer to Datix for reference)	

*Description of the risk: List the **causes** and the **consequences** of the risk **(Copy & paste to add rows where necessary)***

Causes (hazard)	**Consequence** (harm / loss event)

Controls in place: List what processes are already in place to control the risk (Copy & paste to add rows where necessary)

Current Risk Rating (with the controls listed above in place)

Risk subtype: Consequence descriptor: select highest score for Datix (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Current Risk Rating
Patients		x		=	
Injury		x		=	
Quality		x		=	
Human Resources		x		=	
Statutory		x		=	
Reputation		x		=	
Business		x		=	
Economic		x		=	
Targets		x		=	
Environment		x		=	

Action Plan List of actions that can be taken to further control the risk *(Copy & paste to add rows where necessary)*

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

Target Risk Rating (with the proposed actions listed above in place)					
Risk subtype: Consequence descriptor (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Target Risk Rating
Patients		x		=	
Injury		x		=	
Quality		x		=	
Human Resources		x		=	
Statutory		x		=	
Reputation		x		=	
Business		x		=	
Economic		x		=	
Targets		x		=	
Environment		x		=	

Risk Assessment Approval (prior to the entry being input on to Datix)					
Risk Assessor name		**Signature**		Date	
Line Manager name		**Signature**		Date	
NOTE: This Risk Assessment form must be approved by the clinical division / corporate directorate board prior to being entered on to the Datix risk register					
Approved by Division / Director: name		**Signature**		Date	

Risk Review Details	
1st Review Date	

Scoring Guidance:

Consequence score (impact of cause / hazard) and example of descriptors					
Risk Subtype	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which Consequences on a small number of patients	Mismanagement of patient care with long-term effects Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal	Overall treatment or service suboptimal Formal complaint (stage 1)	Treatment or service has significantly reduced effectiveness Formal complaint	Non-compliance with national standards with significant risk to patients if	Totally unacceptable level or quality of treatment/ service Gross failure of patient

	complaint/ inquiry	Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	(stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	unresolved Multiple complaints/ independent review Low performance rating Critical report	safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY (Statutory duty/ inspections)	No or minimal Consequence or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
REPUTATION (Adverse publicity/ reputation)	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business objectives/ projects)	Insignificant cost increase/ scheduled slippage	<5 per cent over project budget Scheduled slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
ECONOMIC (Finance including claims)	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minimal or no Consequence on the environment	Minor Consequence on environment	Moderate Consequence on environment	Major Consequence on environment	Catastrophic Consequence on environment

How to assess likelihood:
When assessing 'likelihood' it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the risk described will occur with the current controls. Likelihood can be scored by considering:

- The frequency (i.e. how many times will the adverse consequence being assessed actually be realised?) or
- The probability (i.e. what is the chance the adverse consequence will occur in a given reference period?)

Likelihood and Risk score
The risk score is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
3 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
4 Likely Will probably happen/recur but it is not a persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%	**4**	**8**	**12**	**16**	**20**
5 Almost certain Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**

RISK RATING (SCORE)	**ACTION REQUIRED**
Low (1 – 6)	Acceptable risk requiring no immediate action. Review annually.
Moderate (8 – 12)	Action planned within six months; commenced within 6 months. Review in 3 months. Place on risk register.
High (15 – 20)	Action planned within three months; commenced within 3 months. Review at monthly intervals. Place on risk register.
Extreme (25)	Action planned and implemented ASAP. Review weekly. Place on risk register.

Appendix: Six

RISK ASSESSMENT ESCALATION STRUCTURE

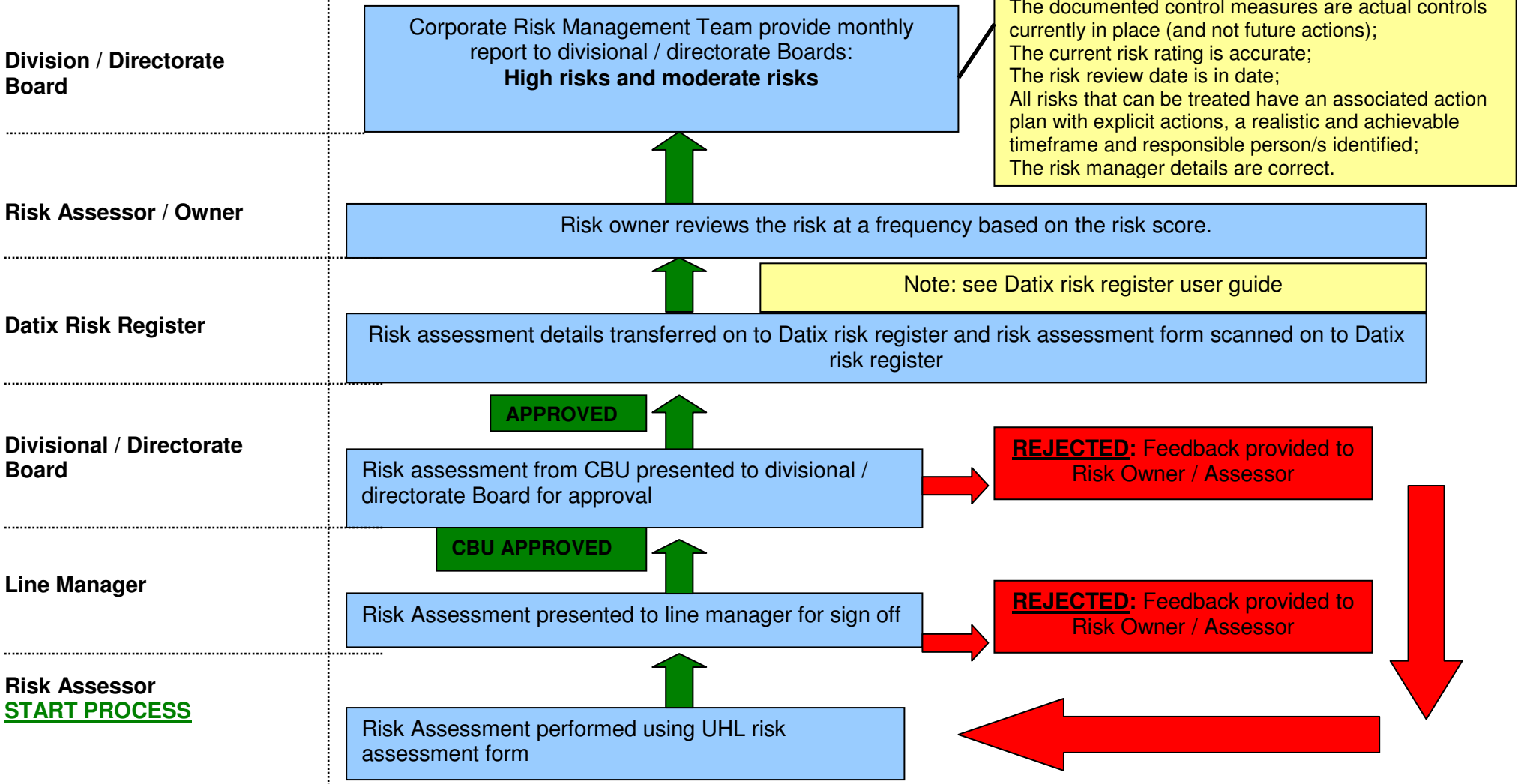


TABLE OF CHANGES WITHIN THE UHL RISK MANAGEMENT POLICY

Policy Section	Amendment	Rationale	Ref. to appx. three
4. (page 6)	Definitions for strategic risks, operational risks, risk register, risk appetite, and Board Assurance Framework (BAF) are now included	There are many occasions where non standard risk terminology is used leading to confusion within the organisation. This change attempts to assist staff to interpret commonly used risk management terminology.	3,10
5.2.1 – 5.2.3 (pages 7 and 8)	Updated roles and responsibilities including changes to director portfolios.	There have been changes to Executive Director portfolios. This will inform of altered portfolios /titles and reporting lines.	14
5.2.4 (page 9)	Risk assessments must be approved by Clinical Divisional / Corporate Directorate Boards prior to entry onto the risk register.	Data quality in the UHL risk register is variable and this can be attributed to lack of quality assurance prior to entry on the register. This change will ensure that boards have an opportunity to quality assure the content of the risk assessment prior to entry onto risk register. It is anticipated that the small investment in time at the 'front-end' of the process will prevent the larger amounts of time spent at the 'back-end' of the process in relation to retrospectively amending register entries. This will ensure that risk data is of value. There have been instances where the divisional directors and /or divisional managers have not been made aware of risks within their areas and are therefore unsighted until a risk register report is received into the local board. This change will ensure they have prior knowledge of risks It is important that risks are understood across a division or directorate and this change will also enable a shared understanding of CBU/ dept risks by the divisional/directorate senior managers.	1, 7, 9
5.2.10 (page	Addition of Occupational	To provide an accurate list of specialist advisors available to assist	n/a

10)	Health Physicians and Nurses, Infection Prevention Team, Research & Development Manager.	members of staff and managers when expert advice is required.	
5.3.2 (page 11)	Trust Board will receive a twice-yearly report to show risks scoring 15 or above on the risk register from the corporate risk management team.	Currently the Trust Board do not receive notification of any operational risks unless they are 'extreme' (i.e. risk score of 25) and may not be adequately sighted to lower level risks within the organisation To improve line of sight 'ward to Board' in relation to UHL high risks and themes it is the intention to provide the Board with a twice yearly report highlighting all high risks. The detail of the report will include: Division CBU Risk description Controls Current and target risk scores Action description Action timescale Risk owner Responsible director	1, 8
5.3.3 (page 12)	Update to role of Audit Committee to receive at each meeting a report comprising the BAF and high risks in addition to any further ad-hoc reports requested to provide assurance.	To reflect changes to UHL committees and risk reporting lines.	15
5.3.4 (page 12)	Removal of regular reporting of risk registers to QAC (formerly GRMC).	As above.	15
5.3.4 (page 12)	Update to role of ET to receive a monthly update of the BAF	The role of ET is to hold divisions and directorates to account (via their respective Director) for the effective management of their risks. The ET	1, 2, 8, 9

	and a report showing risks scoring 15 or above and a twice-yearly report showing risks scoring between 8 and 12 (moderate risks). Update to function of ET to ensure that divisional directors are held to account in relation to the effective management of high risks and their mitigations.	will be expected to challenge those areas where risk reduction actions are seen to be overdue. They will also be required to identify significant risk themes for inclusion on the BAF. The detail of the reports will include: Division CBU Risk description Controls Current and target risk scores Action description Action timescale Risk owner Responsible director Risk movement against previous month. In addition the report includes a list of those actions with elapsed due dates to enable appropriate challenge to be made There is a recommendation from RSM Tenon in relation to the trust considering developing a 'corporate' risk register of which their definition is '*where are all of the high risks (however you define high) brought together and reported so that the Trust has a complete picture of these and can understand the bottom up high risk operational risks and the potential relationship that they might have with each other without them being lost in disparate risk register across the Trust.* The reporting of high risks to ET fulfils this function.	
5.3.5 (page 12)	Update to role and function of QPMG to receive risk reports on quarterly basis instead of monthly.	To reflect changes to UHL committees and risk reporting lines.	12
5.3.6 (page	Divisional and Directorate	The role of local boards is to hold CBUs and departments to account (via	1, 2, 5,

13)	Boards will receive monthly and quarterly risk register reports from the corporate risk management team. On a monthly basis they will receive new risk assessment forms from their CBUs for approval prior to entry on the hospital risk register. Clarification that risk register review must be a standing agenda item at each local board and adequate notes must be recorded and retained to reflect the risk discussions.	their respective managers) for the effective management of their risks. Local Boards will be expected to challenge those areas where risk reduction actions are seen to be overdue. The detail of the reports will include: Division CBU Risk description Controls Current and target risk scores Action description Action timescale Risk owner Risk movement against previous month. The production of these reports centrally by the UHL risk management team will ensure that divisional and directorate boards are using a consistent format for risk reporting and will reduce the administrative burden at a local level. It is important that knowledge of departmental risks is shared across the division or directorate to ensure understanding at local board level of risks within CBUs and departments. There is a need to ensure suitable evidence is available to provide assurance of robust risk management processes at local level. This evidence will normally take the form of meeting agenda, reports and minutes, therefore it is important that accurate minutes are recorded.	6, 9, 11, 12, 13
5.3.7 (page 13)	CBUs to submit new risk assessments to the Clinical Divisional / Corporate Directorate Board.	As 5.2.4	1, 7, 9
6.7.3: (page	Clarification that low risks do	This will reduce administrative burden within divisions and directorates.	n/a

17)	not need to be added to the risk register unless they are to be treated.		
6.8.1 (page 18)	Change of title from Strategic Risk Register/ Board Assurance Framework (SRR/BAF) to Board Assurance Framework (BAF).	Recommendation from RSM Tenon. Reduces potential for confusion across the organisation	3
Appendix one (pages 23 – 26)	Job descriptions for key personnel removed from appendices and replaced with role summaries.	To reduce unnecessary detail within the policy.	n/a
Appendix two (page 27)	Risk reporting framework updated	To reflect changes to UHL committees and reporting lines.	1
Appendix three (page 28)	Datix risk register user guide.	To ensure that staff have appropriate instructions in relation to how to use Datix risk register software.	9
Appendix four (page 34)	Key performance indicators included in new format.	Format recommended by NHSLA to provide a greater degree of understanding across the organisation.	
Appendix five (page 36)	Redesigned risk assessment form. Consequence table and likelihood scores now integrated in the risk scoring matrix.	To capture minimum risk dataset required and to include new risk assessment approval process.	1, 2
Appendix six (page 40)	New risk assessment escalation process described in a flowchart	To provide staff with *'at a glance'* risk escalation guidance.	1, 2
	Terms of reference for Trust Committees removed from appendices.	To reduce unnecessary detail within the policy	n/a

SUMMARY OF ISSUES/ RECOMMENDATIONS

Ref. No.	Recommendation	Agency
1	The Trust should put in place a corporate risk register and a clear process for escalating risks from divisional risk registers.	RSM Tenon
2	The Trust should ensure that action plans to address risks are monitored consistently and 'closing of the loop' with regard to actions to reduce risk ratings to target levels is evidenced	RSM Tenon
3	Consider renaming the SRR/BAF the BAF and ranking risks by strategic goal or objective rather than by risk rating	RSM Tenon
4	As planned the Risk Management Policy should be reviewed and sent to the Board for approval	Ernst and Young
5	Divisional and directorate boards will be reminded of the importance of monitoring risks and providing a sufficient level of challenge which is evidenced through meeting minutes.	PWC
6	Chairs of divisional and directorate boards will ensure that standardised reports on risks produced by the UHL risk management team are discussed at board meetings and an appropriate level of challenge around risk takes place.	PWC
7	As part of the roll out of the new Risk Management Policy, it should be reiterated to all staff that appropriate approval must be sought and obtained prior to entering the risk on Datix, evidenced	PWC
8	The revised Risk Management Policy will be updated prior to being approved to show the additional annual and twice yearly reporting to divisional Boards and the Executive Team.	PWC
9	There is a need to continue to improve data quality within the risk register.	PWC
10	Requirement to provide standard terminology for risk across the Trust to prevent confusion including renaming strategic risk register/ board assurance framework (SRR/BAF to BAF).	Internal assurance
11	Risk information in the divisional board papers presented for review did not always include sufficient information to enable robust risk management discussions; Each board should	PWC

	base discussions on the Corporate Risk Team's standard risk reports;	
12	The level and quality of discussion and challenge at divisional board meetings could be improved. There were some good examples of risk discussion, but this was variable between meetings. There was not always a robust level of challenge on risk ratings, risk mitigations and overdue actions.	PWC
13	Minutes of discussions at local board level are not always taken, and when they are, they do not always show how risk was discussed.	PWC
14	Needs to be organisational clarity about director level risk management responsibilities.	Internal assurance
15	Need to reflect changes to committees/ reporting lines /terms of reference	