Northern Devon Healthcare NHS Trust

Document Control

Title			
Risk Management Policy			
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Directorate Division of Nursing, Workforce and Quality		**Department** Risk and Incident	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	Apr 2008	Draft	Presented to Risk Management Committee on 17.04.08 for approval.
0.2	May 2008	Draft	Amendments made following consultation. Presented to Clinical Services Executive Committee on 20.05.08 for final approval. Policy approved with no amendments.
1.0	Aug 2008	Final	Final corporate proof-check and small amend to the Monitoring Compliance section in line with NHSLA assessment.
1.2	Dec 2011	Review	Audit and Assurance Committee approval.
1.3	Jan 2012	Draft	Additions to policy by Information Governance team describing Information Risk management. Minor amendments by Corporate Governance to formatting for document map navigation, table of contents, hyperlinks, addition of NHSLA compliance monitoring form and handbook references.
2.0	Feb 2012	Final	Approved by Risk Management Committee on 19 January 2012.
2.1	Aug 2012	Revision	Update to Risk Scoring Matrix and revised Strategic Objectives.
2.2	May 2013	Revision	Update to nhs.net email addresses for form (Appendix B).
2.3	Jul 2013	Revision	Update to include role of the Commercial Director and updated Information Governance information.
3.0	Jul 2013	Final	Approved by the Risk Management Committee on the 18 July 2013.
3.1	Aug 2013	Revision	Minor amendments by Corporate Governance prior to publication.
3.2	July 2015	Revision	Changes are: Policy updated on to new template; Change of process in managing Risks scored 0 -10; Change to job titles; Changes to Risk Assessment template to incorporate Trust wide Action template and Guidance to SMART actions added.
4.0	Sep 2015	Final	Final Approved at the Risk Management Committee on 17 September 2015 with amendment to ensure descriptor used to score the risk is recorded.
5.0	Dec	Revision	Update to include the use of the DATIX web system for

	2017		risks, the rewording of risk treatments to follow the 4 T's, inclusion of the process of checking risk actions have been completed and amalgamation of the Risk Management Training Policy.
6.0	Dec 2017	Final	Final Approved at the Risk Management Committee on 21 December 2017 with amendment to ensure Datix is referred to constantly through the document.

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Superseded Documents
NDHT risk management training policy v2.0 2013

Issue Date	Review Date	Review Cycle
November 2017	November 2020	Three years

Consulted with the following stakeholders: (list all)

- Audit and Assurance Committee
- Quality Assurance Committee
- Compliance Team
- Executive Directors
- Risk and Incident Team
- Health & Safety Committee
- Head of Information Governance
- Risk Management Committee
- External Stakeholders (CCG and Sodexo) via the relevant committees

Approval and Review Process

- Risk Management Committee

Local Archive Reference
G:\Corporate Governance
Local Path
Risk and Incident/ Risk/ Policy/ Risk management Policy v 6
Filename
Risk Management Policy - v6.0 Dec 17

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
All staff, Corporate Governance, Risk assessment	Corporate risk register, risk assessment, Scoring matrix, SMART, Action planning

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process to be utilised to ensure that the Trust meets nationally recognised best practice for the identification and management of risks, and statutory and regulatory requirements including those set out in the National Reporting and Learning System, Health and Social Care Act 2008, Department of Health Best Practice in Managing Risk Assessment, NHS Information Security Standards, BSI ISO 31000:2009 Risk Management – Principles and guidelines and standards set by regulatory bodies such as the Health & Safety Executive,. NHS Improvement and the Care Quality Commission.

To set out the minimum standards for the delivery of mandatory risk management training required to ensure that the Trust meets its statutory and regulatory requirements and is assured that staff are equipped to provide safe care within a safe environment. It defines the way in which areas of responsibility for mandatory risk management training within the Trust have been determined, together with the primary method for delivery and monitoring.

Robust risk management systems ensure that the Trust meets the legal requirements of the Health & Safety at Work etc., Act (1974), the Management of Health & Safety at Work Regulations (1999) and the Civil Contingencies Act (2004).

The Trust is committed to ensuring high standards of health and safety, to improving the quality of patient care and to minimising loss of public confidence in the organisation. The risk management system allows all staff to record any clinical or non-clinical actual or potential risk to the organisation.

The system for identifying, recording and managing risks supports the on-going development of a robust patient and staff safety culture across the organisation. Effective management of risks provides a means to make changes to improve working practices.

The policy applies to all Trust staff.

1.2. Implementation of this policy will ensure that:

- Clinical and Non clinical risks are identified, assessed, recorded and scored in a consistent manner across the whole organisation.
- Risk action plans are performance monitored appropriately.
- Risks are routinely reported to the appropriate committees and the Trust Board.
- A risk identification and management culture exists in the organisation.
- Statutory and legislative requirements are met.

2. Definitions

Hazard

2.1. A hazard is something (e.g. an object, a property of a substance, a phenomenon or an activity) that can cause adverse effect or harm. For example:

- Lone working is a hazard, because a member of staff could sustain an injury and be unable to call for assistance.
- Using sharps within Healthcare settings is a hazard, due to the risk of sustaining an inoculation injury.

Harm

2.2. Harm is defined as injury (physical or psychological), ill health, suffering disability, death, loss, damage to property or services).

Risk

2.3. A risk is the likelihood that a hazard will actually cause its adverse effects or harm, together with a measure of the severity or impact (consequence) that this will have. A risk can apply to:

- an individual patient, employee or other person affected by our activities
- more than one person in those categories
- the organisation
- achievement of the organisation's strategic objectives
- the wider community

Risk Assessment

2.4. Is the formal process to record an identified risk.

Risk Scoring Matrix

2.5. All identified risks are subjected to a robust scoring method to ensure the consistent scoring of risks over the whole organisation (Appendix A).

The risk score is determined by using a risk scoring matrix and multiplying the risk consequence score with the risk likelihood score. This provides a quantitative basis upon which to determine the urgency of any actions.

Low

Risks with a score of 0 are defined as risk no longer existing as the actions have been completed, for example where a new piece of equipment has been obtained and replaced an obsolete piece of equipment.

Risks with a score of 1 – 3 are defined as a very low risk where further risk reduction may not be feasible or cost effective.

Risks with a score of 4 – 6 are defined as a low risk where risk control is required, so far as is reasonably practicable. The majority of control measures are already in place, or the likelihood of harm or its consequence is small. Actions may be required in the long term.

Medium

Risks with a score of 8 – 12 are defined as a medium risk where prompt action is required, so far as is reasonably practicable. There is moderate probability of major harm or high probability of minor harm if control measures are not implemented. Action may be required in the medium term.

High

Risks with a score of 15 – 25 are defined as a high risk where there is a significant probability that major harm will occur if control measures are not implemented. Urgent action is required and stopping the activity or procedures should be considered.

Risk Tolerance

2.6. For a risk to be tolerated, the Trust must be satisfied that it was correctly identified, properly assessed and that the completed actions have reduced the level of residual risk to an appropriate level or the existing controls are adequate to manage and tolerate the risk.

Residual Risk

2.7. Where a risk has been tolerated, there will be a residual risk with identified and agreed consequence and likelihood ratings and a final risk score. Any high level risks with a residual risk of 15+ will be presented to the Risk Management Committee prior to approval and acceptance.

Organisational Risk

2.8. A risk that presents the potential for significant harm, injury, service disruption, complaint, claim or enforcement action and that requires robust control measures to reduce the consequences and/or likelihood of it occurring.

Strategic Risks

2.9. These are risks that have been identified and agreed by the members of the Trust Board as risks that could impact on the organisation's business and on achievement of the strategic objectives.

Strategic risks are recorded on the corporate risk register and managed in the same way as other risks, but are raised and accepted by the Trust Board.

Operational Risks

2.10. These are risks that have been identified on an operational level, e.g. risk of missed diagnosis due to obsolete equipment or risk to staff safety due to poor lighting in the car park. All these risks are recorded on the corporate risk register and performance monitored via the Trust's risk management process.

Corporate Risks

2.11. These are risks which impact on an organisation-wide basis. Examples include the risks of poor performance, poor documentation and the risk of non-attendance by staff at statutory training. All these risks are recorded on the Corporate Risk Register and performance monitored via the Trust's Risk Management process.

Divisional Risks

2.12. These are risks on the corporate risk register which relate to a specific Division also known as a local risk register.

Principal Risks

2.13. These are risks that have been identified by the organisation that may threaten the achievement of the Trust's strategic objectives. To date, twelve principal risks have been identified. (Appendix B)

Principal Risk Map

2.14. The principal risk map is a listing of the high scoring risks linked to each principal risk. Principal risks are linked to the Trust's strategic objectives.

Dynamic Risk Assessments

2.15. These are risk assessments carried out in a changing environment, where what is being assessed is developing as the process itself is being undertaken, often used in a major incident when the risk has not been foreseen. This process will be used by lone workers or those in potentially stressful environments to make a swift risk judgement, to identify hazards, likelihood and controls to ensure an acceptable level of safety. The same principals as generic risk assessments apply, however dynamic risk assessments are not normally recorded.

DATIX System

2.16. The DATIX web system is a risk management database used by the Trust to record, monitor and analyse information on a number of areas including incidents, complaints and claims, and is also the system where the corporate risk register is held.

Corporate Risk Register

2.17. The corporate risk register is a log of all clinical and non–clinical risks that may threaten the organisation's ability to achieve its declared strategic objectives. Collation of all the risks into one register enables the risks to be quantified and prioritised. It also provides a structure for collating information about risks both in the analysis of trends, as well as for deciding how the risks should be controlled.

Local Risk Register

2.18. A local risk register is a copy of a sub-set of clinical and non-clinical risks held on the Corporate Risk Register where the risks relate to an individual team, ward, department, service or division. Teams are able to produce a report of their local risks on the DATIX web system.

Strategic Objectives

2.19. The Trust's strategic objectives reflect the Trust's vision. They have been developed to ensure there is a shared understanding and common purpose throughout the organisation about the Trust's strategic direction and what needs to be delivered. (See Appendix C).

Board Assurance Framework

2.20. The Board has developed an assurance framework for the management of Strategic Risks facing the organisation. It enables the trust to review existing controls and assurance mechanisms to manage strategic risks and ensure delivery of the strategic objectives.

3. Responsibilities

Role of all staff

All staff are responsible for:

- Maintaining a general risk awareness at all times and reporting all risks and potential risks as soon as possible.
- Notifying managers of potential risks identified risks and undertaking risk assessments in accordance with agreed procedures.
- Being aware of risk assessments which have been carried out for their place of work.
- Complying with any control measures introduced to reduce and control identified risks.
- Participating in risk management training and education, as well as training around safe working practices.
- Ensuring that contractors and agency staff are informed of the Trust's risk management arrangements and of risks that may affect them in the areas they are working.

Role of the Head of Risks and Incidents

3.1. The Head of Risk and Incidents is responsible for:

- Supporting staff to identify, report and manage risks.
- Developing processes and procedures to deliver a robust risk reporting and management system.
- Reviewing identified risks, and providing support to staff for the completion of risk assessments and supporting action plans.
- Ensuring risk action plans are subject to performance monitoring and updated on the DATIX system.
- Providing staff with access and training to produce routine and ad-hoc risk reports.
- Providing reports to external agencies, e.g. Internal Audit.
- Providing routine reports to the appropriate internal Committee, e.g. Risk Management Committee, Audit and Assurance Committee.
- Developing training programmes to contribute to services and staff development.
- Maintaining the Trust Principal Risk Map.

Role of Director of Nursing, Quality and Workforce

- The Director of Nursing, Quality and Workforce is the lead director for risk management.

Role of Director of Finance

- The Director of Finance is the Senior Information Risk Officer. As this post is presently filled by an acting role the Chief Executive is currently holding this responsibility.

Role of the Risk Management Committee

- The Risk Management Committee is responsible for ensuring that all aspects of clinical and non-clinical risk within the Trust are managed and appropriately and monitored.

Role of the Quality Assurance Committee

The Quality Assurance Committee is responsible for:

- Challenging, receiving and providing assurance to the Trust Board of the effectiveness of the Trust's risk management processes.

Role of the Audit and Assurance Committee

- The Audit and Assurance Committee is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management.

Role of the Trust Board

- The Trust Board is responsible for ensuring the organisation's risk management system and processes are effective and the Assurance Framework meets the Trust's needs.

Risk Management Process

3.2. All risks are recorded, monitored and managed using the DATIX web risk module.

3.3. How to help guides for using the risk module are available at: http://datixweb.ndevon.swest.nhs.uk/Datix/live/WebHelp/index.html#RiskRegister/t_dx_risk_add_new_risk_register_record_to.html

3.4. Identifying a Risk

Any member of staff can identify a risk. Risks can be identified from a range of sources:

- An alert notice from external agencies, e.g. National Patient Safety Agency or the Medicines and Healthcare Products Regulatory Agency, and manufacturers of equipment or goods.
- Internal Audit reviews and reports.
- Complaints and Legal Claims.
- External inspections, e.g. Care Quality Commission.
- Incidents and near-misses, including risks identified through Serious Incidents Requiring Investigation, Significant Event Audits , 72 Hour reports and Information Governance Serious Incident Requiring Investigations
- Information Asset Risk Assessments
- Regulation-specific risks, e.g. Control of Substances Hazardous to Health (COSHH)
- Workplace risk assessments, e.g. Health and Safety issues

3.5. Reporting a new risk

Once a risk has been identified, a risk assessment must be completed in order to have an audit trail of the risk level, the control measures in place and actions identified to mitigate the risk.

Any member of staff may complete a risk assessment. However the assessment needs to be agreed by the nominated Risk Lead and Action Leads prior to completion.

The basic risk assessment and initial risk score details are inputted on to the DATIX system and the details of the risk are sent to the identified Risk Lead to identify the proposed treatment and actions to reduce the risk.

Individual patient or staff risk assessments are not entered onto the Corporate Risk Register. Copies are kept in the healthcare record or personnel files and any control measures and actions are shared with the relevant staff to ensure continuity and safety of care.

3.6. Risk Description

Details of the risk must be recorded on the online risk assessment form on DATIX web. (http://datixweb.ndevon.swest.nhs.uk/Datix/live/index.php?form_id=2&module=RAM).

Information required includes:

- risk assessor details
- risk assessment date
- description of the hazards
- location of the risk
- details of who is at risk
- risk treatment (see section 6.2)
- risk Lead details
- description of existing controls in place
- risk consequence
- initial risk score
- target risk score
- details of supporting risk action plans

3.7. Risk Treatment

The Trust recognises that it is not possible to eliminate all risks. It is therefore necessary to manage or treat the risk in one of the following ways:

- Tolerate – by accepting residual risks after action has been taken to reduce the original risk.
- Terminate– by utilising alternatives or by discontinuing an activity.
- Treat – by developing SMART action plans to reduce the risk.
- Transfer – involving another party to share some or all of the risk, e.g. insurance arrangements or joint ventures.
- Contingency and/or disaster planning – by developing plans to manage these risks should they occur.

Risk Control Measures

3.8. These are the existing processes, systems, training or instructions that are currently in place to prevent the risk event occurring or reduce the consequences of the risk event if it does occur. For example:

- national guidance
- Trust-wide policies and procedures
- standing operating procedures
- training and competency requirements
- equipment or planned preventive maintenance
- personal protective equipment

3.9. Risk Score

All identified risks must be scored using the agreed risk scoring matrix (see Appendix A). This is determined by multiplying the risk Consequence score with the risk Likelihood score, based on a 5 x 5 matrix.

The Consequence is selected as the typical severity. The likelihood is the likelihood of experiencing the consequence of that severity.

An initial risk score must be recorded which indicates the level of risk with the current existing control measures in place. Where a risk could have more than one consequence, the most realistic risk score must be recorded. There is a link to the Risk scoring matrix guide on the initial risk Rating section on DATIX.

A target risk score must also be recorded. Where a risk is to be reduced, the target risk score should reflect the final risk score once the proposed action plans have been completed and additional control measures and assurances have been put in place to reduce the risk.

In cases where the identified risk is to be tolerated immediately as no further action can be implemented to reduce the risk, the final risk score must be the same as the initial risk score.

3.10. Risk Action Plans

Action plan(s) are identified to control the risk to the organisation, or mitigate/ treat the risk.

The action plan(s) must be completed as comprehensively as possible to ensure it is specific, measurable and time-bound. Ensuring actions are SMART and Strong will lead to improved management and mitigation of risks and enable evidence to be provided when necessary to demonstrate that the actions which have been taken have made a difference. Please see Appendix D for advice and guidance on SMART action planning.

For each action plan(s), there must be nominated Action Lead to take responsibility for delivering the agreed action. This may be a different person from the Risk Lead.

The Risk Lead is responsible for ensuring that the action plan is agreed with the nominated Action Leads. The Action lead is responsible for providing updates to the action progress on the DATIX system and for providing evidence that actions have been completed.

4. Building the Corporate Risk Register

The corporate risk register is a central log of all clinical and non–clinical risks that have been identified and which may threaten the organisation's ability to achieve its declared strategic objectives.

There are a number of different steps to building the corporate risk register to ensure data quality, clear audit trails and effective management.

Validating the Risk

Once an online risk assessment has been completed it is recorded on the DATIX system as New Risk Awaiting review. The Risk and Incident Team review and validate each risk assessment to ensure that:.

- The risk has been correctly identified.
- The risk score appropriately reflects the level of risk.
- The proposed action plans are specific, measurable, time bound and appropriate (SMART) and Strong.
- There is a nominated Risk Lead and the risk actions have nominated and agreed Action Leads.

In cases where the risk assessment requires further work, the Risk and Incident Team will provide support to the Risk Lead and Risk Assessor.

Once the risk assessment has been validated, the risk status will be changed by the Risk and Incident Team to either 'Actions in Progress' or 'Risk closed/ Tolerated'.

The nominated Risk Lead is automatically notified when a new risk is added to the system.

Managing the Corporate Risk Register

4.1. Producing Risk Reports

- Staff have access to the risk register to produce reports.

4.2. Reporting New Risks

- Executive Directors, Specialist Advisers, Senior Managers, the Risk Leads and Action leads have access to the risk register to search for new risks for information and challenge. Risk leads have all open risks in their To do List. All new risks, regardless of score, are presented to the monthly Risk Management Committee meetings. Risks with a score of 15+ are routinely discussed in detail by the Committee.

4.3. Updating Existing Risks

- Action Leads will receive an email 5 days before an action is due to be completed with a link to the action plan. They are required to Click on the link and login to DATIX. The link will take you to the action
- The detail of the action required is in the 'description of the action' section
- The 'due date' of the action is shown in the line below
- Previous updates are detailed in 'progress history' found in the Action plan update section at the bottom of the page
- Provide an update in the Progress box, your name and the date will automatically be inputted once saved.

- If the action has been completed select a date in the 'done date' and who has completed the action in the 'Completed by' field. If additional time is needed to complete the action select a realistic date in the 'Due date' field and detail the reasons in the 'progress' section.
- Ensure you press 'save' at the bottom of the page.
- To attach evidence of the action being completed select the 'documents' tab on the left hand side and click 'Attach a new document' select the type of evidence (eg. Email, agenda, File note, minutes, photo, policy) in the 'Link as' field
- Give the document a title to be able to distinguish it (e.g Updated XXXXX policy) in the 'description' field
- Then select the 'Choose file' button to select where the evidence is saved to be able to attach it.
- To view the details of the Risk or action plan that the action relates to select the orange 'Links' tab on the left hand side.
- The Action plan lead will receive an email each day an action plan is overdue.

4.4. Exception Reports

- Exceptions are recorded on the Corporate Risk Register in order to maintain a clear audit trail for individual risks. Exceptions include:
- Action plan due date extended
- Action Plan Lead changed
- Action plan re-opened
- New action plan added
- Risk Lead changed
- Risk re-scored
- Risk re-opened
- Incomplete risks
- No response
- Risk closed and cross referenced to another risk
- Exceptions for all risks regardless of score are presented for information to the monthly Risk Management Committee. Exceptions for risks with a score of 15+ are routinely discussed in detail by the Risk Management Committee.
- The Risk and Incident Team are responsible for recording the risk Exceptions.

4.5. Management of No Responses

- A list of all Action Leads where 'No responses' to the action plan progress request has been received are routinely presented to the Risk Management Committee.
- Where an action plan due date has passed and no response to a request for an update has been received from the Action lead an email is sent to the Risk Lead.
- If no response is received by the Risk Lead a letter is written to the Action Lead and Risk Lead from the Director responsible for Risk Management, requesting an update.

- If there is still no response following the letter being sent, a further letter is written, copying in the Risk Lead's line manager, inviting the Risk Lead to attend a meeting with the Lead Director for Risk Management to discuss any barriers to completing the risk actions.

4.6. Tolerating Risks

- In some cases, an identified risk may be put forward for 'tolerating' immediately as the controls in place are assessed as sufficient to manage the risk and/or no further action can be identified to treat the risk.
- With regard to the risks that are being treated, before a risk can be tolerated all the supporting risk action plans must be completed and the risk re-scored.
- All risks to be tolerated are presented to the monthly meeting of the Risk Management Committee for approval. If the Risk Management Committee does not agree that the risk has been mitigated to an acceptable level, then the Risk Lead for the risk will be requested to identify additional actions.
- Risks that are identified and documented as strategic risks, risks there the origin is a Care Quality Commission report and risks whose score remains 15 or more once all the actions have been completed to the satisfaction of the Risk Management Committee, are recommended for tolerance to the Audit and Assurance Committee. The Audit and Assurance Committee has the responsibility for endorsing the Risk Management Committee's recommendations and approving these categories of risks.
- The Risk Management Committee will identify 2 to 4 tolerated risks/ action plans per meeting and request the action leads provide evidence the actions have been completed.

5. Building the Principal Risk Map

The Principal Risk Map is a listing of the high-scoring risks linked to each Principal Risk. Principal Risks are linked to the Trust's strategic objectives. The map clearly identifies the number of each principal risk assigned to a 15+ risk.

The Principal Risk Map is managed by the Risk and Incident Team. Routine reports on the Principal Risk Map are presented to the Risk Management Committee and the Audit and Assurance Committee which has a role in monitoring and scrutinising the management of the strategic-level risks to the organisation.

6. Training Requirements

Risk Management training applies to all staff. This training will be delivered in a variety of ways including induction, refresher, E learning assessment. Compliance with each delivery method is recorded using the Electronic Staff record, and reported through the monthly Training Status report. Risk management training is included within the Health, Safety and Welfare category of statutory training for all staff.

Practical risk assessment courses are available and can be booked on the Staff Training Access Resource (STAR). The half day training session has been designed to any staff involved in carrying out risk assessments for a variety of work activities. The learning outcomes for the end of the course are:

- Complete a risk assessment
- Complete supporting action plans
- Apply the risk scoring matrix
- Understand how risk assessments are implemented and performance monitored

These training courses can be booked through STAR.
https://nedevonnhs.kallidus-suite.com/KIP/SignIn.aspx?ReturnUrl=%2fKIP%2fSTS%2fIssueClaims.aspx%3fwa%3dwsignin1.0%26wtrealm%3dhttps%253a%252f%252fnedevonnhs.kallidus-suite.com%252fLMS%252f%26wctx%3drm%253d0%2526id%253dpassive%2526ru%253d%25252fLMS%25252f%26wct%3d2017-11-20T11%253a29%253a53Z&wtrealm=https%3a%2f%2fnedevonnhs.kallidus-suite.com%2fLMS%2f

Annual Appraisal

All annual Reviews MUST involve the manager ensuring that the member of staff has achieved outline competencies / attendance and undertaken the statutory and mandatory courses required for the post. Attendance at mandatory training will act as key evidence towards the core dimensions of all KSF outlines. In order to achieve gateway requirements and annual KSF Reviews staff will need to demonstrate attendance at annual mandatory training.

7. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

7.1. Key performance indicators comprise:

- Number of new risks added to the Corporate Risk Register
- Number of 15 + open risks
- Number of 15+ open risks which are open for more than 18 months
- Number of tolerated risks
- Number of risks not accepted by Risk Management Committee
- Number of exceptions reported
- Number of overdue actions

Key performance indicators are routinely provided to the Risk Management Committee.

Process for Implementation and Monitoring Compliance and Effectiveness

7.2. The updated policy will be communicated in the Chief Executives Bulletin.

7.3. Changes to current practices will be identified and communicated in Department Newsletters (Risky Business, Community Nursing, Acute Nursing and Unscheduled care.)

7.4. The Risk and Incident Team will attend departmental meetings to demonstrate the new DATIX web risk register and changes to the processes identified in the policy.

7.5. The changes to process will be monitored by the Head of Risks and Incidents and monitored through the Risk Management Committee at its monthly meetings.

7.6. These will include monitoring the number of overdue actions to ensure there is no increase, monitoring the number of new and tolerated risks to ensure there is not a decrease with the introduction of a new system

Monitoring compliance with this policy will be the responsibility of the Head of Risks and Incidents. This will be undertaken by reviewing on line risks when they are received. Routine reports are produced by the Risk Team on a monthly basis. These are presented to the Risk Management Committee to monitor new risks, tolerated risks and exceptions. Where non-compliance is identified, support and advice will be provided to improve practice.

8. Equality Impact Assessment

8.1. The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age				
Disability				
Gender				
Gender Reassignment				
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership				
Pregnancy	X			Individual staff are risk assessed for their individual needs.

Maternity and Breastfeeding	X			Individual staff are risk assessed for their individual needs.
Race (ethnic origin)				
Religion (or belief)				
Sexual Orientation				

9. References

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission Fundamental Standards
- Health and Safety at Work Act etc. 1974
- The Management of Health and Safety at Work Regulations 1999
- Health and Safety Executive (HSE). (2010). Leading Health and Safety at Work: Leadership Actions for Directors and Board Members. London: HSE. Available at: www.hse.gov.uk
- National Patient Safety Agency. (2008) A risk matrix for risk managers. London: National Patient Safety Agency. Available at: www.npsa.nhs.uk
- National Patient Safety Agency. (2007). Healthcare Risk Assessment made Easy. London: NPSA. Available at: www.npsa.nhs.uk

10. Associated Documentation

- Health and Safety Policy
- Incident Management Policy
- Investigations, Analysis and Improvement Policy
- Information Asset Risk review (now within Information Asset Owners & Administrators Handbook)
- Information Security Risk Review Guidance
- Management of Legal Claims Policy
- Risk Management Strategy
- Risk Scoring Matrix

Appendix A: Risk Scoring Matrix

Risk Consequence Score – Choose the most appropriate Descriptor(s) for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the severity of the risk on the scale from 1-5 to determine the consequence score which is given at the top of the column. More than one descriptor may be identified, in this case choose the most realistic highest consequence score to apply.

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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 < 3 days. Service well below reasonable public expectation	National media > 3 days. Service well below reasonable public expectation MP concern (questions in the House). Total loss of public confidence
Business objectives and projects	Insignificant cost increase/schedule slippage.	< 5% over project budget/schedule slippage.	5-10% over project budget/schedule slippage.	10-25% over project budget/schedule slippage Key objectives not met	Incident leading to > 25% over project budget/schedule slippage. Key objectives not met
Environmental Impact	Minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Finance including claims	Small Loss Risk of Claim remote	Loss of 0.1% to 0.25% of budget Claim < £10,000	Loss of 0.25% to 0.5% of budget Claims > £10,000 to £100,000	Uncertain delivery of key objective Loss of 0.5% to 1% of budget Claims > £100,000 to £1 million Purchasers failing to pay on time	Non delivery of key objective Loss of > 1% of budget Failure to meet specification/slippage Loss of contract payment by results. Claims greater than £ 1 million
Human resources / organisational development/ staffing /competence	Short term low staffing level temporarily reduces service quality (< 1 day)	On-going low staffing level reduces service quality	Late delivery of key objective/service due to lack of staff (recruitment, retention or sickness). Unsafe level or competence (>1 day) Low staff morale Poor staff attendance mandatory/essential 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 training attending mandatory/essential training.	Non-delivery of key objective/service due to lack of staff. On-going unsafe staffing levels or competence Loss of several key staff. No staff attending mandatory/essential training on an ongoing basis.
Impact on the safety of patients, staff or public(physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No absence from work.	Minor injury or illness, requiring minor intervention Requiring time off work <3 days Increase hospital stay 1-3 days	Moderate/illness requiring professional intervention Requiring time off work 4 - 14 days RIDDOR reportable incident Increase hospital stay 4-15 days An event that impacts on a small number of patients/staff/public	Major injury leading to long term incapacity/disability Requiring time off work for >14 days Increase hospital stay >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/staff/public

	1	2	3	4	5
Information Risk: -Confidentially -Integrity -Availability Including information risk covering physical , procedural, personal and technical measures	No impact, little or no extra effort to repair, necessary tools & processes in place to prevent recurrence	Tangible harm, extra effort required to repair	Significant expenditure of resources required, damage to reputation and confidence	Extended outage and or loss of connectivity , comprising of large amounts of data or services	Permanent shutdown, complete data or system compromise
Inspection and Statutory duty	No or minimal breech of guidance/Statutory duty Minor recommendations	Breech of statutory legislation Non-compliance with standards Recommendations given. Reduced performance rating if unresolved	Single breech in statutory duty Non-compliance with core standards Challenging external recommendations/improvement notice	Enforcement action. Multiple breeches in statutory duty Low performance rating Enforcement action Critical report	Multiple breeches in statutory duty Prosecution. Complete systems change required Zero rating Severely critical report
Patient experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care – short term effects	Mismanagement of patient care – long term effects	Totally unsatisfactory patient outcome or experience
Quality / Complaints / Audit	Informal/Locally resolved complaint/inquiry Peripheral element of treatment or service suboptimal	Justified complaint (stage1) Local resolution Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patients safety if unresolved Reduced performance rating if unresolved	Formal complaint (stage 2) Local resolution (with potential to go to independent review) Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Inquest/ombudsman enquiry Totally unacceptable level or quality of treatment or service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Service / business interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility

Risk Likelihood Score

1	Rare	Only occurs in exceptional circumstances,. e.g. less than once a year, 1-5 year strategic risk, <1% of time/events.
2	Unlikely	Could occur at some time, e.g. 1 – 3 times a year, at least annually, 1 – 5% of time /events.
3	Possible	May occur/ recur occasionally, e.g. 3 – 6 times a year, at least monthly, 6 – 20% of time/events.
4	Likely	Will probably occur but is not a persistent issue, e.g. 7 – 12 times a year, at least weekly, 21-50% of time/events.
5	Almost certain	Expected to occur/ is a persistent issue, e.g. more than 12 times a year, at least daily, >50% of time/events.

Risk Score

Where Risk Score = Consequence x Likelihood

By using the equation, a risk score can be determined ranging from 1 (low severity and unlikely to happen) to 25 (almost certain to happen with catastrophic and widespread consequences).

	Consequence				
Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 – Rare	1	2	3	4	5
2 – Unlikely	2	4	6	8	10
3 – Possible	3	6	9	12	15
4 – Likely	4	8	12	16	20
5 –Almost Certain	5	10	15	20	25

Risk Control

The risk score can now form a quantitative basis upon which to determine the urgency of any actions required to control the risk.

1 - 3	Green	Very Low risk	Further risk reduction may not be feasible or cost effective.
4 - 6	Green	Low risk	Risk reduction required, so far as is reasonably practicable. The majority of control measures in place or harm/severity small.
8 - 12	Yellow	Medium risk	Prompt action required, so far as is reasonably practicable. Moderate probability of major harm or high probability of minor harm if control measures not implemented.
15 - 25	Red	High risk	Significant probability that major harm will occur if control measures are not implemented. Urgent action may be required. Consider stopping procedures.

Notes:

1. The risk scoring matrix must be used when completing a General Risk Assessment Form.
2.

Advice and support for completing risk assessments can be sought from the Risk and Incident Team, Suite 1, Munro House, North Devon District Hospital, Raleigh Park, Barnstaple, EX31 4JB.

Northern Devon Healthcare NHS Trust

Appendix B: Principal Risks

PR1 - Financial planning & management There is a risk that the organisation's financial planning and management processes may not be sufficiently robust to ensure all risks to attaining financial balance are identified. Mitigation of the risk will be supported by performance monitored action plans to ensure the Trust achieves year-on-year financial balance.	**PR2 - Strategic & business planning** There is a risk that the organisation's strategic and business planning processes may not be sufficiently robust to ensure all risks to delivering of the Trust's services are identified. Mitigation of the risk will be supported by performance monitored action plans to ensure delivery of the Trust's strategic objectives.	**PR3 - Workforce numbers** There is a risk that the organisation's workforce planning processes may not be sufficiently robust to ensure both the current and future workforce can adequately provide the resources to deliver the change necessary to achieve sustainability. Mitigation of the risk will be supported by detailed directorate-level workforce plans fully aligned with the long-term financial model.	**PR4 - Workforce skills** There is a risk that the organisation's training and development arrangements may not be sufficiently robust to ensure staff can safely carry out their duties. Mitigation of the risk will be delivered by ensuring the staff are adequately trained and opportunities for continuous professional development are provided.	**PR5 - Procedural management** There is a risk that the organisation's processes for developing, maintaining and implementing policies and other procedural documents may not be sufficiently robust to ensure staff understand their roles and responsibilities. Mitigation of the risk will be delivered through the Trust's procedural documents being compliant with legislative and national requirements.	**PR6 - Equipment & facilities arrangements** There is a risk that the organisation's equipment and facilities may not be fit for purpose to ensure the delivery of the Trust's services. Mitigation of the risk will be through ensuring a planned and sustainable approach being maintained to ensure an adequate supply and by ensuring that there are appropriate contingency arrangements in place.
PR7 - Clinical records management There is a risk that the organisation's processes for managing clinical records are not sufficiently robust to ensure staff can safely provide treatment and care. Mitigation of the risk will be through ensuring that a systematic and planned approach is in place to ensure the Trust's clinical records are quality controlled, fit for purpose and created, stored and disposed of appropriately.	**PR8 - Leadership & management** There is a risk that the organisation's leadership and management arrangements may not be sufficiently robust to ensure the support of a clear and fair culture of accountability and to ensure staff are appropriately held responsible for the delivery of the Trust's strategic objectives. Mitigation of the risk will be delivered through regular reviews of leadership capability and Board development.	**PR9 - Unsafe behaviour** There is a risk that staff, patients, visitors, contractors and partner organisations do not adhere to the Trust's policies and procedures, either inadvertently, negligently or maliciously. Mitigation of the risk will be through ensuring knowledge of policies and other procedural documents is maximised through appropriate communication channels.	**PR10 - External demands** There is a risk that the organisation's financial and business planning arrangements may not be sufficiently robust to ensure the Trust can respond effectively to unexpected demands from statutory organisations or other external agencies. Mitigation of the risk will be supported by the planning processes that will enable the organisation to appropriately resource the delivery of the Trust's strategic objectives.	**PR11 - Partnership arrangements** There is a risk that the organisation's partnership working arrangements may not be sufficiently robust to ensure all risks are identified and managed. Mitigation of the risk will be through a frequent and regular review of stakeholder relationships.	**PR12 – Communication** There is a risk that the organisation's employees are not committed to good communication or that the employees do not or are not able to communicate effectively. The organisation may not have effective or robust communication arrangements, systems and processes. Mitigation of the risk will be through the development of a clear and robust Communications Strategy.

Northern Devon Healthcare NHS Trust

Appendix C: Strategic Objectives

Vision

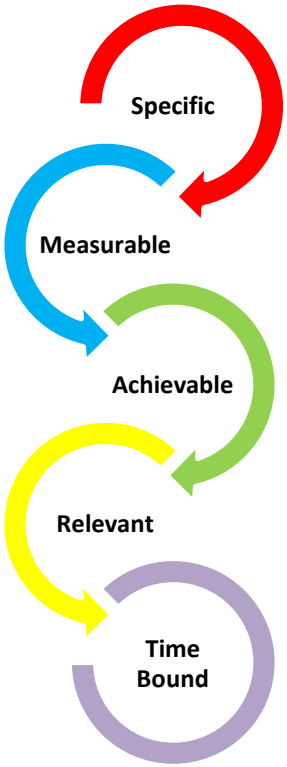
Delivering high-quality and sustainable services that support your health and wellbeing

Strategic Objectives

- We will deliver **high quality** care measured by effectiveness, safety and the person's experience of care.
- We will ensure access to a **sustainable** range of services that are delivered locally through partnerships and networks.
- People will tell their story only once. We will deliver **integrated health and social care**, seamlessly to meet the needs of individuals.
- We recruit and develop a flexible, fulfilled and multi-skilled **workforce** fully engaged in turning our vision into a reality.
- We will **efficiently and effectively** run our services to benefit our local communities.
- We will work in partnership with stakeholders to **promote independence and well-being**.
- We will support **individuals and communities to have more influence** over how services are delivered and encourage others to do likewise.

Northern Devon Healthcare NHS Trust

Appendix D: Guidance for developing SMART Actions



Guidance for developing SMART Actions

The purpose of an action plan on a Risk Assessment, Significant Event Audit report or Serious Incidents Requiring Investigation report is to identify an action that when completed will reduce the consequence or likelihood of the risk or the chance of the incident re- occurring.

Actions need to be Strong as well as SMART, The most effective action plans have stronger actions than education or reminders alone.

Weaker actions include anything where there is a possibility of human error for example staff following procedures or reading signs or posters. Consider, Discuss, Raise, Remind, Reflect, Reiterate and Tell are words to avoid in action planning.

Stronger actions do not depend on staff to remember to do the right thing they include, Testing new devices, processes and documentation, Leadership checks of process and documentation, Simplifying processes, hardware and software enhancements and modifications, Standardising equipment or processes to reduce variation. Complete, Develop, Evaluate, Introduce, Monitor and Trial, are words which will strengthen actions.

Always ensure that action plan leads have agreed to own the action and time frame is realistic prior to submitting.

Do not use abbreviations or jargon in action plans

A 90 second video related to SMART action planning is available at:
http://ndht.ndevon.swest.nhs.uk/?page_id=51933

Creating SMART Actions

S Specific	M Measurable	A Achievable/ Attainable	R Relevant	T Time Bound
The action should spell out precisely what you hope to achieve. It should detail an observable action, behaviour or achievement and where possible be linked to a rate, number percentage or frequency	A system is needed to track or record the action, behaviour or achievement to establish if it is on target, overdue or has been reached. The updated NHS England guidance for Serious incident Framework requires that evidence of whether or not the action plan have resulted in the practice/ system improvement anticipated are available.	The objective needs to be realistic and capable of being reached. Plainly ridiculous actions do not motivate people to completing them. Ensuring the action has been agreed between involved participants rather than enforced will help to ensure the likelihood of successfully completing the action	An appropriate action is something that the Action Plan Lead can actually impact upon or change and is important to the organisation. Once achieved it will ensure that the risk has been reduced or that it has reduced the risk of recurrence of the incident.	There needs to be a realistic finish date or time scale. For the purposes of obtaining updates of the action progress this date needs to be on a last day of a month.

Good Example Action plans

Action Plan							
				Please note that the author must agree the required actions with the proposed action leads before submitting this report			
Driver **S**pecific Issue / gap / objective requiring action	**Monitoring/** **M**easurable How we know we have succeeded	**Ref**	**Actions** **S**pecific, **A**chievable Stated clearly, communicated widely	**Resource demand / constraints** **R**elevant	**Person Responsible**	**Action Completion date** **T**imebound	**Status**
Staff failing to introduce themselves to patients resulting in a raise in complaints.	All staff to sign up to the campaign on BOB, print off image, write name on poster, have photo taken with sign and email as directed on BOB. Ward manager and Senior Nurse to monitor and address any non-compliance.	1.0	All Staff to introduce themselves to patients and visitors by using the phrase 'Hello my name is', as per the campaign on Bob the Trust internet site.	None Ward has access to camera.	Annette Curtain –Ward Manager	31/07/17	B
Non-compliance with the reporting of pressure damage.	Ward mangers during monthly documentation audits,	2.0	Introduce the body map of pre-existing pressure damage or wounds to support assessment and individualised care planning for pressure ulcer prevention and care planning.	Printing charts	Gail Force-Ward Manager	31/08/17	B
To facilitate decision making around complex case issues a Multi-Disciplinary Team meeting should be arranged, inclusive of parents/carers.	Reduction in incidents, complaints. Auditable documentation to support these meetings	3.0	Lead clinical team to co-ordinate a documented Multi-Disciplinary Team discussion – conference call or face to face for all complex cases.	Time availability of all the team and parents/ carers.	Dr I Ball – Ophthalmology	Action Completed 11/05/17	G

Swiftplus system unable to produce a report of patient lists.	User friendly reports available	4.0	Contact manufacturer to explore solutions for producing user-friendly reports, including patient lists, from the Swiftplus system	Time,	Justin Time – IM & T	31/07/17	B
Local ward based specific training for ward staff in the recognition and rescue of deteriorating patients to include; 'Obs no Probs', how to complete manual blood pressure for non-registered staff, the use of SBAR (situation, background, assessment and recommendation) and the inclusion of this patients observations chart as a learning aid.	Audit to determine effectiveness of blood pressure recordings during test of change.	5.0	Work alongside resuscitation team and workforce development to develop a training programme for ward staff to undertake manual blood pressures	Time	Annette Curtain – Ward Manager	Action completed 31/12/17	G
		5.1	Provide manual blood pressure recording equipment	Cost of Equipment	Annette Curtain – Ward Manager	Action completed 30/11/17	G
		5.2	Ward manager, resuscitation team and senior nurse to determine length of test of change and to evaluate the impact on the reliability of observations	Time	Annette Curtain – Ward Manager	31/03/17	B
All neutropenic patients should be managed in the first hour by the ED team	Annual Neutropenic Audit	6.0	Redesign Neutropenic Sepsis Pathway to ensure Nurse in Charge informed of patient arrival, all neutropenic patients are managed by the Emergency Department in the first hour, and a check list for receptionists is in place	Time	Dr A Payne	31/08/17	B