Risk Management Policy and Process

Document Summary

This Policy outlines the Trust's Risk Management Framework, which will ensure the Trust identifies and manages all risks which have potential adverse effects on the quality of care delivered and the safety of patients, carers, staff, visitors and the organisation.

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ACCOUNTABLE DIRECTOR	Director of Quality and Nursing
POLICY AUTHOR	Head of Clinical Governance

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as "uncontrolled" and, as such, may not necessarily contain the latest updates and amendments.

Here for you

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1   SCOPE

This policy applies to all staff and service areas within the Trust.

2   INTRODUCTION

The purpose of this Policy document is to define Cumbria Partnership NHS Foundation Trust as follows:

- To comply with legal & statutory requirements and to comply with the requirements of external regulators and other relevant bodies;
- As guidance to assist with proactive risk management and risk mitigation;
- To support the organisation in its approach to ensuring the safety of staff, patients, visitors and others affected by the Trust's activities.

The Trust has a framework and process in place for identifying, assessing, managing and monitoring risks which have potential adverse effects on the quality of care delivered and the wider business of the organisation. Key strategic risks are identified and monitored by the Trust Board; operational risks are managed on a day to day basis by staff throughout the organisation.

Risk Management, Patient and Staff Safety are the responsibility of all staff at all levels across the organisation.

3 STATEMENT OF INTENT

The Board of Directors recognises that risk and safety management is an integral part of good management practice. The Trust is committed to ensuring that risk and safety management is embedded into its philosophy, practices and business plans. Strategic, clinical, operational, corporate and financial risks will be managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders.   Responsibility for implementation is accepted at all levels of the organisation.

The Trust will comply with the requirements set out by the Department of Health, the Care Quality Commission, Monitor, NHS Litigation Authority, and all other Regulatory bodies, and incorporate those standards into its risk management practices.

The Trust will operate an Assurance Framework and Corporate Risk Register to enable the identification and management of strategic risk within the Trust.

3.1 Aims

Through a coordinated approach to the management of risk and clinical governance within the Trust the aim is to:

- Improve quality of care and patient experience;
- Maintain a safe environment free of unnecessary risks for patient, employees and visitors;
- Ensure the provision of a robust system for reporting and analysis of an incident with timely learning for all staff;
- Ensure that there are effective risk management systems, processes and arrangements in place and that these are monitored on an ongoing basis;

- Create an open approach to incident identification and investigated, supported by a learning culture;
- Develop activity to support the population of the Trust's Board Assurance Framework (BAF), through the ongoing review of local and Corporate Risk registers;
- To support the achievement of the Trust objectives and priorities as set out in the Annual Business Plan;
- To ensure that staff are aware of the process for the management of risk locally and that there are clearly defined roles and responsibilities for the management of risk;
- To use risk assessment and intelligent risk information i.e. risk registers, to inform the overall business planning process;
- To identify the process through which the Board and sub board level committees will review, scrutinise and monitor the Corporate Risk Register and Board Assurance Framework.

3.2 Outcomes
- The Trust will meet its statutory duties and comply with all appropriate regulations, assessment, accreditation and external reporting requirements;
- Trust staff will be aware of their duties and responsibilities in relation to risk management and will manage and escalate risks accordingly;
- Through effective risk management the Trust will meet its objectives, including improved quality and safety and best use of resources for all patient, staff, visitors and the community.
- Demonstrate a learning culture, which centres on patient safety ensuring lessons are learnt from adverse events and encouraging staff to speak up safely when they are concerned about safety or quality of services.

4   DEFINITIONS

4.1   Risk Management
"Identifying all risks which have potentially adverse effects on the quality of care and the safety of patients, staff and visitors; assessing and evaluating these risks; and taking positive action to eliminate or reduce them." (NHS Executive)

Risk management can also be defined as the identification, assessment, and management of issues likely to affect achievement of objectives.

4.2   'Acceptable risk'
An identified risk which is unlikely to lead to an occurrence and, if it did so, would be unlikely to cause illness, injury, damage, or would only cause minor disruption to service. An acceptable risk would be graded under 15 on the Trust's risk grading matrix and have estimated consequences or impact of 1, 2, or 3.

4.3 'Significant risk'
Significant risks are defined as "risks that are significant to the fulfilment of the Trust's objectives".

4.4 Risk response
The approach taken to avoid, accept, reduce or share an identified risk. This will be

determined with reference to the corporate strategy, objectives, and risk management philosophy and risk appetite of the organisation.

5. DUTIES
The Trust Board of Directors is collectively accountable for risk management and has a collective responsibility to ensure that the Board provide review and challenge to support the management of risk. The Board is made up of both Executive and Non-Executive Directors.

5.1 Chief Executive
The Chief Executive has overall accountability for risk management, delegating responsibility to the appropriate Executive Director according to their portfolio.

5.2 Director of Finance
Assists the Chief Executive and is designated as the Executive with overall accountability for financial risk.

5.3 Director of Quality and Nursing
Is the designated Executive Director with overall accountability for risk management, including the management of claims. Is responsible for supporting the co-ordination of risk activity across the Nursing and Allied Health Professionals workforce, to implement and comply with clinical policy and practice in relation to managing risk including nursing revalidation.

5.4 Director of Operations
Is the designated Executive Director with overall accountability for supporting the co-ordination of activity across all operational services in relation to managing risk. They assume the role of the Chair of the Trust Management Group (TMG).. TMG will conduct a quarterly review of the top risks across care groups and support services, which will inform Board-level discussions about the impact of these risks or service delivery and on the risks detailed in the Board Assurance Framework (BAF).

5.5 Medical Director
Is the designated Executive Director with overall accountability for supporting the co-ordination of risk activity across the Medical workforce, to implement and comply with clinical policy and practice in relation to managing risk including medical revalidation.

5.6 All Directors
Will ensure the Risk Management Policy is embedded within their service areas. Directors will take responsibility for risks graded 15 and over (known as the Corporate Risk Register) within their service areas. Directors will also take responsibility for bringing these risks to the attention of the Quality and Safety Committee and Finance Investment & Performance Committee, depending on the nature of the risk.

5.7 Deputy Director of Quality and Nursing
Has responsibility for overseeing arrangements, systems and processes that enable the management of operational risks, across the organisation.

5.8 Associate Director of Corporate Governance and Company Secretary

Has responsibility to ensure that a robust Board Assurance Framework is in place, which provides the Board with line of sight to significant risks within the organisation and informs strategic decision making. They are also responsible for production of the Trust's Annual Report and Annual Governance Statement.

5.9 Head of Corporate Governance

Has responsibility for implementation of the strategic aspects of risk management across the organisation, including the management of the Board Assurance Framework, management of the Trust's business planning cycle and production of the Annual Governance Statement. They also oversee functions within the organisation which provides expertise on health & safety, fire safety and security management issues, and are the liaison between the Trust, the Health & Safety Executive and NHS Security Management Service.

5.10 Head of Clinical Governance

Has responsibility for the implementation of operational aspects of the risk management across the organisation, includes regular updates to the sub board committees as and when required (as per work plans). Has responsibility for the management of the systems used for risk management (Ulysses). Oversees the development of training courses and updates in relation to risk management for all staff.

5.11 Management and Clinical Leads

Have a duty to understand and support the embedding of the Trust's Risk Management Policy within their service areas, and ensure appropriate and effective risk management processes are in place within their designated scope of responsibility.

They should refer to Operational Managers, Quality and Safety Leads and Care Group Senior Leadership Teams for help and support in responding to significant risks or where the risk has wider organisational impact.

5.12 All Employees

All employees are required to:

- Report significant events; incidents; accidents and near misses in accordance with Trust Policy for Serious Incident which Require Investigation and Incident Policy.
- Work within Trust policies, guidance and risk assessments to protect the health, safety and welfare of themselves and anyone affected by the Trust's business.
- Raise concerns about safety or risk issues of which they are aware and contribute to risk identification and risk assessment processes within their service areas.

6. Organisation Risk Management Structures

Appendix E outlines the Trust's risk management structure detailing all of the Committee/Groups which have some responsibility for risk management and how they interface to ensure an integrated, embedded approach to risk management.

The Terms of Reference for Committees/Groups with responsibility for management risk are regularly reviewed and monitored by the relevant committee chair. The Associate Director of Corporate Governance & Company Secretary coordinates the annual evaluation of Board Sub-Committees. As a minimum the evaluations will include:

- Duties;
- Reporting arrangements
- Membership
- Required frequency of attendance by members;
- Requirement for a quorum;
- Frequency of meetings;
- Process for monitoring compliance with all of the above.

6.1 Trust Board

The Board of Directors will ensure that the Trust has a framework and process in place to identify, assess, manage and monitor risks which could have significant strategic or operational impacts. A balanced and risk-based approach will be adopted to mitigate risks which could have patient safety, quality, and financial impacts.

The Board of Directors will review the strategic risk landscape on at least an annual basis in order to inform the framing of the Board Assurance Framework and the setting of business plan priorities.

Significant risks arising from operational activities or identified through internal or external quality governance evaluations, will be evaluated and escalated in accordance with the Trust's governance frameworks. The Board of Directors will ensure it has line of sight to arrangements for the identification and management of significant risks through a robust Board Assurance Framework and through its governance structures and arrangements. Governance structures and arrangements are described separately in the Trust's Governance manual which is maintained by the Corporate Governance Department.

The Trust will endeavour to comply with the requirements set out by the Department of Health, the Care Quality Commission, Monitor, and all other Regulatory bodies, and incorporate those standards into its risk management practices.

The Trust Board undertakes to ensure the adequate provision of resources, including financial, personnel, training and information technology is, as far as reasonably practicable, made available for the effective management of risk.

As part of the Annual Governance Statement contained within the Annual Report, the Trust will make a public declaration of compliance against meeting risk management standards.

6.2 The Audit Committee

Is the primary Board-Sub Committee and has statutory duties to seek assurance on the Trust's arrangements for internal control. The Audit Committee must be satisfied that the Trust's Risk Management Strategy and Risk Management arrangements are

appropriate to the scale and complexity of the organisation, and are being effectively implemented.

6.3 Quality and Safety Committee

The Quality and Safety Committee is a sub-committee of the Trust Board and is the Committee with responsibility for gaining assurance on the effectiveness of clinical governance and associated risks across the Trust. The Committee makes recommendations to the Board of Directors on their level of assurance on the management of strategic risks.

6.4 Finance Investment & Performance Committee

The Finance Investment & Performance Committee is a sub-committee of the Trust Board and is the Committee with responsibility for gaining assurance on the management of financial and operational performance and associated risks across the Trust. The Committee makes recommendations to the Board of Directors on their level of assurance on the management of strategic risks.

6.5 Trust Management Group (TMG)

Acts as the overarching Executive-Led group which undertakes review of Risk Registers and Risk Management. Membership consists of Executive Directors, Deputy Directors, Associate Directors of Nursing, Associate Medical Directors, Associate Directors of Operations and Head of Support Services. TMG is a sub group of the Executive Committee and through to Board. TMG ensure that there is:

- Rigorous review of the high level and corporate registers on a quarterly basis;
- To ensure that there is clear and robust management arrangements at all level of the organisation in relation to risk management;
- Intelligent information is available to support decision making and effective operational management to ensure safety service delivery.

6.6 Trust Wide Clinical Governance Meetings

This meeting provides an update to the Quality and Safety Committee on a monthly basis. The aims of this group are as follows:

- To act as a focus for constructive challenge and improvement on all issues relating to the quality of clinical care offered by the trust.
- To promote continuous improvement in patient safety, clinical effectiveness and patient experience.
- Through the use of the care group highlight reports and other high level reports, the identification of risk, which are appropriately escalated to TMG. Trust Wide Clinical Governance Meeting can, as appropriate, escalate risks directly to the Quality and Safety Committee in accordance with the Trust's governance arrangements.

6.7 Care Group Clinical Governance

Each Care Group has Clinical Governance arrangements in place at a team, network (or service) and care group level where risks and incidents should be discussed. The Care Groups should manage these risks and the escalation of risks as shown in Appendix A and B.

Each Care Group Senior Leadership Team should meet with the Deputy Director of Quality and Nursing and the Clinical Governance Manager on a quarterly basis to review their care group risk registers, scores and process with action plans. This process should be replicated throughout the care group clinical and operational structures. Risks for proposed escalation will be taken by the Clinical Governance Manager and discussed with the Head of Corporate Governance for consideration for inclusion on the Corporate Risk Register and any potential impact on the Board Assurance Framework.

6.8 Support Services Governance

For risks which are highlighted through support services, then a similar process will be followed as the process which is in place for care groups. There is an expectation that support services will review and discuss any current or emerging risks through regular team meetings. High level risk should then be discussed in more detail, on a quarterly basis at the Heads of Support Services Meetings.

Any risks which are assessed as 15 or above would be included as part of the quarterly review at Trust Management Group (TMG), which will review the risk, agree supportive actions and can escalate to Finance Investment and Performance Committee or Quality and Safety Committee (as required). TMG will consider the impact of all risks on the Board Assurance Framework (BAF).

7. RISK MANAGEMENT PROCESS

Risks impacting upon the activities and resources of the Trust may arise from a variety of sources including; strategic, clinical, operational, corporate, financial, economic, political and regulatory.

Risk management is an approach that addresses risks associated with the activities and environment of an organisation. It involves the identification of all sources of risk, the evaluation and assessment of identified risks for potential frequency and severity, and the identification and implementation of appropriate risk control and risk financing strategies to eliminate, minimise, transfer, finance or retain risks. This holistic approach towards risk management is known as enterprise risk management.

Effective risk management can enable the organisation to meet its objectives and also identify opportunities to improve the quality and effectiveness of services, which in the case of the Trust would lead to improvements in clinical care and patient experience.

7.1 Identifying Risk

Managers at all levels are responsible for ensuring processes are in place on an on-going basis for the identification, evaluation and assessment of risks. Proactive and reactive measures will be used as part of the continual process of risk identification, evaluation and assessment.

All risks that are not specific to individual patients will be graded against the standard risk grading matrix (Appendix C) and will be recorded on the Risk Register.

Risks must be reviewed at least annually to ensure that control measures are still appropriate.

7.2 How to perform risk identification

The key steps necessary to effectively identify risks from across the organisation are:

1. Gather information from different sources to identify risks (e.g., complaints, claims, incidents, clinical audit, internal / external reviews etc.)
2. Apply risk identification tools and techniques;
3. Use risk categories for comprehensiveness;
4. Document the risk;
5. Document the risk assessment process;
6. Assess the effectiveness of the risk identification process.

Process for Risk Assessment and Scoring

7.3 Introduction to risk assessment

Risk assessment is a systematic process to quantify or qualify the level of risk associated with a specific threat or event, to enrich the risk intelligence available to the organisation. The main purpose of risk assessment is to help prioritise the organisation's most important risks and to understand whether all reasonable steps have been taken to minimise the likelihood of the risk materialising and/or its impacts.

Risks should be assessed on the basis of the likelihood of the risk occurring and the impact/consequence of its occurrence on the Trust/service objective(s). Consideration should also be given to the controls and assurances in place to manage/mitigate the risk.

7.4 Recording of Risk Assessments

Risk assessments must be documented in a clearly understandable and unambiguous manner, stating the actual management practices that are operated to control or mitigate the risk. All risk assessments will be recorded on the 'online risk assessment tool' within Ulysses, which is accessible via the intranet.
Please note that the exception to this is person/patient specific risk assessment should be stored and located in the patient notes either manual records or the electronic patient record.

Risk assessments must be entered onto the database at the local level by any member of staff, however a local manager must review and sign the risk assessment off before this will be added to a risk register. Risk assessments entered onto the online tool populate the Trust's risk registers.

Please note: Not all risk assessments go onto the Ulysses system so the paragraph should maybe say 'with the exception of person specific risk assessments'. Person specific risk assessments are completed at a local level for patients and staff e.g. patients with a history of violence and aggression, particularly in the community and return to work risk assessments for staff following illness or stress. The patient risk assessments go into patient notes either manual records or EMIS. Staff risk assessments go into their personal files.

7.5 Review and Monitoring of Risk Assessments

All risk assessments must be reviewed, and where necessary updated. The time between reviews is dependent on the nature of the risk and subject matter of the risk

assessment. As a minimum risk assessment must be reviewed at least annually or:

- When the nature of the work activity / environment / risk source changes;
- After an accident, case of ill health or dangerous occurrence relating to the identified hazard;
- Developments in work practices or management arrangements suggest the assessment may no longer be valid;
- Monitoring of reported incidents and near misses highlights areas of concern with findings of risk assessment;
- Identified actions to reduce or control risk further have been undertaken or completed.

7.6 Risk Scoring/Grading Matrix

Once a risk assessment has been completed on the Ulysses system the risk should be scored using the standard risk scoring/grading matrix tool to estimate the Likelihood x Consequence of the risk being realised and giving an overall risk score.

The Trust's Risk Scoring/Grading Matrix are included as Appendix C.

8. Overview of Risk Registers

The Trust utilises the Ulysses Risk Module to record risk assessments. Entries on the database are collectively known as the risk register. Risk assessments can be added by any member of staff, but will be reviewed and signed off by a member of staff before they are added to a risk register.

Risks identified by other trigger events, i.e. incidents, complaints, service reviews etc. will also be assessed, graded and added to the risk register. This approach will ensure a systematic approach to all risk assessments throughout the organisation.

Risks recorded on the Ulysses risk database that are graded 15 or above will automatically be considered as part of the corporate risk register for the Trust and therefore will be reviewed at both the Care Group Clinical Governance Meeting and the Trust Management Group.

All risks, irrespective of the grading, must be managed as far as reasonably practicable within the remit and resources available to the respective manager. Where managers consider escalation of a risk is appropriate, this will be conducted via line management or clinical governance structures, ultimately to Executive Directors. Directors take responsibility for risks graded 15 or above (known as the corporate risk register) that fall within their service areas. The Trust accepts that all risks recorded on risk registers that are not assessed as 15 or above, are being adequately controlled at the local level by the relevant service manager, and are therefore 'acceptable' risks.

8.1 Key Principles of Risk Registers

- Risk Registers should be a dynamic management process used by managers to manage risk and prioritise resources across the Trust. Care Group and Corporate Services should identify the key risks associated with delivering their services and achieving the Trust's key objectives.
- Risk Registers should only be used for risks that cannot be immediately

resolved.

- In identifying risks, consideration should be taken of other information from performance monitoring, results of local/national audit programmes or through the reporting of incidents (including patient experience, complaints, claims, etc.).
- Risks that cannot be sufficiently managed (and are 'high-risk') within a Care Group or Corporate Services will be escalated to the Trust Management Group (TMG) for review.
- Accuracy of data is essential and when risks are entered onto this system all relevant fields on the form should be completed. The risk register must include source of the risk, description of the risk, the risk score, the action plan, dates of risks review and the target score (this is the residual risk score/risk appetite).

9. Board Assurance Framework and Risk Registers
In order to ensure that risks are identified and quantified at all levels of the Trust, a Board Assurance Framework (BAF) and Corporate Risk Registers are in place, both of which are the responsibility of the Board of Directors. These tools underpin the Trust's Risk Management Strategy.

9.1 Risk scored as 15 or above (Corporate Risk Register)
The Corporate Risk Register will contain all types of risks, i.e. Strategic; Organisational; Clinical; Financial; and Service Delivery. Population of local risk registers in accordance with the Service Delivery Health and Safety Risk Assessment Policy will enable this to occur.

The Corporate Risk Register is designed to define operational risks, as well as those with an organisational impact. Usually only risks graded 15 and over and which impact on the activity of a strategic target will be included in the Corporate Risk Register, however risks graded less than 15 may also be included following discussion at Trust Management Group (TMG).

Some risks on local risk registers that have wider implications may be unresolved at local level. These unresolved risks with wider implications to the organisation will be considered for inclusion in the Corporate Risk Register and escalated to the Trust Board through governance structures.

The Quality and Safety Committee or Finance Investment & Performance Committee may also identify and agree risks for inclusion onto the Corporate Risk Register. The relevant Executive Director will be responsible for the ongoing management of such risks.

The Quality and Safety Committee will review the corporate risk register on a quarterly basis. The Audit Committee will receive assurance of the management of risks on the Corporate Risk Register on at least an annual basis. The Board of Directors will receive assurance on the management of strategic risks on a quarterly basis.

10. Organisation-Wide Overview of Risk Assessments
A combination of Local risk registers, the Corporate Risk Register, the Board Assurance Framework, analysis/data reports from the Ulysses risk database, together with annual and other quality, safety and performance reports and reports from internal

and external audit will be used by the Board, Quality and Safety Committee, Trust Management Group and relevant subgroups of these Committees, to gain an organisation wide overview of risk within the organisation.

10.1 Incident Reporting and Management
Data on reported incidents provides an evidence base upon which objectives can be identified and prioritised. It provides an indicator of risk management performance and identifies potential areas of weakness in risk management systems. This essential information and data feeds into the Trust's risk and safety management systems and advises on the control measures the organisation needs to have in place.

Please refer to the Trust's Policy for Incidents and Serious Incident which Require Investigation Policy for further detailed information.

10.2 Claims Management
An agreed system of dealing with claims is in place, in line with existing NHS Claims guidance. Please refer to Claims Management Policy and Procedure.

10.3 Complaints Management
An agreed system of dealing with concerns and complaints is in place, in line with existing NHS Complaints Guidance. Please refer to Complaints Policy.

10.4 Duty of Candour/Being Open
Please refer to the Trust's Being Open Policy for details as to how the Trust ensures that the requirements set out under the Duty of Candour Regulation.

10.5 Stakeholder Involvement
It is essential risk management practice to involve Stakeholders in all areas of the Trust's activities; this includes informing and consulting on the management of any significant risks and safety issues.

Stakeholders of the Trust include (but are not limited to):
- Service Users and Carers; Trust Board
- Trust staff
- Cumbria Clinical Commissioning Group
- NHS England
- North Cumbria University Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Cumbria County Council
- Internal Audit
- Counter Fraud & Security Management Service
- Health and Safety Executive
- Medicines and Healthcare Products Regulatory Agency
- National Patient Safety Agency
- Care Quality Commission
- Monitor

11. TRAINING
Training in risk management will be available to all staff in a number of ways:
- Risk management for managers training - face to face training for all staff in

management or leadership role (available from September 2016).

- Bespoke training for teams – for example training and presentations at team meeting etc. (available now).

12. MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed

The Management of risk is in accordance with this policy, to include:
▪ organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk
▪ process for board or high level committee review of the organisation-wide risk register
▪ process for the management of risk locally, which reflects the organisation-wide risk management strategy
▪ duties of the key individual(s) for risk management activities
▪ authority of all managers with regard to managing risk
▪ process for assessing all types of risk, notably strategic
process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation
▪ assignment of management responsibility for different levels of risk within the organisation
▪ The Risk Register contains;
   o source of the risk (including, but not limited to: incident reports, risk assessments and directorate risk registers),
   o description of the risk
   o risk score
   o summary risk treatment plan
   o date of review
   o residual risk rating.
	Annual review of systems , including a review of the minutes and reports of Sub-Committees to:
	▪ Quality and Safety Committee
		Clinical Governance Manager	Annual	Audit Committee	Director of Quality and Nursing

Process for the management of risk locally (including risk escalation) is being followed	Review of risk registers Review of minutes from clinical and operational at care group and trust wide level	Clinical Governance Manager	Annually – inclusion in the annual care group clinical governance reports	Quality and Safety Committee	Director of Quality and Nursing
Review of Trust's Risk Management arrangements are included in Internal Audit schedule of work	Internal Audit Annual Audit Plan and	Head of Internal Audit	Two-yearly	Audit Committee	Director of Quality and Nursing
Risk management training for all staff within the organisation at various levels as set out in the Trust's annual Learning Needs Analysis	Attendance at training will be managed in accordance with the Learning and Development Policy.				

13. REFERENCES/ BIBLIOGRAPHY

Health and Safety at Work Act (1974)

The Management of Health and Safety at Work Regulations (1999)

An Organisation with a Memory (DH, 2000)

Building a Safer Place for Patients (DH, 2001)

Seven Steps to Patient Safety (NPSA, 2004)

Safety First (DH, 2006)

Risk Assessment Programme (NPSA, 2006)

Healthcare Risk Assessment Made Easy (NPSA, 2007)

A Risk Matrix for Risk Managers (NPSA, 2008)

Essential Standards of Quality and Care (CQC, 2011)

Duty of Candour (CQC, 2014)

Risk Assessment Framework (Monitor, 2014)

14. RELATED TRUST POLICY/PROCEDURES

Risk Strategy

Duty of Candour/Being Open Policy

Serious Incident and Incident Policy

Incident and Serious Incident which Requires Investigation Policy

Complaints Policy

Claims Management Policy

Central Alert System Policy

Health & Safety Policy

Security Policy

Fire Safety Policy

Cumbria Partnership **NHS**
NHS Foundation Trust

APPENDIX A: RISK ASSESSMENT PROCESS

Possible Risk Identified
- Risk Assessment (RA) completed on Ulysses
- discussion with line manager

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Risk Assessment reviewed in team/ service

Consider for risks scored very low or low (1-6)
Manage Risk Locally
- RA reviewed and agreed by local manager
- RA added to risk register
- Regularly review and scrutiny through team and network clinical governance

Consider for risk scored as moderate (8-12)
Manage risk at network or care group level
- RA Reviewed and agreed by local manager
- RA added to risk register
- Regular review and scrutiny through network clinical governance

Consider for risk scored as high (15+)
Manage risk at care group level
- RA Reviewed and agreed by local manager
- RA added to risk register
- Regular review and scrutiny through care group clinical governance
- Reviewed at TMG

De-escalate to be managed at network or team level

Managed at care group level

Added to top risks on care group risk register

Reviewed quarterly at team or network clinical governance forums

Reviewed at monthly Clinical Governance/ heads of support services meeting

Quarterly review of organisation top risks at TMG
- Review all risks and determine management
- Consider impact on BAF

APPENDIX B – RISK RATED 15+ ESCALATION FLOW CHART

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┌────────────────────────────────────┐
│   Risk identified through various   │
│               sources               │
└────────────────────────────────────┘
                  │
                  ▼
┌────────────────────────────────────┐
│         **Local management**        │
│   Review of risk assessment and risk│
│   registers at team, network and care│
│   group level through clinical      │
│   governance structures             │
└────────────────────────────────────┘
                  │
                  ▼
┌────────────────────────────────────┐
│      **Trust Management Group**     │
│   Quarterly review of organisational│
│   top risks                         │
└────────────────────────────────────┘
       │                  │
       │                  ▼
       │      ┌────────────────────────────────────┐
       │      │      **Trust Management Group**     │
       │      │   Decision to:                      │
       │      │    - Agree explicit link to BAF     │
       │      │    - Refer back to care group for   │
       │      │      further information            │
       │      └────────────────────────────────────┘
       │                  │
       ▼                  ▼
┌──────────────────────────┐  ┌──────────────────────────┐
│   Audit Committee        │  │   Trust Board            │
│   - Scrutiny of corporate│  │   - Quarterly review of  │
│     risk register and BAF│  │     BAF                  │
│   - Scrutiny of risk     │  │                          │
│     management processes │  │                          │
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APPENDIX C: Determining the Risk Grading

A risk grading must be decided upon for the task/activity/hazardous situation in question. This should be done taking into account how likely the people at risk are to be exposed to the identified hazards bearing in mind the control measures already in place to eliminate or minimise exposure.

The Trust operates an established risk grading system based on a 1-5 scale for likelihood and consequence, known as the 5 x 5 matrix. Using this scale the lowest risk is graded as 1, and the highest risk is graded as 25. Risks graded 15 or above are considered High Risk and are eligible for consideration onto the Corporate Risk Register. The matrix operates on the following descriptors (adapted from the tool available on the NPSA website **www.npsa.nhs.uk**

Model matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, 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 Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal 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 Formal 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 complaints/ independent review Low performance rating 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/ 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 duty/inspections	No or minimal impact 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
Adverse publicity/reputation	Rumours 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 objectives/projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule 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
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
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Very low risk
	4 - 6	Low risk
	8 - 12	Moderate risk
	15 - 25	High risk

APPENDIX D: Management of Risk/ Escalation process

Current Grade Score		Escalation Process – Action Required	Escalated by whom
Very Low Low **1-3 (Green)** / **4-6 (Yellow)**		Acceptable risk Risk graded into this less serious category will either require no action or can be mitigated through local action by appropriate person To be reviewed at team meetings	All employees Team leader oversight and escalation as required
Moderate 8 – 12 (Amber)		Moderate risk – as above plus: Review and consideration at network care group meetings and departmental meetings	Network Managers Clinical Directors Heads of Support Services
High and Very High 15 -25 (Red)		Significant risk – as above plus: Report to Care Group Escalation to TMG Consider escalation to Corporate Risk Register and The Board Board Assurance Framework (BAF)	Associate Directors of Operations Heads of Support Services Associate Directors of Support Services Executive Directors