

CONTROLLED DOCUMENT

Risk Management Policy

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Risk Management Policy

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1 Policy Statement

- 1.1 Risk Management is a key objective for University Hospitals Birmingham NHS Foundation Trust (“the Trust”). The Trust’s commitment to Risk Management is outlined within the Risk Management Strategy.
- 1.2 Risk Management is essentially the process where an organisation adopts a proactive approach to the management of future uncertainty and facilitates the evaluation and control of risk.
- 1.3 The Trust recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances, by their nature, incur risks. The Trust accepts its corporate responsibility to provide the highest standards of patient care and staff safety, and as such, the process of Risk Management is viewed as an essential component in maintaining and improving standards at the Trust.
- 1.4 The objective of this policy is to ensure that the Trust has an effective system for identifying and managing risks with the aim of:
 - 1.4.1 achieving its objectives;
 - 1.4.2 protecting patients, staff, members of the public; and
 - 1.4.3 protecting assets.

2 Scope

This policy applies to all areas and activities of the Trust and to all individuals employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

3 Duties

3.1 Chief Executive Officer

The overall responsibility for all risk management issues and compliance with statutory requirements, legislation and Department of Health guidance rests with the Chief Executive. In line with the general philosophy of the Trust maximum delegation of responsibility will occur and managers will be accountable for the active management of risk within their designated areas.

3.2 Director of Corporate Affairs

The Director of Corporate Affairs has delegated responsibility for ensuring that the Trusts obligations for Risk Management are discharged accordingly and that Risk Management principles are embedded throughout the Trust. This includes compliance with the NHS Litigation Authority Risk Management Standards.

3.3 Director of Finance

The Director of Finance is responsible for ensuring the effective operational management and strategic development of all financial risks. This includes the Standing Financial Instructions.

3.4 Chief Operating Officer

The Chief Operating Officer has delegated responsibility for ensuring that effective operational arrangements are in place throughout the Trust and across both sites. This includes the management of operational risks.

3.5 Director of Delivery

The Director of Delivery has delegated responsibility for ensuring the effective operational management of all Human Resources and Health and Safety Risks. This includes compliance with Health and Safety Executive (HSE) guidance and legislation.

3.6 Medical Director

The Medical Director has responsibility for ensuring the effective operational management of all relevant professional risks.

3.7 Chief Nurse

The Chief Nurse has delegated responsibility for ensuring the effective operational management of all relevant professional risks. The Chief Nurse also has responsibility for the management of infection control, patient involvement, and the Patient Advocacy and Liaison Service.

3.8 New Hospital Project Director

The New Hospital Project Director has delegated responsibility for the risk management of the contractual building of the new hospital. They are responsible for ensuring that the members of the Board of Directors are informed of the appropriate risks.

3.9 Directors of Operations/Group Managers and Heads of Departments

3.9.1 Divisional Directors of Operations/Group Managers and Heads of Departments have delegated responsibility for

preparing local Divisional/Group/Departmental policies and procedures to ensure all necessary risk assessments are carried out within the Division/Group/Department and appropriate control measures are implemented and monitored. All employees at all levels must be made aware of the risks within their work environment and of their personal responsibilities. They must also be given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

- 3.9.2 Divisional Directors of Operations/Group Managers and Department Managers are responsible for ensuring that inspection, testing and maintenance of equipment used within their areas of managerial control is carried out and are responsible for ensuring all risks identified are minimised as far as is reasonably practicable.

3.10 Head of Governance

The Head of Governance has direct operational managerial responsibility for implementation of all aspects of governance, clinical effectiveness and risk management, through the management of the Governance and Risk Management Teams.

3.11 Trust Risk Management Advisor

The Risk Management Advisor has the delegated responsibility to achieve high standards of risk management for the Trust, including the ongoing review and development of the Trust's Risk Management Strategy. They are responsible for the continuing development of a proactive risk management culture and practice throughout the organisation; actively promoting and ensuring good risk management practices, an open, just and fair culture and the achievement of national risk management standards and performance indicators.

3.12 All Employees

- 3.12.1 All employees are required to implement the policy by:
- a) complying with all Trust rules, regulations and instructions;

- b) ensuring they work in a manner which is safe and secure for themselves, colleagues, patients and visitors.
- c) being aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others who may be affected by their acts or omissions;
- d) undertaking safe clinical practice in diagnosis and treatment;
- e) being familiar with the Divisional/Group/Departmental clinical procedures, and complying with these;
- f) neither intentionally or recklessly interfering with or misusing any equipment provided for the protection of health and safety;
- g) being aware of emergency procedures including cardiopulmonary resuscitation procedures relating to their particular location.

3.12.2 Any employee who fails to comply with the Trust or local policies or guidelines on risk, or recklessly interferes with or misuses any equipment, provided for the protection of health and safety, will be subject to disciplinary action.

4 Framework

4.1 In a healthcare environment, risk can be defined as:

“the possibility of injury, harm or loss to patients, staff, visitors or the structural/financial integrity of the organisation”.

4.2 This section describes the broad framework for the management of risk. Operational instructions for risk management, investigation of incidents, and learning from incidents are detailed in separate procedural documents which are ratified by the Director of Corporate Affairs

4.3 In addition, there are also corporate risks inherent in the financial and contractual stability of the Trust. The Trust must also seek to manage risks that threaten its ability to achieve its business objectives.

4.4 The risks in a health care environment are significant and ever changing. Risk must be managed through the systematic analysis of actual and potential risks and the development and implementation of measures to counteract those risks.

- 4.4 Risk Management is essentially made up of three stages:
 - 4.4.1 Risk identification
 - 4.4.2 Risk analysis
 - 4.4.3 Risk control
- 4.3 Risk identification
 - 4.3.1 The Trust requires that all departments must carry out risk assessments and review their risks on a regular basis following the Risk Register process. When new activities or changes to existing activities are contemplated, a risk assessment must be carried out and risks recorded on risk registers. (See Procedure for the Development and Ongoing Management of Risk Registers). Risks to the achievement of objectives should be assessed at the time that the objectives are set. (See Cycle of Governance Process)
 - 4.3.2 The risk assessment process is consistent throughout the Trust and the same methodology is adopted for both clinical and non-clinical risks.
 - 4.3.3 Risk registers at specialty, Divisional and Corporate level are recorded on Performance Accelerator. At ward level an Excel spreadsheet system is applied; however the same parameters for update and review still apply. See Procedure for the Development and Ongoing Management of Risk Registers
 - 4.3.3 Model Risks will be developed and adopted by the organisation for core aspects of risk that are reflected at varying levels within the Divisional and Corporate structures; they will include infection control, manpower and health and safety.
 - 4.3.4 All departments are required to review and update their risk registers at least quarterly. Divisional Directors of Operations must confirm that this has been carried out and record that fact in the Health and Safety folders.
- 4.2 Risk analysis
 - 4.2.1 Once a risk has been identified, it must be analysed to establish a reasonable estimate of its likely occurrence and its likely consequences with no controls in place. This analysis will identify the "Initial Risk". Risks to Trust objectives, structural or financial integrity or Trust assets must be assessed to identify the likely consequences for the Trust. Risks to patients, staff or visitors will need to be assessed both from the viewpoint of consequences for those patients, staff or visitors and from the view point of the consequences to the Trust.

4.2.2 The Trust is committed to use a consistent methodology for the analysis of identified risks. The method of analysing risk is based on an adaptation of the Australian/New Zealand Risk Management Standard AS/NZ 4360:1999. It requires each risk to be assessed on the basis of consequence and likelihood. Analysis of consequence and likelihood provides the severity of the risk enabling a list of prioritised risks to be developed. [Refer to Procedural Document].

4.2.3 Specialist Advisors

The Trust has a number of advisors who provide specialist advice to managers who are assessing risks. These are listed in the accompanying procedural documents.

4.3 Risk control

4.3.1 Risks may be controlled by reducing the likelihood of the risk occurring or by mitigating the consequences of a risk, or, indeed a combination of both. Each control that is identified and implemented has an effect on reducing the “initial risk” severity score. The “current risk” describes the initial risk with controls implemented. The “residual risk” is a future prediction if all the identified controls are fully effective.

4.3.2 The Board of Directors shall determine what level of risk tolerance is deemed to be acceptable to the Trust. All risks above this level must either have controls set up that will reduce them to or below that level or the Trust must consider whether the activity associated with that risk should be continued. Divisional Management Teams must also ensure that any risks quantified as high should have controls and action plans in place. Any high level risks that cannot be controlled within the Divisional/specialty structure should be escalated to the Board of Directors for consideration of actions to be taken; that may be to allocate resource to accept the risk, mitigate the risk or to discontinue the activity to negate the risk. Decisions about the escalation of risk and the decisions as to the outcome should be clearly documented in the minutes of the appropriate meeting to provide an audit trail.

4.3.3 The level of acceptable risk is set out in the Risk Management Strategy.

4.3.4 Existing controls should be periodically reviewed to ensure that they remain effective or can be discontinued if no longer required. Where existing controls are considered not to be effective an action plan should be developed to implement new or enhanced controls in order to reduce the level of risk over an appropriate time scale.

4.4 Incident Reporting

- 4.4.1 All accidents/incidents will be monitored with the intention of identifying incident trends to help prevent recurrence where reasonably practicable. There will be close co-operation between the Risk Management, Clinical Governance, Patient Services and Legal Services departments.
- 4.4.2 For the Risk Management programme to be effective, staff must report all adverse incidents and near misses that they have been involved in or witnessed. If all incidents including near misses are reported, areas of potential risk can be identified and any trends analysed.
- 4.4.3 Lessons from incidents and near misses must be learnt and risks eliminated or reduced before more incidents occur. Therefore the Trust promotes a 'just culture' to give staff the confidence to report incidents and near misses (see The Management of Incidents Policy).

4.5 The Clinical Governance Support Unit

- 4.5.1 The Clinical Governance Support Unit is responsible for ensuring collation of evidence to demonstrate compliance with the Standards for Better Health.
- 4.5.2 The Risk Management Department as part of the Clinical Governance Support Unit has delegated responsibility for the implementation of risk management activities throughout the Trust providing a support role to Divisional Clinical Quality Groups. They also provide support for other committees within the Trust as required.
- 4.5.3 The Risk Management Department is responsible for ensuring collation of evidence to demonstrate compliance with the NHS Litigation Authority Risk Management Standards.

4.6 Occupational Health and Safety Department

The Occupational Health and Safety Department has delegated responsibility for the management of the process for Health and Safety risks throughout the Trust. This includes advice on compliance with HSE legislation, Manual Handling and Control of Substances Hazardous to Health (COSHH) assessments.

5 Implementation and Monitoring

- 5.1 Internal Audit carry out a biannual audit on risk processes within the Trust. Recommendations that are identified from these audits are reported to the Audit Committee and actions plans put in place.
- 5.2 The NHS Litigation Authority (NHSLA) Risk Management Standards require that there are risk management processes in place that are implemented and monitored. These assessments take place either once a year, every 2 years or every 3 years depending on the level the organisation has been awarded. Any areas of non-compliance that are identified are amalgamated into an action plan and monitored through the Audit Committee.
- 5.3 The Healthcare Commission Standards for Better Health require that there are risk management processes in place. The Trust self assesses against the Standards on a quarterly basis to provide evidence of compliance; the process includes two Star Chambers for in-depth review and assurance by Directors of the Trust.. Any areas of non-compliance that are identified are amalgamated into an action plan and monitored through the Audit Committee.
- 5.4 All risk registers in the Trust are reviewed on a quarterly basis at the relevant committees or Divisional and specialty groups. See Procedure for the Development and Ongoing Management of Risk Registers for further information.
- 5.5 Performance review

Divisional Risk registers are included in the Performance Review process every six months and are reviewed for progress against action plans.

6 References

- 6.1 Australian/New Zealand Risk Management Standard AS/NZ 4360:1999
- 6.2 NHSLA Risk Management Standards
- 6.3 Health Care Commission Standards for Better Health

7 Associated Policy and Documentation

- 7.1 Risk Management Strategy
- 7.2 Policy for the Prevention and Management of incidents including Serious Untoward Incidents

- 7.3 Procedure for the Development and Ongoing Management of Risk Registers).
- 7.4 Procedure for the Reporting of Incidents
- 7.5 Procedure for the Investigation of Incidents Including Serious Untoward Incidents