Trust Board Paper X

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	**Outcome 16 – Assessing and Monitoring the Quality of Service Provision**

Title:	**UHL RISK MANAGEMENT POLICY**

Author/Responsible Director: CHIEF NURSE

Purpose of the Report: To provide the Board with an overview of changes to the UHL Risk Management Policy for endorsement.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:

- The Risk Management Policy has been updated to reflect changes in organisational structure. A list of changes from the previous version is provided on page 3 of the policy (attached).
- As a 'category A' document this requires ratification by the Board prior to uploading onto the hospital's document management system (InSite).

Recommendations:
The Trust Board is invited to:

a. Receive and note the contents of the UHL Risk Management Policy.
b. Ratify the changes outlined on page 3 of the policy.

Previously considered at another corporate UHL Committee?
Yes – UHL Policy and Guidelines Committee 18 July 2014

Board Assurance Framework: No	**Performance KPIs year to date:** N/A

Resource Implications (eg Financial, HR):
N/A

Assurance Implications:
N/A

Patient and Public Involvement (PPI) Implications:
Yes

Stakeholder Engagement Implications: No

Equality Impact: Assessment completed – no impact
Information exempt from Disclosure: No
Requirement for further review? Next review due June 2017

University Hospitals of Leicester NHS
NHS Trust

RISK MANAGEMENT POLICY

Approved By:	**Trust Board**
Date Approved:	**31 July 2014**
Trust Reference:	**A12/2002**
Version:	**5.0 (July 2014)**
Supersedes:	**Version 4**
Author / Originator(s):	**Corporate Risk Management Team**
Name of Responsible Committee/Individual:	**Peter Cleaver / Richard Manton**
Review Date:	**May 2017**

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REVIEW DATE AND DETAILS OF CHANGES MADE DURING REVIEW

Document reviewed and revised March 2014 to reflect changes in organisational structure (including committee structures).
Risk scores referred to as a numerical value rather than low, moderate, high and extreme throughout the whole document.
Change of terminology from 'division' or 'divisional' to CMG throughout whole document.
Change in terminology from 'Clinical Business Unit' (CBU) to 'specialty' throughout whole document.
Change in terminology from 'Divisional Directors' to 'Clinical Directors' throughout whole document.
Change in terminology from 'strategic risk' to 'principal risk throughout whole document.
Removal of reference to 'Medical Leads' throughout whole document.
Section 3 inclusion of reference to LLR Elective Care Alliance.
Section 5.2.2 amendment to Medical Director and Chief Nurse portfolios.
Section 5.2.3 change from Director of Communications and External Relations to Director of Communications and Marketing.
Section 5.2.4 (n) addition of CAS responsibility.
Section 5.2.6 removal of 'Quality and Safety Manager', CBU Managers, and CBU Medical Leads
Section 5.2.9 Addition of 'Risk and Safety Manager' and change from 'Senior Health and Safety Manager' to 'Health and Safety Services Manager'
Section 5.3 removal of reference to Quality and Performance management Group (QPMG).
Section 6.3.5 addition of text to read 'In cases where a risk has been entered directly on to the risk register it would be acceptable to have some other form of correspondence from the relevant director to demonstrate that the risk has been approved (i.e. an email, a signed print out of the Datix risk entry, a copy of minutes/notes etc)'.
Section 6.7.1 and 6.7.2 addition of text to read 'When the implementation of risk control measures is beyond the authority or resources available to the CMG/ directorates then the Clinical Director/ General Manager are responsible for escalating this to the relevant executive director and / or Trust committee so a decision can be reached as to whether the risk will be accepted at this level or whether resources will be made available to treat the risk.
Section 6.7.5 and 6.7.6 addition of text to read 'The assessment must be reviewed by the relevant manager and monitored by the CMG board at least quarterly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed'.
6.7.7 New section
Section 6.9.3 text amended to read 'National Reporting and Learning System (NRLS)'.
Section 6.9.5, 7.1.2 and section 11 addition of document reference numbers

Appendices
Appendix one: Previous appendix removed and appendices renumbered to reflect this.
Appendix two: Addition of new section 4 to appendix.

Keywords Risk, risk management, Risk management process, Risk Assessment, strategic risks, operational risks, risk register, Board Assurance Framework, BAF.

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

2 POLICY AIMS / STATEMENT OF INTENT

2.1 The Trust Board of Directors (hereafter known as the '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. 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.
h. To secure optimum levels of investment (staffing and other resources) in the management of risk.
i. Strategic and operational objectives (i.e. organisational, Clinical Management Group (CMG)/ directorate and Specialty/ 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.
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 CMGs and corporate directorates and the Trust as a whole.
j. Enable staff to be empowered to report risks and register concerns about unsafe practice.
k. Enable all aspects of risk management to be approached in a structured manner, in line with the CQC registration standards and Foundation Trust Compliance framework,
l. Provide guidance on the risk management process and the benefits of how effective risk management will enable the Trust to contribute to a wider risk network within the health community.

3 POLICY SCOPE

3.1 This policy applies to members of staff directly employed by the Trust for whom the Trust has legal responsibility and includes the Leicester, Leicestershire and Rutland (LLR) Elective Alliance. 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 consequence (impact on the organisation if the risk occurs).

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

Consequence: The potential harm or loss caused by the risk.

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 CMG/ directorate or specialty/ department level.
Risk Register (Datix): The Trust's database of CMG, specialty, directorate or 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 Board developed and managed document identifying the Trust's strategic objectives, the principal 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 CMG 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. This will include the identification and management of risk and oversight of progress against the BAF. 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 comply with the CQC registration standards and leading on the Trust's fulfilment of its clinical governance and risk management responsibilities (clinical and non-clinical health and safety management, patient safety and complaints management, infection prevention, safeguarding adults and children, information governance.

Medical Director

Is responsible for minimising risks to clinical effectiveness, research and development, clinical education, clinical quality and improvement, medical appraisal and revalidation. This portfolio is discharged via Deputy. Associate and Assistant Medical Directors

Director of Finance and Business Services

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

Director of Human Resources

Is responsible for minimising risks relating to workforce and service equality.

5.2.3 **Corporate Directors:**

Director of Marketing and Communications
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 'safeguarding' issues.

Director of Corporate and Legal Affairs
Is responsible for minimising risks to 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.

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.

Chief Operating Officer
Is responsible for minimising the risks to the delivery of all operational targets, emergency preparedness and business continuity.

Managing Director of LLR FMC
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.

5.2.4 C**linical Directors** shall discharge their responsibilities for clinical risk management by:

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

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

a. Ensuring risks to the achievement of CMG/ directorate objectives are identified, assessed and effectively managed to minimise those risks as far as practicable.
b. Ensuring adequate resources and expertise are made available to effectively manage risks within their areas of responsibility

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

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

5.2.7 **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 'signed off' by their line manager, reviewed by specialty/ department managers at specialty boards and presented at CMG/ directorate boards for consideration and approval prior to entry onto the risk register.
e. Contribute to CMG/ directorate training programmes for risk assessment and risk 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
- Risk and Safety Manager
- Senior Safety Manager (clinical risk and complaints)
- Health and Safety Services Manager
- Head of Privacy (Information Governance)
- Local Security Management Specialists (LSMS)

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 CMGs and directorates with relevant advice, guidance and information.
b. Participating in the activities of Trust committees / groups as required.
c. Facilitating corporate risk management training and contributing to CMG and corporate directorate risk management training programmes.
d. Producing information materials on risk management within the Trust for staff, patients, stakeholders and the public.
e. Maintaining and developing the Trust risk register.
f. Advising the TB on risk management strategies for the Trust and CMGs / corporate directorates; auditing achievement in line with those objectives.
g. Developing corporate risk management tools.
h. Producing reports on risk management activities for relevant Trust committees and local boards.
i. 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 one. 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 the Trust's strategic objectives, principal risks, the 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 BAF.

The TB will also receive a monthly report to show all risks scoring 15 or above opened within the reporting period and this will be supplemented with a quarterly report of all risks scoring 15 or above on the UHL risk register.

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

a. Develop, review and comment upon the BAF, as it deems appropriate;
b. Note the actions identified within the BAF to address any gaps in either controls or assurances (or both);
c. Identify any areas in respect of which it feels that the Trust's controls are inadequate and do not effectively manage the 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.
f. Be aware of risk trends developing within the organisation and the strategies adopted for their control.
g. Agree the levels of risk appetite and tolerance that the Trust is prepared to accept in the pursuit of its strategic objectives

5.3.3 **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 principal 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 risk process to monitor that the assurance framework is effective and there is a robust system in place for the identification, assessment and prioritisation of risk including a means of escalating significant risks to relevant Trust committees and providing a line of sight for risks from 'ward to Board'.
g. Holding CMGs to account for the effectiveness of local risk frameworks.

At each meeting it will receive an updated BAF and risk report to show all risks scoring 15 or above. In this way the AC provides assurance to the TB regarding its controls systems and supports the annual Governance Statement.

5.3.4 **Executive Team (ET)**

This is an executive level group led by the Chief Executive that meets weekly. Membership includes executive and corporate directors, and clinical directors.

The ET will receive monthly an update of the BAF and a report showing all risks scoring 15 or above and, twice yearly, a report of all risks scoring 8 to 12.

The function of the ET in relation to risk management is to;

a. Develop, review and update the contents of the BAF prior to submission to the TB.
b. Identify whether any risks from the UHL risk register are of strategic significance and decide whether the risk(s) are already linked to themes within the BAF or whether there is a requirement for a new principal risk to be entered.
c. Ensure that clinical directors, corporate directors and CMG general managers are held to account in relation to the effective management of local risks and their mitigations. This will include monitoring of risks scoring 15 or above on the risk register where there is a risk with one or more elapsed action due date and / or elapsed risk review dates.

5.3.6 **CMG/ directorate Boards**

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

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

The function of the CMG/ directorate boards will be to:-

i. Approve risks for entry onto CMG/ directorate risk registers.
ii. Ensure relevant personnel are held to account for those risks within CMGs / directorates.
iii. Ensure appropriate quality in relation to the content of the risk register. This will include challenge and confirmation 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 robust and 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.
    g. The risk owner details are correct.
    h. Monitor action plans to ensure that actions are completed within specified timeframes and where an action due date has elapsed challenge will be made to the risk owner about the reason why.
iv. Analyse risk themes across the CMG/ directorate in order to identify trends.
v. 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 the risk register must be a standing agenda item at each CMG/ directorate board and the notes of the meeting shall evidence involvement in approving assessments and reviewing open risk register entries including seeking assurance of current control measures, challenging risk ratings and monitoring progress of action plans.

5.3.7 **Specialty boards (where applicable)**

Will be responsible for:-

a. Submitting new risk assessments to the CMG/ directorate board for consideration and approval.

b. Monitoring that all actions to reduce risks are being implemented in line with the specified timeframes.

5.3.8 **Reporting to Commissioners**
All new risks scoring 15 or above are reported to our 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 Risk identification and assessment systems are vital to the success of the Trust's risk management process and there are a number of internal and external sources of risk identification that can be used. 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. 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 assessments are essential components of the Trust's risk management programme and must not be solely an annual 'snapshot' but rather an embedded and cyclic process to ensure that risks

are regularly identified, assessed, managed, monitored and reviewed. Assessments must 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 must be assigned a separate risk score. The domain with the highest risk score should be selected when entering the risk on to the risk register. Risks will normally link to UHL or CMG/ directorate objectives.

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

6.3.5 The risk assessment must be approved by the appropriate CMG/ 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. In cases where a risk has been entered directly on to the risk register it would be acceptable to have some other form of correspondence from the relevant director to demonstrate that the risk has been approved (i.e. an email, a signed print out of the Datix risk entry, a copy of minutes/notes etc).

6.3.6 Each risk must be reviewed at a frequency based on the severity of the risk score (see section 6.7.3 to 6.7.6). The risk owner must perform the review along with others who were involved in the initial assessment in order to provide consistency in risk scoring. Following review the owner 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 Identify the causes of the risk (i.e. **Hazard Identification)**
This involves examining all causes of risk from the perspective of all stakeholders, both internal and external. Causes of risks (hazards) can be systematically identified from a number of proactive and reactive processes/sources including but not limited to:-

6.4.2 **Internal Sources**

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

- Surveys (e.g. patient and staff satisfaction surveys)
- Training evaluations
- Unions
- Whistle blowing

6.4.3 **External Sources**

- Coroner reports
- Media
- National standards, guidance and new/updated legislation
- Horizon scanning of the external healthcare environment and learning from others
- Central Alerting System broadcasts
- External Audits
- Corporate Health and Safety Performance Index (CHaSPI) score
- Reports from assessments, inspections from external bodies, e.g., CQC, 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 (i.e. the consequences of the risk)**

Health and Safety issues must always be considered e.g. are there risks to the safety and well-being of patients, staff and others? This may include people who might not be in the workplace all the time for example, domestics, contractors, delivery personnel, etc. Consideration must also be given to risks affecting the business of the Trust, for example risks to quality, finance, business objectives, reputation of the Trust, or continuity of service, etc.

6.4.5 **Identify Current Controls in Place**

Consider how the causes are already being controlled to reduce the likelihood of the risk occurring and how consequences are being mitigated should the risk event occur.

6.4.6 **Evaluate the Risk**

The likelihood of the risk occurring and the consequence of the risk must be measured.

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

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

6.5 Risk Scoring

6.5.1 Once a cause (hazard) is identified the severity of risk is measured using a matrix giving a numerical value to the consequence and the likelihood 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 four.

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

- Current score – i.e. the level of the risk at present time taking into account any current controls. 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 the risk have been implemented) or withdrawn 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: Where the current risk score equals or is less than the target risk score the risk should have been treated as far as is reasonably practicable and the risk can 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 appropriate to control low scoring risks that have an consequence score of 4 or 5.

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

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

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

6.7 Local Accountability for Risk, Review & Escalation

6.7.1 Risk assessments must be reviewed by CMG/ directorate boards 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. When the implementation of risk control measures is beyond the authority or resources available to the CMG/ directorates then the Clinical Director/ General Manager are responsible for escalating this to the relevant executive director and / or Trust committee so a decision can be reached as to whether the risk will be accepted at this level or whether resources will be made available to treat the risk.

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

6.7.3 <u>Risk Score 1 – 6 (Low Risks)</u>

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 CMG/ directorate board and reviewed on an annual basis until the target risk score is achieved.

6.7.4 <u>Risk Score 8 - 12 (Moderate Risks)</u>

Risk assessment details must be entered onto the risk register following approval by the appropriate CMG/ directorate board, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG

board at least quarterly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. 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 approved and recorded on the risk register.

6.7.5 Risk Score 15 – 20 (High Risks)
Risk assessment details must be entered onto the risk register following approval by the appropriate CMG/ directorate board, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG board at least monthly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. In instances where the risk is accepted at a high level (i.e. no actions can be taken to reduce risk) then it must still be approved and recorded on the risk register.

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

6.7.7 Following consideration and approval of new risks by the CMG/ directorate board (Quality and Safety Board or equivalent) the risk assessment form must be 'signed-off (electronic signature is acceptable) by the appropriate Corporate/ CMG Director, CMG General Manager or Head of Nursing prior to entry onto the risk register. In circumstances where a risk needs to be entered onto the risk register as a matter of urgency where it cannot wait until the next scheduled board meeting then the risk assessment must be considered and approved by the appropriate Corporate/ CMG Director, CMG General Manager or Head of Nursing.

Risk Escalation

Risk Rating / Score	Risk Owned by	Reviewed by	Reported to/ Monitored by
1 – 6 (Low)	Dept Manager	Dept manager	Dept manager
8 – 12 (Moderate)	Dept Manager	Dept manager	CMG/ directorate board (quarterly), ET (twice yearly)
15 – 20 (High)	Dept Manager	Dept manager	CMG/ directorate board (monthly), ET (monthly), TB (Quarterly), AC.
25 (Extreme)	Dept Manager	Specialty/ Dept Manager, CMG/ directorate board, relevant exec director, ET, TB	ET(ASAP), TB (monthly)., AC.

6.7.8 Where the risk rating for an open risk has either increased or reduced the risk must be presented to the CMG/ 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 dates and responsible personnel.

6.8 Risk Recording:

6.8.1 BAF

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

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

The minutes of the TB shall evidence that it identifies, records, assesses and analyses the Trust's principal 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 CMGs/ directorates to assist in informing clinical, non-clinical and business decisions.

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

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

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

6.9 Learning

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

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

- Patient Safety/ Patient Information and Liaison (PILS) team
- Litigation (Claims) team
- Health and Safety Services team

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

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

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

- Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims. B28/2007
- UHL Policy for Reporting and Management of Incidents (including the investigation of serious incidents. B57/2011
- Claims Handling Policy and Procedure. B24/2008
- Management of Complaints Policy. A11/2002

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.

7.1.3 TB 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 the AC and used to inform the development of action plans to remedy deficiencies and to inform future strategies. Existing audit / review mechanisms shall be used wherever possible to avoid duplication.

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

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

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

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 CMG/ 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. A17/2002
- UHL Safer Handling Policy – Risk Assessment. B65/2011
- UHL Policy for Reporting and Management of Incidents (including the investigation of serious incidents. B57/2011
- UHL Information Governance Policy. B4/2004
- UHL Statutory and Mandatory Training Policy. B21/2005
- UHL Corporate and Local Induction Policy for Permanent Staff. B4/2003
- Management of Complaints Policy. A11/2002
- UHL Claims Handling Policy and Procedure. B24/2008
- UHL Central Alerting System (CAS) Policy. B1/2005
- Datix Risk Register User Guide
- UHL Maternity Risk Management Strategy. C22/2011

- Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims. B28/2007.

12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

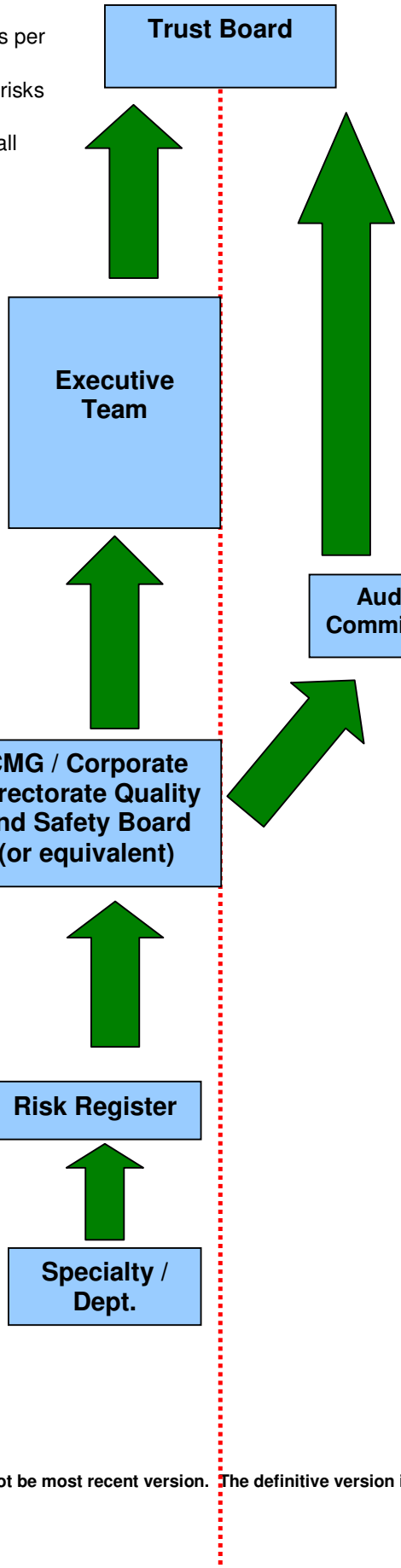
12.1 Following ratification by the TB and UHL Policy and Guidelines Committee new versions of this document will be uploaded onto SharePoint by Trust Administration and previous versions will be archived automatically through this system. Access for staff to this document is available through UHL 'InSite'.

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

UHL RISK REPORTING FRAMEWORK

Executive Function | **Assurance Function**



- Will review the BAF no less than 4 times per year.
- Will receive monthly notification of new risks scoring 15 or above
- Will receive a quarterly report showing all risks scoring 15 or above.

- Will receive immediate notification from CMGs / 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 all risks scoring 15 or above and associated mitigating actions not completed within agreed timescales.
- Will receive a twice yearly report showing risks scoring between 8 and 12 (moderate risks).
- Will hold CMGs / directorates to account for the effective management of local 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 the corporate risk management team showing CMG or directorate risks scoring 15 or above (high and extreme) and between 8 and 12 (moderate risks).

- Approved risks entered on to risk register.

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

1. Introduction

1.1 This guidance is intended to provide support to Datix users in relation to data entry and searching for risks on the UHL risk register.

2. Scope

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

3. Recommendations, Standards and Procedural Statements

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

3.2 Adding a Risk to the Risk Register

3.2.1 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. Users cannot enter data into this field.
Site*	Select from the drop-down list the site or sites that are affected by the risk.
CMG*	Select from the drop-down list the CMG or directorate affected by the risk.
Specialty	Select from the drop-down list the specialties within specific directorates affected by the risk (**NB:** if you require additional specialties to be added please contact the Datix 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	**THIS FIELD IS NOT CURRENTLY USED**
Risk Subtype*	Select from the drop-down list the risk subtype (domain) that scores highest on the risk assessment.
Objectives	Users need not enter data into this field. The corporate risk team will link risks to the Trust's objectives.
Assurance Sources*	Identify either **Internal** or **External** sources of risk information (i.e. how have you identified that a risk is evident). This may relate to inspections / reports from sources such as HSE, Care Quality Commission, internal /external audits, internal policies and procedures, etc. Select from the multi-pick field.
Handler	This field is populated automatically with the name of the person who is logged in to record the risk. (Please note if you require additional names to be added to this list please contact the Datix 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 for easier viewing 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 for easier viewing by pressing 'Ctrl' and 'E'.** Describe the measures that are already in place to control the risk.
Approval Status	**THIS FIELD IS NOT CURRENTLY USED.**
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***:At first this field will reflect the 'initial' consequence and likelihood descriptors however this field should be revised following periodic reviews of the risk action plan to reflect the level of risk at the time of the review. When all actions have been implemented it is expected that the rating will be the same as the 'target'. **Target*:** The 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 descriptors have been entered.
Level	As above.
Cost of risk	An estimate of costs to the Trust if the risk came to fruition (if known)
Investment	Automatically populated from any figures entered in the 'Cost' column of the action plan.
Type	If costs have been identified please specify whether the costs are actual or estimated.
Adequacy of Controls	Specify whether these are Adequate, Inadequate or Uncontrolled.

Field	Information required
Cost/Benefit	Automatically populated by Datix if costs are entered on the action plan. The cost benefit is the cost per risk point between the initial and target score and is calculated by dividing the investment cost by the difference between the initial score and the target score.
Review Date*	A future date must be entered when the risk will be reviewed (in line with review frequency outlined in the UHL Risk Management Policy). **NB:** When an action has been completed it should be entered as a 'control' and the current score should be revised if appropriate to reflect the lower risk.

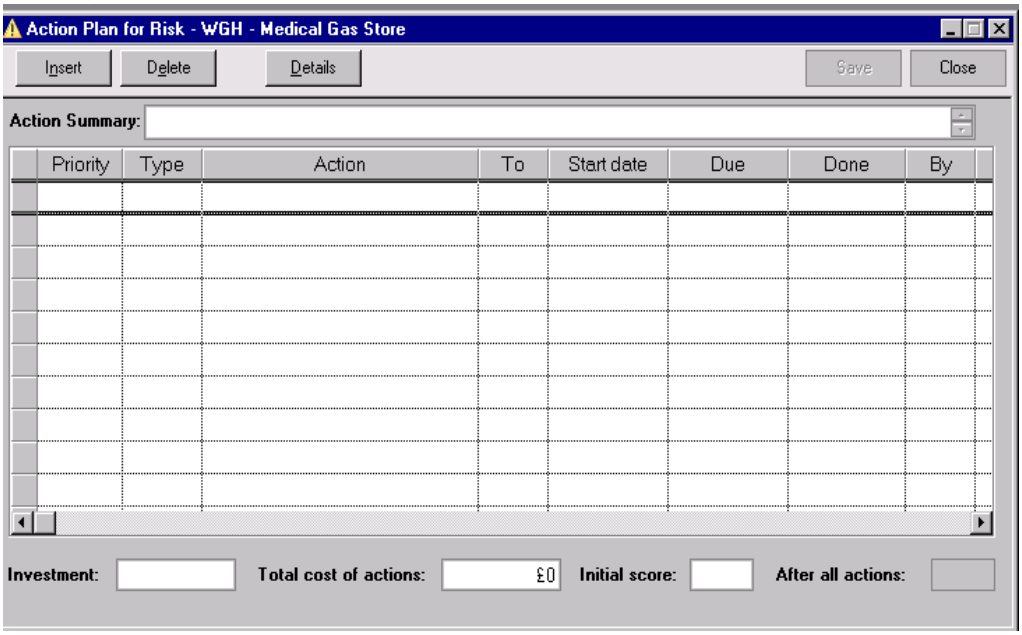
3.2.3 When all information is entered, click '***SAVE'***. This will generate a risk ID.

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'.

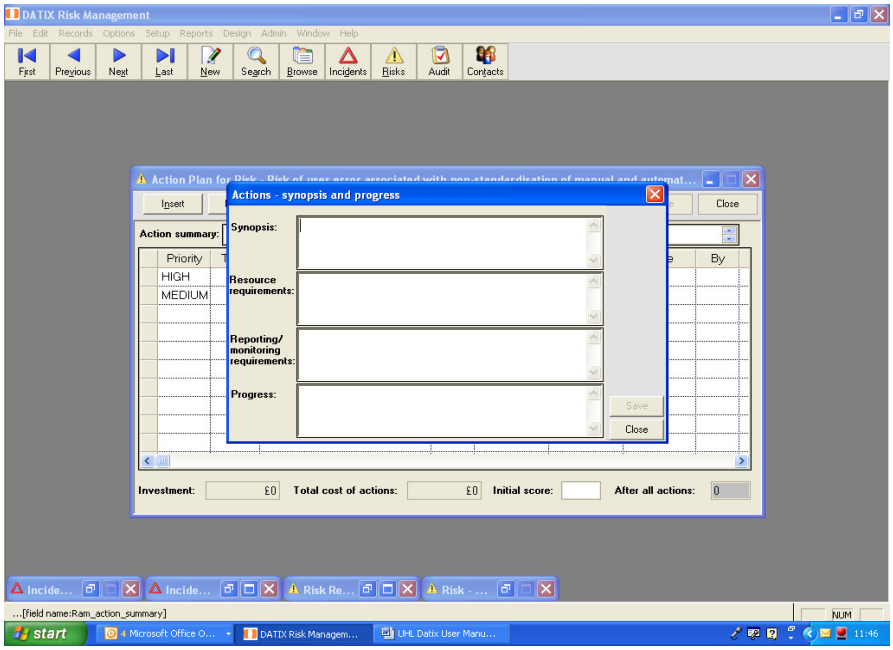
A list of actions to further control (reduce) the risk must be added in this section. An estimated completion date must be entered alongside each action in the ***'Due'*** field. Actions listed in the ***'ACTION'*** field in the main body of the screen must also be copied into the ***'ACTION SUMMARY'*** 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 has completed the action(s).
Cost (optional)	Insert any cost associated with each action (if known). These will automatically populate the 'investment' field and will enable Datix to calculate a cost/ benefit analysis
Cost Type (optional)	Specify whether the costs are capital or revenue or charitable funds (i.e. non-exchequer funded).

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

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

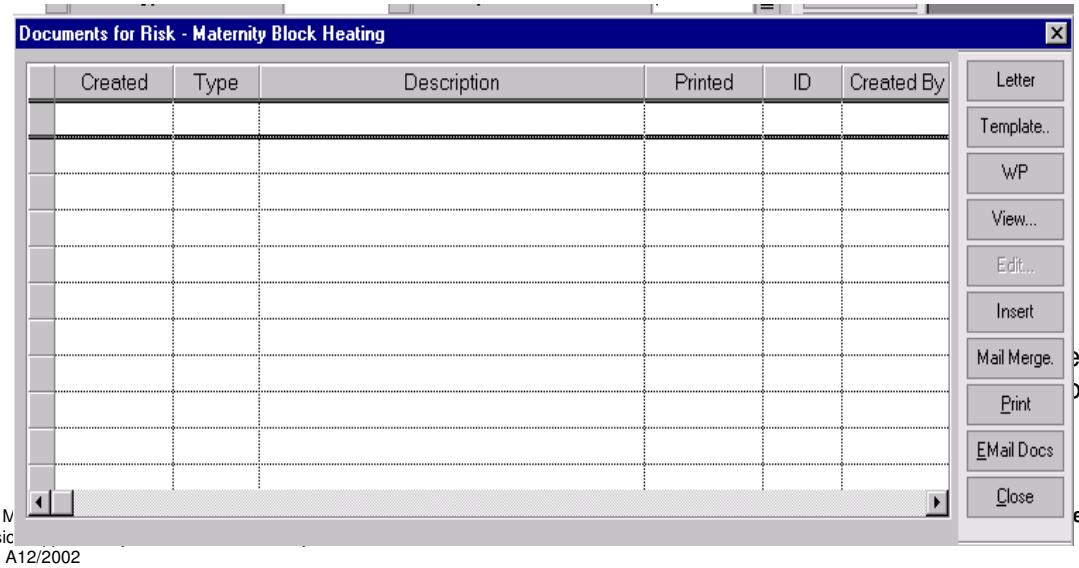


3.3.8 The fields shown in the screen shot above are accessed by clicking on '***DETAILS'*** (above the action summary field). If information has been entered, click '***SAVE'*** then '***CLOSE'*** **to** return to the action plan screen.

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

3.4 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 elected a tion. Please

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

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

3.5 Using Notepad

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

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

4. Searching for a Risk on the Risk Register

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

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

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

Search symbol	Fields to search	Information required
*	Title / description / controls	The asterisk is used to tell Datix that your search criteria include a number of unknown characters. e.g. A search under BROWN* will retrieve all risks beginning with BROWN, i.e. BROWN, BROWNE, BROWNING etc. The asterisk can also be used for key word or phrase searches, e.g. *infusion* will retrieve all risks with the word infusion in the specific search field chosen. Type the 'word' with the asterisk/s and then select the Start button.
:	Opened date / reviewed date / closed date	The colon allows you to search for a range of variables by specifying start and end dates. e.g. 01/01/13:31/03/13 will retrieve risks for the first quarter of 2013.
<	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'less than' symbol enables you to search for value less than a specified amount, or dates before a specified date. e.g. <01/01/14 will retrieve risks for before 1st January 2014.
>	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'more than' symbol enables you to search for values greater than a specified amount, or dates after a specified date. e.g. >01/01/14 will retrieve risks after 1st January 2014.

Search code	Fields to be used	Information required
'Is null' or '=0'	Closed date	If this is entered in the closed date field, it will retrieve all records which do not have data entered in that field. For example if 'is null' is entered in the 'Closed date' field, only cases where there is no date in this field will be identified, i.e. records that are 'open'. This can be entered in upper or lower case.

5. Education and Training

5.1 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).

6. 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

7. 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

8. Supporting Documents and Key References

UHL Risk Management Policy.

9. Key Words

Datix, risk register, guidelines, user guide, search

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)**
13/2/14	3	P Cleaver	Addition of 'search' instructions.

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**

Appendix: Three

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, and AC in 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 stakeholders via ET, AC and CMG/ directorate boards.
	Risk and Assurance Manager	Risk reports to CMG/ 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 CMG /directorate	Annually	As above	As above	As above
High level review of risk register	Risk and Assurance Manager	Risk reports to ET and AC in line with reporting framework.	Annually	As above	As above	As above
Board Assurance framework	Risk and Assurance Manager	BAF reports to TB, ET, and AC in line with reporting framework	Annually	As above	As above	As above
Local management of risk	CMG/ Corporate Directors and Managers	Risk reports to CMG/ directorate boards in line with reporting framework	Annually	As above	As above	As above
	CMG/ Corporate	Actions to mitigate risks being taken within	Annually	As above	As above	As above

	Directors and Managers	timescales				
	CMG/ 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
Risk Reports	Risk and Assurance Manager	Risk reports showing involvement of key individuals in risk management	Annually	As above	As above	As above

Appendix Four

UHL RISK ASSESSMENT FORM				Local Ref. No.	
Title of risk (i.e. There is a risk of/that… resulting in…)					
CMG/Corporate Directorate		Specialty		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*

Causes of the risk (hazard)

Consequences of the risk (harm / loss event)

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

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

Risk subtype: Consequence descriptor: select highest risk subtype score to enter on to Datix risk register (Delete risk subtype if not applicable to the risk in question)	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: What 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	Completed 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 (All risk assessments must be approved prior to being entered on to Datix)

Risk Assessor name		**Signature**		Date	
Line Manager name		**Signature**		Date	
NOTE: This Risk Assessment form must be approved by the CMG / corporate directorate board prior to being entered on to the Datix risk register					
Approved by CMG / 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. Not requiring first aid	Minor injury or illness, requiring minor intervention (including first aid, additional therapy and/ or medication) Increase in length of hospital stay by 1-3 days An event that consequences on 1 – 2	Moderate increase in treatment defined as a return to surgery, unplanned readmission, prolonged episode of care (4-15 days), extra time as an outpatient, cancellation of treatment or transfer into hospital as a result of the incident. Moderate injury requiring	Mismanagement of patient care with long-term effects Prolonged episode of care by >15 days An event that consequences on 16 – 50 patients	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients (i.e. > 50)

		patients	professional intervention RIDDOR/agency reportable incident An event which Consequences on 3 -15 patients		
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. Not requiring first aid No time off work	Minor injury or illness, requiring minor intervention. Requiring first aid. Requiring time off work for <3 days	Moderate injury requiring professional intervention and / or counseling Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability and / or counseling 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 complaint/ inquiry	Overall treatment or service suboptimal verbal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness (written) 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	Non-compliance with national standards with significant risk to patients if unresolved Multiple, repeated complaints/ independent review Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient 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)	Ongoing low staffing level that reduces the service quality 75% – 95% staff attendance at mandatory training	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence 2-5 days) Low staff morale Moderate / minor error due to poor staff attendance for mandatory/key training 50% -75% staff attendance at mandatory 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 Major/ serious error due to no staff attending mandatory/ key training 25%-50% staff attendance at mandatory training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Critical error due to no staff attending mandatory training /key training on an ongoing basis Less than 25% staff attendance at mandatory training
STATUTORY (Statutory duty/ inspections)	No or minimal consequence or breech of guidance/ statutory duty. Small number of recommendations that focus on quality and safety improvement issues	Single breech of statutory duty Reduced performance rating if unresolved Minor recommendations that can be implemented by low level of management action	multiple breeches in statutory duty Challenging external recommendations/ improvement notice that can be addressed with appropriate action plan	Multiple breeches in statutory duty with subsequent enforcement action Improvement notices Critical report	Multiple breeches in statutory duty with subsequent prosecution Complete systems change required Severely critical report and subsequent prosecution
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	Insignificant cost increase/ or	<5 per cent over project budget	5–10 per cent over project budget	Non-compliance with national 10–25	Incident leading >25 per cent over project budget

objectives/ projects)	slippage of project but recoverable to original timescale	Slippage of project with uncertain recovery to original timescale	Slippage of project affecting original timescale but within contingency plans	per cent over project budget Slippage of project affecting original timescale with uncertain recovery within contingency plans Key objectives not met	Late delivery of project (outside of contingency limits). Key objectives not met
ECONOMIC (Finance including claims)	Loss of £1 - £999 Risk of claim remote	Loss of £1,000 - £9,999 Overspend or 0.1–0.25 per cent of budget Claim less than £10,000	Loss £10,000 – 50,000 Overspend of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of £100,000 - £1 million 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	Loss > £1 million 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)	Minor on-sit release of substance No direct contact with patients, staff, members of the public.	On-site release of substance contained. Minor damage to Trust property <£10,000	On-site release with no detrimental effect Moderate damage to Trust property £10,000 – £50,000	Off-site release/ on-site release with potential for detrimental effect. Major damage to Trust property >£50,000	On-site/ off-site release with realised detrimental/ catastrophic effects Loss of building

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	**4**	**8**	**12**	**16**	**20**

persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%					
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)	Review at least quarterly. Place on risk register.
High (15 – 20)	Review at least monthly. Place on risk register.
Extreme (25)	Review weekly. Place on risk register.

Appendix: Five

RISK ASSESSMENT ESCALATION PROCESS