

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

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INTRODUCTION

The Countess of Chester Hospital NHS Foundation Trust is committed to delivering high levels of safe and effective patient care. In order to achieve this, the management of risk continues to be an integral component of the Trust's corporate and patient safety agendas.

The purpose of this strategy and the underpinning operational policy is to ensure that the Trust identifies, assesses and appropriately manages all risks to people, structures, reputation and any other issues which could impact on or compromise the ability of the Trust to carry out its normal duties and continue to deliver high levels of safe and effective health care.

It is acknowledged that risk is inherent in all aspects of the Trust's activities including the treatment and care we provide to our patients, the determining of our service priorities, the projects and developments we manage, the equipment we purchase, the decisions we take on our future strategies and in deciding when no action is to be taken.

The Trust recognises that effective risk management requires commitment from all staff in order to ensure that risks are identified and managed effectively.

AIMS

The aims of the strategy are to ensure that:

- The Trust continues to recognise risk management as a key element of all activities
- Risk management systems and processes are embedded locally across all Divisions and Departments
- All risks are identified that may have a potential adverse effect on the quality of care, safety and well-being of patients, staff, volunteers and visitors, and on the business, performance and reputation of the Trust
- The Trust maintains a co-ordinated approach in managing risks through a systematic process of identification, assessment, control and management of risk.

OBJECTIVES

The principal objective of the risk management strategy is to provide the Board of Directors with sufficient assurance that appropriate structures and processes are in place to minimise risks and loss of assets and reputation and that the reporting processes for risk are maintained.

The strategy will also seek to:

- ensure that the risk management processes are integral to the organisational working practices and culture
- encourage the reporting of incidents, within a fair blame culture ensuring that lessons are learned and preventative measures introduced
- ensure that, through the strengthening of risk management arrangements there are continual improvements to patient safety
- minimise claims for accident or injury against the Trust
- support systems which eliminate, transfer or reduce risks to as acceptable a level as possible
- secure the highest possible standards of risk management in terms of external validation, including the NHS Litigation Authority (NHSLA) Risk Management Standards and CQC Inspection Process

PRINCIPLES OF RISK MANAGEMENT

The following principles underpin the strategy:

that risk management will be embedded in the core processes and systems of the Trust, including guidelines and procedures, operational policies, the business planning cycle, business case development, performance management and corporate governance.

- risks will be actively managed and positive assurance sought
- the risk registers will be live, actively managed and reviewed documents
- that risk management is the responsibility of all staff within their own sphere of work
- that high risk areas and activities will attract greatest focus and attention
- that there will be learning from analysis of incidents, complaints and claims and explicit roll-out of identified improvements

the strategy will actively promote and underpin the acquisition of relevant accreditations, including the NHS Litigation Authority (NHSLA) Standards and the registration requirements of the Care Quality Commission (CQC). It will also support the CQC inspection process

RISK MANAGEMENT STRUCTURE

Board of Directors

The Board of Directors is responsible for reviewing the effectiveness of risk management throughout the Trust.

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

The Board of Directors will review the Board Assurance Framework and Strategic Risks quarterly.

- Receives minutes from sub committees as a means of assurance and demonstration of effective management of clinical and non-clinical risk throughout the Trust.

Corporate Directors Group

The Corporate Directors Group (CDG) has delegated responsibility for reviewing the Executive Risk Register and Board Assurance Framework.

The CDG:

- Meets to review the Executive Risk Register and Board Assurance Framework prior to being presented to Board
- Reviews newly included risks entered on the Executive Risk Register.
- In reviewing organisational risks, make decisions on escalating or de-escalating risk scores

Quality, Safety and Patient Experience Committee

The Board of Directors discharges its' responsibility via the Quality, Safety and Patient Experience Committee to oversee the on-going development, implementation and monitoring of all matters relating to Quality, Safety and Patient Experience within the Trust.

- Receives feedback from the Divisions regarding Quality, Safety and Patient Experience issues and potential risks

Health and Safety Committee

The Board of Directors discharges its responsibility to the Health and Safety Committee to oversee the ongoing development, implementation and monitoring of all matters relating to Health and Safety within the Trust.

Divisional Boards

Receives and reviews action plans and escalated risks from the sub groups and specialties throughout the Division:

- Reviews the Divisional Risk Register and ensures appropriate development of treatment plans for remedial action
- Reviews the action plans from sub groups and specialties throughout the Divisions to ensure progress and closure
- Reviews any escalated risk and decides on acceptance, remedial action or escalation to the Executive Risk Register.
- Reviews minutes from sub groups and specialties throughout the Divisions which give assurance of effective risk management.
- Receives Health & Safety issues, incidents, national guidance and other relevant governance/risk issues through the monthly governance report

Appendix A provides an overview of the high level risk committees and the reporting arrangement to the Board of Directors.

Appendix B demonstrates the process for ensuring that senior management within the Trust undergo training in risk management awareness.

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

Definitions of risk

- **Risk** is the chance that something will happen that will have an impact on the Trust's aims and objectives. It is measured in terms of likelihood (probability or frequency of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).
- **Risk management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
- **Clinical risks are** risks, which have the ability to affect patient care and may cause harm to the patient. This covers anything related to the diagnosis, treatment and outcome of each patient. Psychological harm or distress is also included. The following are some examples of clinical risks.
- **Non-clinical risks** are risks, which have the ability to affect people other than patients such as staff, visitors and contractors. This includes fire, security, environmental and health and safety issues.
- **Financial risk** - those risks which have the ability to affect the financial well-being of the Department, Division or Trust.
- **Strategic risks** are those risks, which have the ability to affect the development, implementation and control of agreed strategies.

RISK MANAGEMENT OPERATIONAL POLICY

This Operational Policy should be read in conjunction with the Countess of Chester Hospital NHS Foundation Trust Risk Management Strategy, which outlines the Trust's ongoing commitment to Risk Management.

This policy aims to define the essential structures, duties and processes throughout the Trust which supports effective Risk Management.

HOW RISK IS MANAGED LOCALLY

The Trust has a system of risk management which allow the logging of risks locally onto a ward, departmental or escalation onto the divisional risk register.

The source of the risks may be as a result of review of e.g. incidents, risk assessments, claims, health and safety risks, external reviews and standards. Risks must be logged onto the ward/departmental risk registers, any risks reviewed which no longer present a risk can be removed and logged.

Risk Management Process:

Risk assessment

A risk assessment is completed for all risks on the risk registers.

Risk Score & Level of Risk Register

All risks are assessed and scored using a Trust approved scoring matrix (appendix C) which takes into account the likelihood and severity of each risk. This results in each risk being awarded a score of between 1 (very low) to 25 (High).

Owner of Risk Register informed

Following a risk assessment, if the risk score is significant (see thresholds explained below) the risk is entered onto the Datix Risk Register module and the risk owner (ward/dept manager) is identified on the form. The Datix Risk Register module will then automatically generate a confirmation email to notify the identified risk owner of the added risk.

Risk Register Structure

LOCAL RISK REGISTER

If the risk score is 11 or less, this must be entered on the Datix Risk System as a Local Risk and will be held on the Local Risk Register (ward/dept risk register) and managed by the manager of that area. The manager will ensure that all of these risks are entered with final approval in the Datix Risk Register module.

DIVISIONAL RISK REGISTER

If the risk score is 12 or above (or if the risk carries significant concern but with a lower risk score) this must be entered on the Datix Risk Register module as a Divisional Risk and will be highlighted for inclusion on the Divisional Risk Register and will be reviewed by the divisional lead for quality and safety and at the appropriate Divisional Board for possible inclusion onto the Divisional Risk Register.

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

The Divisional Board will consider the clinical, financial, divisional and corporate impact of the risk; and will decide on whether to reject or accept the risk onto the Divisional Risk Register.

The Divisional Director is responsible for the Divisional Risk Register.

The Datix system will automatically notify the identified person within the Division that there has been a risk entered for consideration onto the Divisional Risk Register.

At the relevant Divisional meeting, the risk register and any new risks will be reviewed:

- If the new risk is approved for inclusion on the Divisional Risk Register – it will be held at Divisional Level and it will be given final approval in the Datix Risk System.
- If not approved for inclusion on the Divisional Risk Register – the risk will be recategorised as a 'Local Risk' and will appear as such on the Local Risk Register (ward/dept) and it will be given final approval in the Datix Risk System. The identified person within the Division will inform the Local Risk Manager (ward/Dept Manager) that the risk has not been accepted on the Divisional Risk Register

EXECUTIVE RISK REGISTER

If the Division identifies a risk score of 16 or above (or if the risk carries significant concern but with a lower risk score) for consideration onto the Executive Risk Register, the Divisional Director (or deputy) will present the risk to the Corporate Directors Group (CDG) for transfer to the Executive Risk Register (by the Head of Risk & Patient Safety).

It is acknowledged that Division Risk Registers may hold risks with a risk score of 16 or above that have not been transferred to the Executive Risk Register. Such risks will be presented to the Corporate Directors Group (CDG) on a quarterly basis for further assurance.

1. Reviewing Risk Registers

Local risks are required to be reviewed on an annual basis, or more frequently if there is cause for concern. Divisional Risk Registers are required to be reviewed monthly. The Executive Risk Register is reviewed at each Corporate Directors Group (CDG).

Resolved risks will be removed or risks with reduced risk scores de-escalated to a lower level of risk register.

BOARD (OR HIGH LEVEL RISK COMMITTEE) REVIEW OF THE EXECUTIVE RISK REGISTER

The Trust has an Executive Risk Register which reflects the Trust's internal highest operational risks. These risks are both clinical and non-clinical in origin. The source of the risks may be as a result of review of e.g. incidents, risk assessments, claims, health and safety risks, external reviews and standards, significant risks from divisional risk registers.

The Trust also has a Board Assurance Framework which carries the strategic, health economy wide risk and the individual risks on the Executive Risk Register are linked to the appropriate sections of the Board Assurance Framework.

As explained in the section above, the Corporate Directors Group (CDG) will consider the clinical, financial, strategic and corporate impact of the risk; and will decide on whether to confirm or reject the risk on the Executive Risk Register. This will then be linked to the appropriate section of the Board Assurance Framework.

- The Divisional Director will present the risk to the Corporate Directors Group (CDG) where the risk will be agreed or reject for inclusion on the Executive Risk Register.

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

- If the risk is accepted it will remain on the Executive Risk register and will be updated to progress reduction, elimination or transfer of the risk.
- If not agreed by the Corporate Directors Group (CDG), the risk will continue to be managed by the Division.
- The notes of the Corporate Directors Group (CDG) will be sent to the Board of Directors as a means of assurance.

RISK REGISTER MINIMUM DATA SET

All risk registers must include the following:

- Source of the risk (including, but not limited to, incident reports, risk assessments, locals registers and external recommendations)
- Description of the risk
- Risk score
- Summary risk treatment plan
- Date of review
- Residual risk rating

DUTIES OF THE KEY INDIVIDUAL(S) FOR RISK MANAGEMENT ACTIVITIES

Chief Executive

The Chief Executive, as accountable officer, has overall responsibility for ensuring the implementation of an effective risk management system, for development of corporate governance and for meeting all statutory requirements. This is delegated to the Director of Nursing and Quality as executive lead for risk management. The Chief Executive has overall responsibility for the Executive Risk Register and the Board Assurance Framework.

The Chief Executive chairs the Corporate Directors Group (CDG).

Director of Nursing and Quality

The Director of Nursing and Quality is the executive lead for risk management in the Trust and ensures the policy and strategy is implemented effectively.

Director of Operations and Planning

The Director of Operations and Planning carries specific responsibilities for operational and performance risks.

Chief Finance Officer

The Director of Finance carries specific responsibility for financial risk management.

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

Medical Director

The Medical Director supports the implementation of the risk management strategy and has the responsibility for all medical staff.

Deputy Director of Nursing and Quality

Deputy Director of Nursing and Quality, on behalf of the Director of Nursing and Quality will support the implementation of the risk management strategy and is responsible for raising awareness/profile of risk management.

Divisional Directors

Responsible for implementing risk management within their Divisions. They are responsible for the development and ongoing maintenance of Divisional Risk Registers which in turn will inform the overall Executive Risk Register and the Board Assurance Framework.

Divisional Medical Directors

The Divisional Medical Directors have delegated responsibility for the implementation of risk management strategy have the responsibility for all medical staff. They are responsible for engaging all medical staff in the risk management process and are responsible for ensuring that medical staff receive the necessary level of risk management training.

Head of Nursing/Midwifery

- Responsible to ensure that there is effective risk management processes are in place within departments for the identification, management or escalation of risks.
- Responsible for ensuring that their staff receive the necessary level of risk management awareness/training in order to ensure that they are competent to identify, assess and manage risk within their working environment.
- Responsible for ensuring that there are adequate systems in place for the maintenance, monitoring and follow up of attendance records

Head of Risk and Patient Safety

The Head of Risk & Patient Safety has the delegated responsibility for maintaining the Executive Risk Register.

The Head of Risk & Patient Safety also advises the organisation on patient safety and risk issues, enabling the organisation to achieve key governance and risk objectives.

Head of Estates

The Head of Estates has delegated responsibility for the management of the estates. The Head of Estates has corporate responsibility for Fire and Health and Safety providing advice help and support on requirements to comply with civil and statutory Health Safety and Fire obligations, use of best practice to further improve standards and a pro-active approach to ensure continuous improvement.

Head of Security (Local Security Manager Specialist)

The Head of security has direction from the NHS Counter Fraud and Security Management Service [CFSMS].

RISK MANAGEMENT STRATEGY & OPERATIONAL POLICY

Corporate Health and Safety Advisor

Leads and gives guidance on all matters relating to health and safety.

Legal Services Co-ordinator

The Legal Services Co-ordinator is responsible for managing claims against the Trust, liaising with solicitors/insurers (where appropriate), to ensure timely and cost effective claims handling. Further, ensuring that any risk management issues/remedial action identified during the course of a claim, or during the review process on closure, is referred appropriately for action.

Head of Complaints and Patient Advice & Liaison Services (PALS) Manager

The Head of Complaints is responsible for the management and co-ordination of the investigation of formal and informal complaints.

Ward / Departmental managers

- Responsible for carrying out appropriate risks assessments.
- To manage their risk register and escalate as appropriate
- To ensure the all their staff attend appropriate risk management training and that they are logged onto the Electronic Staff record system (ESR)
- To escalate risk as appropriate

Risk and Patient Safety Leads

- The Risk & Patient Safety Leads will be responsible for facilitating and supporting the Corporate and Divisional risk management and quality agendas.
- Managing, monitoring and investigating incidents logged on the Datix incident reporting system.
- Escalating incidents where appropriate
- Coordinating and supporting clinical leads in the investigation, documentation and monitoring of serious incident reviews.

All Staff

All staff have a responsibility to:

- participate in the reporting, assessment and management of risk within their individual work area.
- attend risk awareness training as outlined in the training needs analysis.
- report any incidents using Datix
- be familiar with Trust policies, guidelines and procedures

COMMUNICATION OF STRATEGY

Managers are responsible to communicate within their departments.

The policy will be available on the Trust's document management system, Sharepoint.

SOURCES/ REFERENCES

NHS Litigation Authority. (2013/14).

NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care 2011/12.

London: NHSLA. Available at: www.nhsla.com

GLOSSARY OF TERMS

NHSLA, National Health Service Litigation Authority

CDG, Corporate Directors Group

CFSMS, Counter Fraud and Security Management Service

COCH, Chester Hospital NHS Foundation Trust

CQC, Care Quality Commission

ESR, Electronic Staff Record

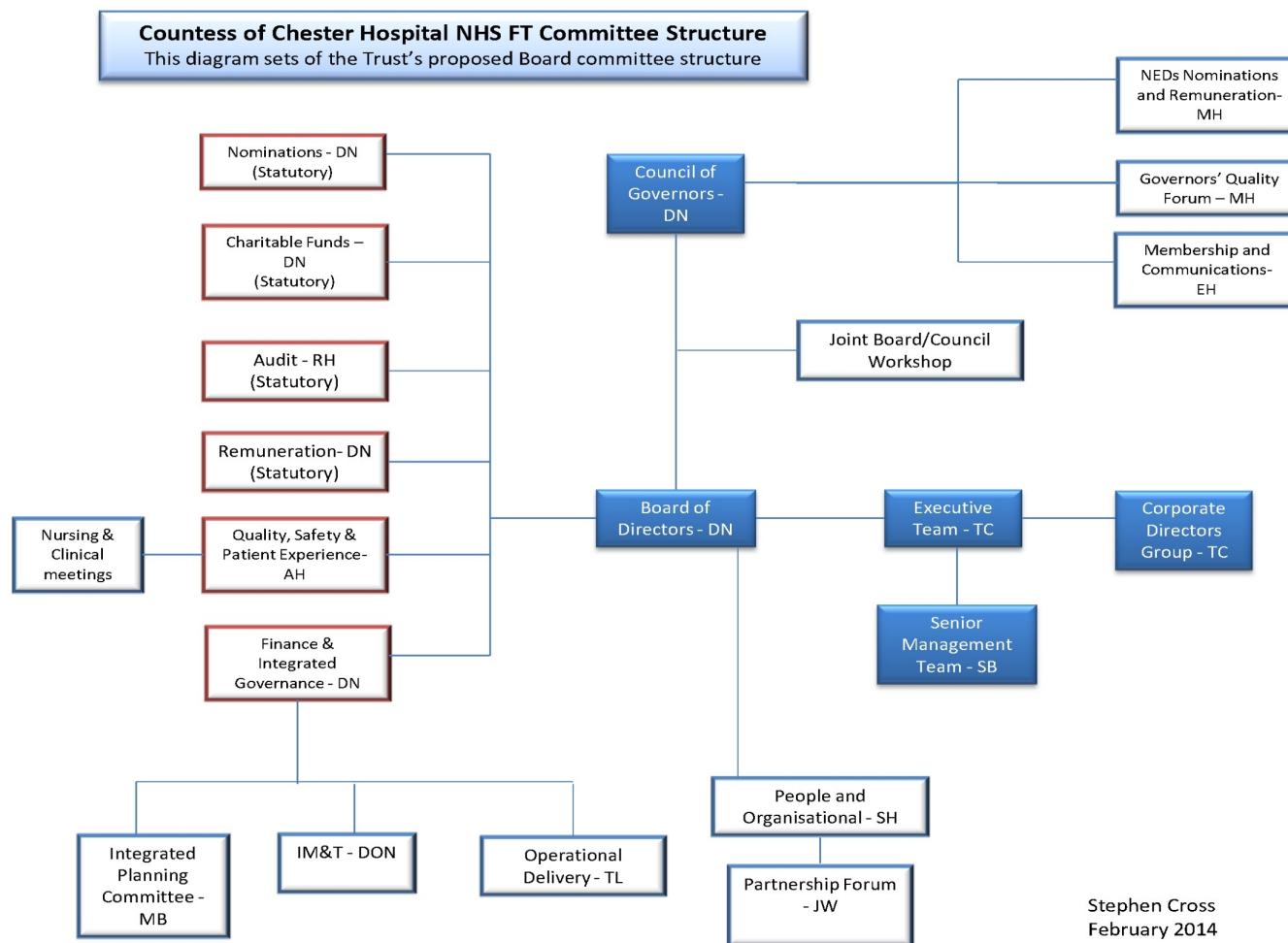
NHSLA, National Health Service Litigation Authority

NPSA, National Patient Safety Agency

PALS, Patient Advice & Liaison Services

TNA, Training Needs Analysis

APPENDIX A - HIGH LEVEL RISK COMMITTEES REPORTING ARRANGEMENTS TO THE BOARD



Stephen Cross
February 2014

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APPENDIX B RISK MANAGEMENT AWARENESS TRAINING FOR SENIOR MANAGEMENT

How risk management awareness training is delivered to Board Members and senior managers in line with the training needs analysis (TNA)

Board of Directors

- The Board of Directors receive risk management training every 3 years
- Risk management training is presented through induction and mandatory training programmes as described in the training needs analysis (TNA)

Senior management team

Senior management team are all managers Band 8A and above and all Divisional Medical Directors and Clinical Directors:

- Have to attend the risk management training as outlined in the training needs analysis (TNA)

How attendance is recorded

Board of Directors

Attendance is recorded via an attendance record and then this is recorded on the corporate electronic staff record (ESR) system.

Senior management team

Attendance is recorded via an attendance record and then this is recorded on the corporate electronic staff record (ESR) system.

How non-attendance is followed up

Board of Directors

- Non-attendance would be followed up as outlined in the training needs analysis (TNA).
- Attendance is recorded via an attendance register and then this is recorded on the corporate electronic staff record (ESR) system.

Senior management team

- Non-attendance would be followed up as outlined in the training needs analysis (TNA).
- Attendance is recorded via an attendance register and then this is recorded on the corporate electronic staff record (ESR) system.
-

APPENDIX C HOW ALL RISKS ARE ASSESSED

How all risks are assessed

The Trust has 2 key processes that facilitate the management of risks throughout the organisation:

1. Risk Assessment Process (outlined below)
2. Risk Register Process (outlined in the Risk Management Policy)

Risk Assessment Process

Risks are identified through feedback from many sources, such as, incident reports, risk assessments, trends, clinical audit data, complaints, legal claims, patient and public feedback, stakeholders/partnership feedback and internal and external assurance assessments, significant risks from directorate risk registers.

The Trust has adopted the Health & Safety Executive's (HSEs) '5-Steps to Risk Assessment' model which is supported by the NPSA. The '5-Steps to Risk Assessment' uses a numerical principle based on a 5x5 matrix. To calculate and assess all types of risk the following formula and matrix is utilised in incident reporting, risk assessments and risk registers:

Risk Scoring Matrix

Likelihood	SEVERITY/IMPACT RATING				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 - Almost Certain 1/10	5	10	15	20	25
4 - Likely 1/100	4	8	12	16	20
3 - Possible 1/1000	3	6	9	12	15
2 - Unlikely 1/10,000	2	4	6	8	10
1 - Rare 1/100,000	1	2	3	4	5

RISK  Very low  Low  Moderate  High

How risk assessments are conducted consistently

Under the HSE Regulations, risk assessments only have to be repeated when there is either a significant change or reason to believe that the assessment is no longer valid, however it is recommended that all risk assessments are reviewed annually.

The minimum dataset for risk assessments for this Trust are:

Workplace Risk Assessment	All areas
Clinical Risk	All clinical Areas

Assessment	
Display Screen Equipment (DSE)	Must be person specific for employees who use display screen equipment as a significant part of their normal work (i.e. office workers)
Manual Handling	Conducted separately by the Manual Handling Department and detailed within the Manual Handling Policy. There are a series of Manual Handling risk assessment templates for use according to the work in the area. The manual handling department review the risk assessments for the purposes of audit.
Security	Conducted separately by the Security Department and detailed within the Security Policy. The Security department review the risk assessments for the purposes of audit.
Fire	Conducted separately by the Fire Officer and detailed within the Fire Policy.

- Risk assessments must be carried out by persons who have practical knowledge skills, experience of the work activities, areas and processes and have received instructions on the risk assessment process. [Support can also be sought from a number of risk advisors including Health and Safety Advisor, Manual Handling Team, Risk and Patient Safety Leads].
- As part of an effective audit and review of the health and safety management system risk assessments must be reviewed at least annually.
- To ensure consistency the Trust has developed risk assessment templates for use in all areas.
- Any significant risks identified must be logged on to the appropriate risk register and escalated as necessary with appropriate risk reduction process in place.

Authority levels for managing different levels of risk within the organisation

Generally, the risk score will indicate the level at which the risk will be managed in the organisation and which risk register it must be input onto, however the manager's discretion is encouraged.

Risk Colour	Remedial Action	Decision to accept risk	Risk register Level
Green 1-5	Ward / Dept Manager	Ward / Dept Manager	Ward / department
Yellow 6-8	Ward / Dept Manager	Ward / Dept Manager	Ward / department
Orange 9-11	Ward / Dept Manager	Ward / Dept Manager	Ward / department
Orange 12- 15	Head of Nursing, Midwifery / Pathway Manager/Senior Manager	Head of Nursing, Midwifery /Senior Manager/ Divisional Director	Divisional
Red 16-25	Divisional Director and Executive Director	Corporate Directors Group	Organisational Risk Register

How risks are escalated through the organisation

Risks are escalated through the risk register process (outlined in the Risk Management Policy)

MONITORING COMPLIANCE WITH ACUTE NHSLA RISK MANAGEMENT STANDARDS

Risk Management Strategy Standard 1 Criterion 1

Minimum Requirements (Bold)	Process for monitoring	Responsible individual for Audit & Action Plan	Frequency of audit	Responsible Committee for review of audit results & review of action plan
How risk is managed locally	Audit of the Risk Management process	Head of Risk and Patient Safety	Annual	Corporate Directors Group

Risk Management Committees Standard 1 Criterion 3

Minimum Requirements (Bold)	Process for monitoring	Responsible individual for Audit & Action Plan	Frequency of audit	Responsible Committee for review of audit results & review of action plan
Reporting arrangements into the high level risk committee(s)	Audit of the process	Head of Risk and Patient Safety	Monthly	Monthly Executive Risk Register report to the Corporate Directors Group
Reporting arrangements in to the Board from the high level risk committees	Audit of the process	Head of Risk and Patient Safety	Monthly	Monthly Executive Risk Register report to the Corporate Directors Group

RISK MANAGEMENT PROCESS STANDARD 1 CRITERION 4

Minimum Requirements (Bold)	Process for monitoring	Responsible individual for Audit & Action Plan	Frequency of audit	Responsible Committee for review of audit results & review of action plan
How all risks are assessed	○ Audit of the Risk Assessment process ○ Audit of the Risk Register Process	Head of Risk and Patient Safety	Annual Monthly	Corporate Directors Group Monthly Executive Risk Register report to the Corporate Directors Group

Risk Register Standard 1 Criterion 5

Minimum Requirements (Bold)	Process for monitoring	Responsible individual for Audit & Action Plan	Frequency of audit	Responsible Committee for review of audit results & review of action plan
Level 3: You must evidence that the Executive Risk Register is being monitored	○ Audit of the Process for review of the Executive Risk Register	Head of Risk and Patient Safety	Monthly	Monthly Executive Risk Register report to the Corporate Directors Group
○ Source of the risk ○ Description of the risk ○ Risk Score ○ Summary risk treatment plan ○ Date of Review ○ Residual Risk Rating	○ Audit of the process	Head of Risk and Patient Safety	Monthly	By exception within the monthly Executive Risk Register report to the Corporate Directors Group

Risk awareness Training for senior management Standard 3 Criterion 6

Minimum Requirements (Bold)	Process for monitoring	Responsible individual for Audit & Action Plan	Frequency of audit	Responsible Committee for review of audit results & review of action plan
How risk management awareness training is delivered to Board Members and senior managers in line with the training needs analysis (TNA).	○ Audit of the process	Head of Learning and Development	Annual	People & Organisational Development Committee
How non-attendance is followed up	○ Audit of the process	Head of Learning and Development	Annual	By exception to the People & Organisational Development Committee

