City Hospitals Sunderland NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY 2014 - 2017

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Appendices

1. INTRODUCTION

This Risk Management Strategy states the Trust's objectives for managing risk, and the goals which must be met to achieve those objectives. It defines individual and organisational responsibilities. It describes the Trust's organisational arrangements for risk management, and the systems and processes by which the Trust's aims will be achieved.

While the Trust is committed to the management of all risks to its services, including clinical, organisational and financial risks, this strategy is a statement of CHS' particular commitment to maintaining and improving patient, staff and public safety through performance-driven risk management, supported by an open, fair, transparent and learning culture.

The Trust supports and applies a "fair blame" culture. In the majority of cases where risks arise, they are due to systemic weaknesses rather than to a failing on the part of any individual. Even when an individual can be said to be at fault, this can usually be remedied by full support including retraining where necessary, and this is normally the approach which will be applied. However, exceptional cases sometimes occur, where there is clear evidence of wilful or gross neglect, contravening the Trust's policies and/or procedures and/or professional codes of conduct, or repeated evidence of poor performance despite intervention and the provision of full support to remedy the issue. Where this is the case, the Trust's Disciplinary Procedure is applied.

This strategy is implemented through the policies detailed in the Associated Documentation section, and those wishing to read more on the operational management of risk within the organisation are encouraged to refer to those documents, which can be found on the CHS intranet.

This strategy will last for a period of three years after approval. Progress against its objectives and goals will be monitored by the Corporate Governance Steering Group by way of an annual report.

2. DEFINITIONS

Definitions of some of the phrases used within this strategy are as follows:

Adverse Event: Any event which exposes the organisation to risk, for example an incident, or a complaint, or a circumstance which results in litigation against the Trust.

Assurance Framework: The CHS assurance framework provides a structure and process which enables CHS to focus on the most significant risks to achieving its principal objectives, and to be assured that adequate controls over these risks exist. The Assurance Framework documents these risks and how they are to be managed.

Assurance Programme: A structured and systematic annual programme which checks and monitors compliance with the Assurance Framework and a range of quality standards including the Care Quality Commission.

Business Continuity Planning: Planning to ensure that business continues as usual if an unforeseen threat to its processes occurs e.g. flood, fire damage.

Corporate Risk Register: a risk register showing those risks which have been scored at 15 or more on local risk registers (see definition below), and risks which have been identified as corporate in nature, in that they affect the Trust as a whole or across more than one area.

Duty of Candour: an enforceable duty placed on healthcare providers to be open and honest with patients and carers, if harm or potential harm has befallen a patient. The duty resulted from the Francis Report and forms part of the Government's plans to modernise the NHS by making it more accountable and transparent.

Litigation Profile: data showing the issues faced by an organisation which are being dealt with through legal proceedings

Local Risk Register: A register showing risks which have been identified in a service area, e.g. a directorate, or a central function such as Human Resources. Risks are identified in many ways, for example from proactive annual assessments of health and safety risks, or through the reporting of incidents.

Major Incident: A major incident is any incident which requires special plans and cannot be managed by simple scaling up of normal arrangements. It usually involves other services, such as the fire service or the ambulance service.

Mitigation: any action or change which, once applied, reduces the likelihood of a risk recurring.

Residual risk: the risk of an event recurring once all mitigating opportunities have been applied, either locally or corporately.

Risk: the likelihood of injury, damage or harm occurring to the Trust's patients, staff, stakeholders, finances or reputation.

Risk Tolerance: the level of risk which an organisation is willing to accept, without taking action to reduce it.

Risk Grading Matrix: a tool used to calculate the seriousness of a risk, by reference to the likelihood of its occurring, and the consequences if it does. The matrix is attached as **Appendix 1** to this document.

Risk Register Owner: the person whose responsibility it is to maintain a risk register. While Directorate Managers may devolve this responsibility to other staff, they remain accountable for the content and management of the risk register.

Risk Score: the score which the risk grading matrix gives to a risk. **Appendix 1** shows how a risk score is calculated, by multiplying the likelihood of occurrence by the severity of the consequences. Scores range from 1 to 25. Scores which remain higher than 15 once locally mitigated are added to the corporate risk register.

Serious Incident (SI): an incident which results in a serious outcome such as unexpected or avoidable death, serious harm requiring life-saving intervention, or allegations of abuse. A full list of SIs can be found in the NHS Commissioning Board's Serious Incident Framework.

Special Measures: Special measures are designed to offer hospital trusts which need to improve their performance the support they need, at the same time as giving the public the ability to hold them to account. The decision to place a hospital trust into special measures is taken by Monitor, the regulatory body for foundation trusts.

3. JUSTIFICATION AND CONTEXT

This risk management strategy supports the Trust's vision of "Excellence in Health – Putting People First" and contributes to the Trust's objective of becoming one of the safest healthcare organisations in England. The strategy's content is guided by the Trust's values of delivering the highest quality healthcare, at the highest level of safety.

This version of the strategy has been informed by several national reports published throughout 2013, by the introduction of the Duty of Candour, and by changes to the NHS Litigation Authority's role in identifying risks inherent within the business of acute hospital trusts.

3.1 Francis Report

Key findings from the Francis Report, published in 2013, included the failure of the Mid-Staffordshire NHS Foundation Trust board to ensure that deficiencies which were brought to its attention were corrected, and also identified its failure to tackle a disengagement from managerial and leadership responsibilities.

Through careful setting of objectives and goals, this strategy seeks to ensure that learning loops are fully closed, and that all staff recognise and deliver their responsibilities in respect of risk management within the Trust.

3.2 Keogh Report

Following the Francis Report, the Prime Minister asked Professor Sir Bruce Keogh, the NHS Medical Director, to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. A total of 14 hospital trusts were investigated and 11 of the 14 were subsequently placed into special measures.

This strategy includes the use of mortality rates to monitor the Trust's performance and ensure its position as a provider of safe care to its patients. Clearly mortality rates are a key measure of risk as well as quality of care and are thus included within the tools to manage risk identified in this strategy.

3.3 Berwick Review

The Prime Minister also asked the National Advisory Group on the Safety of Patients in England, led by Professor Don Berwick, to carry out a review of patient

safety. The report acknowledged that safety issues exist within the NHS as they do within all other healthcare systems in the world, and that in the majority of cases it is the systems, procedures, conditions, environment and constraints which hospitals face which lead to patient safety problems, rather than failings on the parts of individual staff. The review also observed "When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is."

The identification of systemic weaknesses, and the clear allocation of responsibilities to address those weaknesses, are addressed within the goals underpinning this strategy.

3.4 Duty of Candour

In his report on the findings of the Mid-Staffordshire Inquiry, Robert Francis QC described candour as "the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made".

CHS is now subject to a contractual requirement from its commissioners to ensure that it is honest and open with patients and carers if harm, or potential harm, is caused to a patient. While it has always been the Trust's approach to be as open as possible, this strategy acknowledges the requirements of commissioners in relation to matters such as timeframes around responses.

3.5 Ceasing of NHS Litigation Authority assessments and the withdrawal of the NHSLA assessment process

A hospital's litigation profile tends to show clusters of litigation around vulnerable points of process. Historically, the NHS Litigation Authority (NHSLA) provided hospital trusts with a general indication of the whereabouts of these vulnerabilities, by analysing successful litigation taken against the NHS in various different settings, including acute hospital trusts. It then assessed trusts' robustness in respect of these vulnerabilities by way of a programme of two and three-yearly assessments.

The NHSLA ceased to provide these analysis and assessment functions in 2013. In future, hospitals which wish to improve safety issues, including those which result in litigation, must identify, analyse and address their own vulnerabilities.

The need to identify and address risks through the analysis of litigation data is identified within this strategy's objectives.

4. KEY OBJECTIVES AND GOALS

This strategy contributes to CHS' objective of becoming one of the safest organisations in England, in terms of its risk profile. This strategic objective will be met by achieving the following goals:

Goal 1 Achieving the Trust's Level 1 Objectives, Goals, Strategy and Measures (OGSM) insofar as they relate to risk management, including:

- → reducing avoidable deaths
- → acting promptly on, and learning from, incidents and complaints

→ improving patient safety as measured by the NHS Safety Thermometer
→ reducing healthcare acquired infections

Goal 2 Convergence of clinical and non-clinical risk management functions and activities, by the use of standardised reporting and monitoring methodologies

Goal 3 Identification of existing risks by qualitative analysis of litigation data

Goal 4 The continued development of local and corporate risk register processes which identify significant risks to the Trust, and define responsibility for managing those risks

Goal 5 Exploitation of the full capability of the Trust's incident reporting system

Goal 6 An improved level of reporting of incidents through the Trust's incident reporting system

Goal 7 Creation of risk-based dashboards for the identification of risks and monitoring of the effectiveness of mitigation activity

5. KEY DELIVERABLES

The following deliverables are key to ensuring that this strategy is implemented. Several of these deliverables are already in hand and some are already captured by level 2 OGSM documents across the organisation. Others, however, are in an early stage of development and will be the focus of work throughout the coming year and beyond.

5.1 Achievement of level 1 OGSM

Achievement of the Trust's Level 1 OGSM will be delivered through a robust programme to support local business planning, led by members of the Trust's Business Development Team. Local areas will develop their own level 2 OGSM plans, through which the organisation's business objectives will be delivered. In its turn, this will ensure delivery of those elements of the level 1 OGSM which relate to the provision of highest safety in clinical and non-clinical care.

The organisation's level 1 OGSM goal, of learning lessons from incidents and complaints, requires the successful development of a culture which accepts that mistakes will still occur despite proper and appropriate training, and that most of the time, these mistakes will be due to weakness in processes, rather than failure on the part of any individual member of staff. It is important, therefore, that identified weaknesses in processes are identified and then addressed, in order to avoid a repetition of the mistake. At a local level, this requires directorate managers and heads of service to monitor incidents and complaints in order to identify trends within the data. Where an incident or complaint carries the risk of repetition, this risk must be considered for inclusion within the local risk register. Where there are a number of incidents and/or complaints showing common themes, there is clearly already repetition of adverse events, and the underlying risk must also be considered for inclusion within the local risk register. The risk underlying these adverse events is calculated by using the risk matrix shown at **Appendix 1.**

At a corporate level, the Trust has a range of methods to ensure that lessons are learned from adverse events, including:

- Local arrangements for the effective and timely dissemination of learning within directorates and other service areas, such as local risk management meetings, directorate meetings and others.
- "Lessons learned" seminars, held at least eight times a year on specific topics, to enable staff to share information and improvements in practice. These sessions are open to all staff. The objective is to minimise the recurrence of incidents, complaints, claims and issues arising from inquests. A summary of each presentation is held on the CHS intranet site, so that staff who were unable to attend the session can still obtain details of the information shared at the event.
- Weekly "key messages" email to staff, which advise on issues which have been identified from high risk adverse events at each weekly Rapid Review Group meeting.
- Local arrangements in high-risk clinical areas, such as a maternity risk newsletter.
- Highlighting of any major risk issues in the Trust's monthly Team Brief
- Immediate email notifications to all staff if significant and immediate risks are identified.

The operational management of risk described at **Appendix 2** ensures that where risks are identified as the result of an adverse event or events, corrective action is monitored through risk registers until it is proven to be effective.

5.2 Systematic Implementation and Monitoring of the Trust Risk Management Framework

Appendix 2 details the organisation's risk management framework. Goals 2 and 4 of this strategy will be achieved by applying the framework rigorously throughout the organisation. Progress will be monitored by the Corporate Governance Steering Group, particularly in respect of risk register management. This will deliver standardised reporting of risk across the organisation, which will provide a high level view of risks and risk mitigation across the Trust.

5.3 Qualitative Analysis of Litigation Exposure

The NHSLA has begun to provide litigation information on a secure website, but currently this information is presented on a case by case basis only. The NHSLA has stated that it intends to work with Trusts to improve learning from litigation, but this objective is currently limited to providing aggregated quantitative information e.g. number of claims received. This level of analysis is not sufficient to allow for specific process weaknesses to be identified and addressed.

As a result, this strategy's third goal will be achieved by the building of processes in-house to provide the analysed litigation data which the NHSLA currently does not provide. The data will show trending information on qualitative issues rather than quantitative data. Such issues might include types of claims received, the areas of the hospital where incidents leading to claims occur, and other such issues. This analysis will be carried out on the NHSLA's raw data and will be reported to the Corporate Governance Steering Group.

5.4 Incident Management

Strategic goals 5 and 6 will be achieved by the organisation investing in improvements to the Trust's incident management system. This will deliver an enhanced ability to analyse data from incidents and complaints, and provide trending qualitative as well as quantitative information. This will enhance the existing monitoring of trends within adverse events which is delivered by directorate managers and heads of service.

The Trust risk team will continue to work with all staff groups to improve incident reporting rates, particularly in respect of incidents where no harm has been caused or the effect has been minor. This will enable the early identification and resolution of issues.

5.5 Risk Based Dashboards

Once qualitative information is flowing from litigation data and the improved risk management system, goal 7 will be achieved by constructing dashboards which identify and monitor metrics which relate to key risks. These dashboards will act as an early warning system of downward trends in performance, and will also provide an efficient tool for the monitoring of the effectiveness of improvement measures.

Some dashboards already exist, such as the monitoring of mortality rates; others are yet to be developed. Pilot work will be carried out within the maternity service throughout the year, and if the dashboard model proves effective, it will be rolled out across the Trust.

6 RISK TOLERANCE

Every organisation is willing to accept a certain level of risk within its business, particularly in respect of pursuing its business objectives. However, it is important to be able to define the line beyond which a risk is no longer acceptable and must be mitigated.

An organisation's tolerance for risk may change over time. Should this occur during the period of this strategy, the operational processes underpinning risk management within the Trust will be adjusted.

7 THE OPERATIONAL MANAGEMENT OF RISK

Within CHS, where a risk scores 15 or higher on the Trust's risk matrix (**Appendix 1**) the Corporate Governance Steering Group and/or Clinical Governance Steering Group monitor mitigation of those risks and refer them to Governance Committee when necessary. Governance Committee considers whether the Board should be advised of those risks and whether it should recommend to the Board that those risks are added to the Assurance Framework.

Further detail in respect of the processes underpinning this management of the organisation's risk tolerance can be found at **Appendix 2.**

8 MAJOR INCIDENT AND BUSINESS CONTINUITY PLANNING

CHS is obliged to ensure that its Incident Response Plans are kept up to date and that they reflect and support the plans of other planning partners, such as the ambulance service and fire service. Of equal importance, however, is the risk posed by a breakdown in "business as usual", as opposed to the risk posed by a specific major incident. The Trust's obligations to plan for business disruption are described in the NHS England Standard Contract Service Conditions and also in the NHS England frameworks for Business Continuity Management and Emergency Preparedness. Therefore each business area maintains its own business continuity plan, ensuring that potential risks to its services are considered and that action plans are to hand if required.

If there are risks which affect these plans, they are added to local risk registers and mitigated by application of the process described at **Appendix 2.**

9 IMPLEMENTATION AND EVALUATION

9.1 Governance Arrangements

The implementation of this strategy, and the evaluation of its effectiveness, will be monitored and measured through the governance arrangements already in place within the Trust. Those governance arrangements are as follows:

The Board of Directors has overall responsibility for ensuring a system is in place for risk management. It reviews the Trust's Assurance Framework six monthly and is responsible for ensuring that any *ad hoc* requests from the Governance Committee for additions to the Framework are considered.

The Governance Committee seeks assurance in respect of the effectiveness of the Trust's risk management processes. It is a subcommittee of the Board of Directors. It receives assurance from the Clinical Governance Steering Group (CGSG) and Corporate Governance Steering Group (CorpGSG) by way of monthly reports that clinical and non-clinical risks are being managed appropriately, and directs the work of each of those groups. The Committee also receives regular reports in relation to the Assurance Programme and thereby assurance as to the effectiveness of the Assurance Framework. The Governance Committee approved this strategy and will monitor its implementation through reports received from the Corporate Governance Steering Group.

The Audit Committee has a formal role to approve the Assurance Framework and the Annual Governance Statement. The Assurance Framework provides evidence to support the Annual Governance Statement which is an audited statement and is included in the Annual Report. Due to overlapping duties of the Audit Committee and the Governance Committee in respect of the Annual Accounts and Report process including risk and governance, the Chair of the Governance Committee is also a member of the Audit Committee, and the Chairs of both Committees meet quarterly with the Executive Director leads for each Committee, to consider any areas of joint responsibilities.

The Corporate and Clinical Governance Steering Groups have duties relating to risk management which include receiving monthly reports relating to risk management from the Rapid Review Group and from the Trust Risk Management and Patient Safety Team. They also receive the corporate risk register from the Risk Register Review Group quarterly, and are responsible for monitoring the mitigation of risks which score 15 or more on the Trust Risk Matrix. They assist in mitigation where appropriate, and report to Governance Committee in respect of those risks which, when fully mitigated both locally and corporately, still score 15 or above on the risk matrix.

Corporate Governance Steering Group will monitor the implementation of this strategy, and will report on progress to Governance Committee.

9.2 Individual Postholders Contributing to Implementation

The successful implementation of this strategy is dependent on individuals with risk management responsibilities being aware of, and delivering on, those responsibilities. Those individuals and staff groups who have particular responsibilities in respect of risk management are acknowledged below; however, all staff have a responsibility to ensure that their everyday actions and practices reflect the Trust's safety culture.

The Chief Executive is designated as the Accounting Officer of the Foundation Trust under the Health & Social Care Act (2008). Accordingly, the Chief Executive maintains responsibility for ensuring the overall organisation, management and staffing of the Trust and is accountable to the Board of Directors for ensuring the Trust has in place an effective system of risk management and internal control.

The Executive Director of Finance has delegated responsibility for financial security of the Trust and business developments. This responsibility includes the management of the Assurance Framework. The Executive Director of Finance chairs the Corporate Governance Steering Group and is a member of Governance Committee.

The Medical Director and Executive Director of Nursing & Quality have delegated joint responsibility for managing the strategic development and implementation of clinical risk management and clinical governance, with responsibility for risk and adverse incident analysis and the promotion of learning across the Trust. They jointly chair the Trust Clinical Governance Steering Group. Both the Medical Director and Executive Director of Nursing & Quality are members of the Governance Committee and of the Rapid Review Group. The Medical Director is also the Director of Infection Prevention and Control. The Executive Director of Nursing and Quality is responsible at Board level for assurance and risk management. The Executive Director of Nursing and Quality has overarching responsibility for the management and external reporting of major clinical incidents known as Serious Incidents, or SIs.

The Director of Operations has overarching responsibility for the operational management of the Trust, and is supported in this role by Divisional General Managers. Immediate and significant risks are escalated to the Director of Operations for action.

The Director of Corporate Affairs As Director of Emergency Planning Resilience and Response, they are also the Accountable Emergency Officer as described in the NHS Commissioning Board Emergency Preparedness Framework 2013. The Director of Corporate Affairs also ensures that the Terms of Reference of the groups managing risk at a corporate level within the organisation are reviewed as required, and is a member of the Governance Committee and the Rapid Review Group.

The Head of Estates has delegated responsibility for the management of organisational and environmental risk including the management of fire, health and safety and the appropriate reporting of non-clinical incidents to external agencies (i.e. HSE, RIDDOR, MHRA), and is a member of the Corporate Governance Steering Group.

The Head of Nursing and Patient Safety has responsibility for the operational management of patient safety and clinical risk, through the patient safety team and the risk team, and is a member of the Corporate Governance Steering Group, the Clinical Governance Steering Group, the Risk Register Review Group and the Rapid Review Group.

The Assurance Manager plans, delivers and monitors the annual Assurance Programme, which provides an independent test of Trust management of the issues identified within the Assurance Framework. The Programme also tests the level of Trust compliance with regulatory and quality standards, including those of the Care Quality Commission. The Assurance Manager is a member of the Governance Committee.

The Head of Corporate Risk has delegated responsibility to:

- Ensure compliance with risk management across the Trust, advising Corporate Governance Steering Group and Governance Committee from a corporate perspective
- Identify those areas of practice (clinical and non-clinical) which adversely affect the Trust's litigation risk, and work with staff to mitigate that risk
- Ensure that risk management issues are monitored via appropriate governance processes.
- Report annually to the Corporate Governance Steering Group on the progress of this strategy.

The Head of Corporate Risk is a member of the Corporate Governance Steering Group, the Governance Committee and the Risk Register Review Group.

The Associate Medical Director for Clinical Governance assists directorates in the development of local clinical governance and assurance systems. The Associate Medical Director is a member of the Clinical Governance Steering Group.

The CHS Emergency Planning Coordinator (EPRR Coordinator) supports the Accountable Emergency Officer (Director of EPRR) in ensuring that CHS meets its statutory obligations as a category 1 responder under the Civil Contingencies Act 2004 (CCA) and complies with all relevant Emergency Preparedness Resilience & Response (EPRR) and business continuity guidance. The EPRR Coordinator leads in the development and implementation of all arrangements relating to CHS

preparedness for, and resilience to, significant incidents and emergencies as defined in the Civil Contingencies Act 2004.

Trust Risk Managers have delegated responsibility for:

- Management of the Trust's incident system, ensuring incidents are appropriately and fully investigated with appropriate actions taken. This includes reviewing all incidents received to ensure that gradings are appropriate.
- Complying with the reporting requirements of NHS England, using the National Reporting and Learning System.
- Managing the development of the corporate risk register, associated action plans and monitoring compliance with identified actions.
- Coordinating and supporting the development and management of directorate/specialty risk registers and managing the link between the corporate and directorate/specialty risk registers.
- Providing timely, comprehensive reports analysing incident statistics and trends for the Clinical Governance Steering Group and Corporate Governance Steering Group on a quarterly basis.
- Providing timely, comprehensive reports analysing incident statistics and trends for local risk management groups on request
- Developing the Trust incident management system to ensure the availability of detailed and accurate incident information and statistical data.
- Designing and delivering appropriate multi level risk management training packages including induction training, ongoing risk management awareness training and training in investigation techniques.
- Liaising with the Patient Services Manager to ensure a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis.
- Contributing to the work of directorates by supporting governance arrangements and ensuring that lessons are learned from incidents, inquests and legal claims.

Directorate Managers/Heads of Service

These managers are responsible for the management of risk locally and must ensure that:

- The Risk Management Strategy is implemented and clinical and non-clinical risk management developed within their directorates and service areas.
- Appropriate and effective frameworks are in place for governance and risk management, including a minimum of four clinical governance meetings per year in each clinical directorate/speciality.
- Staff are made aware of the risks within their work environment and of their personal responsibilities.
- Appropriate information, instruction and training has been provided to enable staff to work safely.
- A formal programme of continual risk assessment and action planning is developed in relation to organisational, clinical risk and financial risk management, in line with corporate and national frameworks and strategies.
- All risks are identified and quantified which may affect the directorate/department's ability to deliver service objectives or which might impact on other areas of the Trust.

- Appropriately trained and competent staff are responsible for assessing risks and determining adequate control measures within the working environment through proactive and reactive risk assessments as described in the Trust's Policy on Health and Safety.
- The likelihood of recurrence of an adverse event is considered and added to the local risk register if appropriate
- Trends within incidents and complaints data are identified and implicit risks are added to the local risk register for mitigation action to be taken and monitored.
- Risk issues are included in the directorate/specialty risk register as they occur.
- Risk management control measures are implemented and monitored.
- Any significant risk requiring a formal change in process and commitment of resources is fed into the framework for the CHS Annual Plan.
- An open reporting and learning culture exists for staff to report incidents and near misses.
- All risk events such as incidents and complaints are investigated in an effective and timely fashion, adhering to deadlines for completion of investigations, action plans and remedial action, thereby ensuring that the Trust complies with the requirements of the Duty of Candour in relation to the investigation of Serious Incidents and its own timeframes for managing such events.
- All potential claims are investigated thoroughly and reported appropriately in accordance with Trust policies.
- Business Continuity Plans are maintained.

Divisional General Managers (DGMs)

DGMs are responsible for:

- Ensuring the implementation of the Risk Management Strategy in their divisions.
- Ensuring the development of clinical and non-clinical risk management within their divisions.
- Signing off root cause analysis investigations within their divisions.
- Escalating significant immediate risks to the Director of Operations.

Matrons are required to ensure that they:

- Facilitate nursing staff participation and contribution to the risk management agenda and implementation of the Risk Management Strategy.
- Identify and prioritise key risk issues.
- Monitor risk assessments being appropriately completed, actioned and updated at ward/departmental level.
- Participate in the management and investigation of adverse events or near misses in accordance with Trust policies.
- Participate in the development of the directorate/specialty risk register.
- Provide support to nursing staff and give appropriate feedback during and following any investigation process.
- Implement all actions and changes needed following investigations of incidents or complaints.
- Ensure that risk management issues are considered when completing the annual training needs analysis.

Ward/Departmental Managers provide operational support to the Directorate Manager and are required to:

- Ensure ward/department staff receive appropriate workplace induction and training in the use of any relevant or new equipment
- Ensure ward/department risk assessments are completed and appropriate action plans devised and implemented.
- Ensure staff are aware of and use the Trust's incident reporting system and encourage an open reporting culture.
- Ensure risk management training needs are considered when completing the annual training needs analysis.
- Participate in the investigation of adverse events or near misses as required.
- Provide support to ward/department staff and appropriate feedback during and following the investigation process.

9.3 Operational Groups Contributing to Implementation

The Rapid Review Group

The Rapid Review Group meets weekly and acts as an early warning system through the rapid review, assessment and initiation of appropriate levels of investigation for all serious incidents, complaints, litigation and inquests. It ensures coordination and oversight of cases where there is a complaint, claim, incident and/or inquest in parallel. It identifies and assesses emerging trends, themes and risks and ensures that mitigating action is taken where indicated. It reviews and ratifies all completed root cause analysis investigation reports and receives assurance that action plans are delivered and effective. This group has the authority to upgrade incidents to red incident status. Conversely, it also has the authority to downgrade incidents if necessary.

The Rapid Review Group reports monthly on its activity to both the Corporate Governance Steering Group and the Clinical Governance Steering Group.

The Risk Register Review Group

The Risk Register Review Group meets twice a quarter. The first meeting reviews the quarterly updates of local risk registers and produces the draft Corporate Risk Register for review and approval by the Corporate and Clinical Governance Steering Groups. The second meeting is held to debrief on, and implement, feedback from those two steering groups.

A diagram showing CHS committee structures and information flows in respect of risk management can be found at **Appendix 3.**

10 APPROVAL, RATIFICATION AND REVIEW

This strategy has been approved by Executive Committee and ratified by Governance Committee.

This strategy has a three-year lifespan and will be reviewed by way of an annual progress report by the Head of Corporate Risk to Corporate Governance Steering Group.

11 REFERENCES

Francis R. Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (The First Francis Report)

Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Final Francis Report)

Keogh B. Keogh Mortality Review 2013

National Advisory Group on the Safety of Patients in England: A Promise to Learn – A Commitment to Act 2013

NHS Commissioning Board Serious Incident Framework March 2013

NHS England Model Job Description & Competencies for EPRR Officers (Coordinator) 2013

NHS England Emergency Preparedness Framework 2013

NHS England Business Continuity Management Framework 2013

10 ASSOCIATED DOCUMENTATION

The Risk Management Strategy is supported by the following key risk management documents:

- Incident Policy
- Investigation and Improvement Policy
- Complaints Policy
- PALS Policy
- Mandatory Training and Induction Policy
- Training Needs Analysis and Annual Prospectus
- Disciplinary Procedure
- Whistleblowing Policy
- General Policy on Health & Safety
- CHS Infection Prevention and Control policies
- Development and Management of Procedural Documents Policy
- CHS Level 1 OGSM 2014/2015
- CHS Level 2 OGSMs 2014/2015
- Claims Management Standard Operating Procedure
- Major Incident Plan
- Local Business Continuity Plans
- CHS Assurance Framework
- CHS Corporate Risk Register
- Local risk registers

Appendix 1

Risk Grading Matrix

LIKELIHOOD	IMPACT				
	Negligible 1.	Minor 2.	Moderate 3.	Major 4.	Catastrophic 5.
5. Certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5

A risk is the likelihood of an event occurring which will adversely affect the business area's ability to reach its objectives. The impact of the event can range from negligible to catastrophic, and its likelihood can range from rare to certain. To calculate the risk of that event occurring, the likelihood score is multiplied by the impact score as shown in the table above. Thus an event which is certain to happen (5) but will only have a minor impact (2) has a risk score of (5 x 2) 10.

An event which is certain to happen (5) and which will be catastrophic (5) is scored at (5 x 5) 25.

Directorate Managers and Heads of Service are responsible for assessing risks in their service areas and for managing them appropriately through their local risk register, which shows the initial risk score of every local risk and monitors progress to reduce that score.

Clinical risks scoring 15 or more are monitored by the Clinical Governance Steering Group and non-clinical risks scoring 15 or more are monitored by the Corporate Governance Steering Group, by inclusion on the corporate risk register. **Appendix 2** gives detail of the process of inclusion of local risks within the corporate risk register.

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Appendix 2

RISK MANAGEMENT FRAMEWORK – RISK IDENTIFICATION, ASSESSMENT AND MITIGATION

Risks have the potential to reduce the Trust's ability to provide safe, accessible, effective, efficient and appropriate services to patients and staff. It is important that the organisation can identify such risks, assess their extent, and mitigate them.

Risk Identification

CHS identifies risks from a number of sources, including but not limited to:

- the organisation's objectives
- routine and *ad hoc* risk assessments
- consultation with, and feedback from, staff and patients
- complaints, incidents and claims data
- internal inspections and audits
- national enquiry reports
- external requirements

Risk Assessment

When a risk is identified, the likelihood of its happening, and the severity of the risk if it does occur, are assessed with reference to the grading matrix at **Appendix 1.** As the matrix shows, a risk can score at any level from 1 to 25.

Once the risk has been assessed, it is added to a risk register; usually this will be the register held by the business area in which the risk was identified, but risks may be added direct to the corporate risk register or to the Assurance Framework.

- Directorate Managers/Heads of Service add risks to local risk registers
- Recommendations to add risks to the corporate risk register are made by the Risk Register Review Group and are considered by the Corporate Governance Steering Group or Clinical Governance Steering Group, dependent on whether the risk is non-clinical or clinical.
- Recommendations to add risks to the Assurance Framework are made by either Steering Group to the Governance Committee.

Assessment and Reporting of Significant and Immediate Risks

Local risks scoring 15 or more are deemed so significant that they require immediate escalation to a corporate level. In the event of a significant risk arising in hours, the risk is thoroughly assessed by the relevant Directorate Manager/Head of Service, who adds the risk to the local risk register and informs their Divisional General Manager (DGM) if they feel that escalation to divisional level is required. If their DGM is unavailable, they inform an alternate DGM. The DGM considers the risk, and if they feel that further escalation is appropriate, they discuss the risk and any required action with the Director of Operations. The Director of Operations considers whether the risk and actions being taken to mitigate it should be reported to the Chief

Executive. In his turn, the Chief Executive considers whether the Board of Directors should be informed.

Out of hours a similar process of escalation is followed: the manager who is first on call escalates to the person second on call as necessary. Second on call is a member of the Executive Committee and they consider whether the Chief Executive should be informed.

While all risks are scored using the matrix at **Appendix 1,** the score of a risk which is escalated from a local risk register to the corporate risk register, or from the corporate risk register to the Assurance Framework, will almost certainly change as it escalates. This is due to context; for example, a financial risk of £1million is more significant to a directorate than it is to the Trust as a whole. The Risk Register Review Group is responsible for considering any risks which have been scored at 15 or higher within local risk registers. While all risks which score at this level are included within the corporate risk register, the Risk Register Review Group is responsible for re-scoring those risks from a corporate perspective, before adding them to the corporate risk register.

Risk Mitigation

Risk management within CHS is based on a continuous cycle which identifies risks, records them, mitigates them to the extent that they can be mitigated and manages the residual risk. Risks are eliminated where possible, otherwise they are reduced to a level acceptable to the Trust.

Where a risk is identified, it is entered onto the relevant local risk register by the risk register owner, usually the Directorate Manager. Initial mitigation of a risk is carried out locally.

Where a local risk scores 15 or higher on the Trust risk grading matrix (**Appendix 1)**, the Risk Register Review Group re-scores the risk from a corporate perspective and includes the risk on the corporate risk register. The corporate risk register is considered quarterly at the Corporate and Clinical Governance Steering Groups.

If local actions mitigate the risk to a risk score of less than 15, the risk is removed from the corporate risk register. If the risk cannot be mitigated locally to a risk score of less than 15, management of the risk is escalated, as follows.

- If the risk is clinical in nature, it is considered by the Trust Clinical Governance Steering Group. If the risk is non-clinical, it is considered by the Trust Corporate Governance Steering Group. Some risks may be both clinical and non-clinical in nature; in such cases, the Chairs of each steering group liaise to ensure that the risk is being effectively managed both from a clinical and non-clinical perspective.

- The Steering Groups consider those risks which have a local risk score of 15 or over and which have been fully mitigated at a local level. If the risk is considered acceptable from a corporate perspective, no further action is taken, although the risk remains on the corporate risk register for regular review. If the risk is unacceptable, the Steering Groups consider and direct further

mitigation activity until the risk is eliminated, the residual risk is acceptable, or the Groups can identify no further available mitigation.

- The Steering Groups advise the Governance Committee of any risks being managed in this fashion. The Governance Committee considers whether the Board should be advised of those risks, and whether the risks should be added to the Assurance Framework.

Process Monitoring

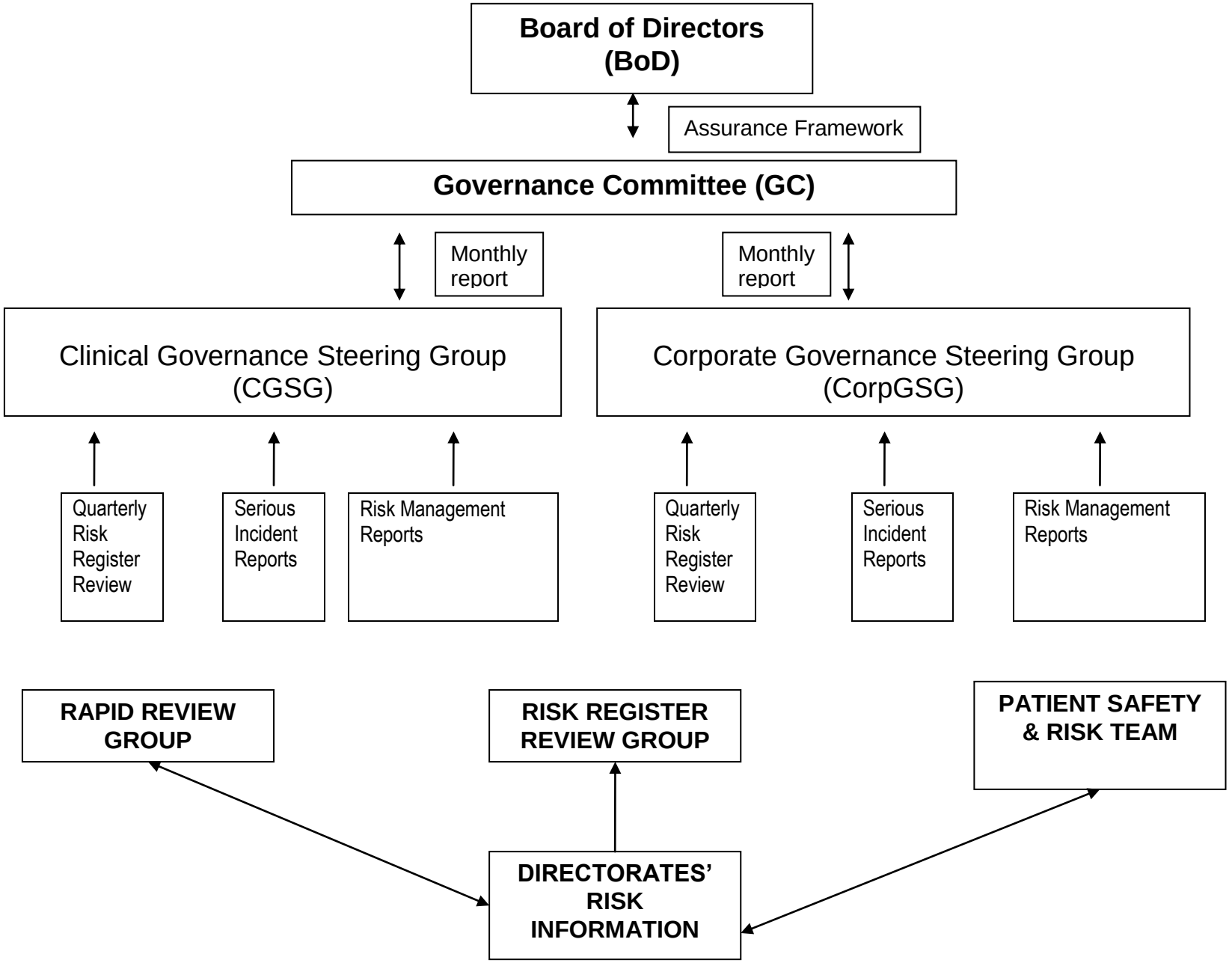
To ensure that all risks are being appropriately managed locally, a review of local risk registers is carried out at least quarterly by an appropriate local group such as the directorate clinical governance group or the directorate meeting. The review includes the identification and addition of new risks, a review of all existing risks including their current risk score, and the closing and moving to archive of any fully mitigated risks whose residual score is less than 15. Action plans support the risk registers, and minutes taken at these meetings are stored electronically for audit purposes.

Local risk registers are submitted quarterly to the Risk Register Review Group, to ensure that they are being appropriately managed, and so that identified local risks can be considered for inclusion within the corporate risk register.

Trust Assurance Framework

The Assurance Framework provides the Trust with a comprehensive framework for the management of the principal risks which may threaten the organisation's objectives. It also provides a structure to support the evidence for the Annual Governance Statement.

The Board reviews the Assurance Framework every six months to inform itself of all significant risk exposures, the nature of controls and action plans. All high risks which are identified as being a threat to the organisation's objectives are added to the Assurance Framework on the recommendation of the Governance Committee. They are then included in the Assurance Programme for compliance monitoring.


Board of Directors (BoD)
Assurance Framework
Governance Committee (GC)
Monthly report
Monthly report
Clinical Governance Steering Group (CGSG)
Corporate Governance Steering Group (CorpGSG)
Quarterly Risk Register Review
Serious Incident Reports
Risk Management Reports
Quarterly Risk Register Review
Serious Incident Reports
Risk Management Reports
RAPID REVIEW GROUP
RISK REGISTER REVIEW GROUP
PATIENT SAFETY & RISK TEAM
DIRECTORATES' RISK INFORMATION