Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I - DECEMBER 2011

Agenda Item Number: 199/11
Enclosure Number: (6)

Subject:	Risk Management Strategy
Prepared by: **Sponsored by:** **Presented by:**	*Sheena King: Head of Risk Management and Legal Services* *Peter Mellor: Company Secretary* *Peter Mellor: Company Secretary*
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board approval Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Strategy was circulated to all Trust Board members and was presented and discussed at Trust Board workshop on 27 October.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Trust Board are asked to ratify this strategy
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Strategy will be • Published on intranet • Disseminated to CSCs • Used to support NHSLA assessment March 2012
Consideration of legal issues (including Equality Impact Assessment)?	Strategy has undergone Equality Impact Assessment
Consideration of Public and Patient Involvement and Communications Implications?	N/A

Portsmouth Hospitals NHS
NHS Trust

RISK MANAGEMENT STRATEGY

To err is human
To cover up is unforgivable
To fail to learn is inexcusable

Sir Liam Donaldson

September 2011

VERSION	DATE RATIFIED	BRIEF SUMMARY OF CHANGES	AUTHOR
1.0	Trust Board June 2008	NHSLA/Internal Audit informed review	Head of Risk Management, Complaints and Legal Services
2.0	Trust Board January 2010	Minor amendments in light of changes to Trust processes and committee responsibilities	Head of Risk Management and Legal Services
3.0	Trust Board May 2010	Minor amendments in light of changes to Trust processes and committee responsibilities	Head of Risk Management and Legal Services
4.0	Trust Board December 2011	Minor amendments in light of changes to Trust processes and committee responsibilities	Head of Risk Management and Legal Services
In the case of hard copies of this strategy, the content can only be assured to be accurate on the date of issue marked on the document For assurance that the most up to date strategy is being used, staff should refer to the version held on the intranet			

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1. INTRODUCTION

The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Portsmouth Hospitals Trust (the Trust) Board with assurance on the framework for clinical, non-clinical and corporate governance.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options.

The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the culture of the organisation and becomes an integral part of the Trust's objectives, plans, practices and management systems.

2. STATEMENT OF INTENT

The Trust Board is committed to leading the organisation forward to deliver a quality service and achieve excellent results. Thereby ensuring the organisation delivers the best patient-centred care possible, in the hospital of choice whilst making the very best use of public funds.

The Board recognises that to achieve these goals, there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and support better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: a cornerstone of building safer care for the future.

3. WHOSE RESPONSIBILITY IS RISK MANAGEMENT?

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

However, the day-to-day management of risk is the responsibility of everyone in our organisation and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

4. OBJECTIVES

The key objectives of the Risk Management Strategy are to:

- Support delivery of the Trust's Strategic Aims;
- Develop a culture where risk management is integrated into all Trust business;
- Ensure appropriate, systematic structures are in place to manage risk;
- Reduce risks to patients, carers, staff, members of the public and others;

- Ensure all staff are aware of their duties and authority for the management of risk, through clearly defined roles and responsibilities;

- Encourage an 'open and just' approach in which risk management is part of continuous improvement and learning; and

- Ensure the Trust complies with relevant statutory and mandatory requirements, including those of the Care Quality Commission (CQC) and the National Health Service Litigation Authority (NHSLA).

5. ORGANISATIONAL RISK MANAGEMENT STRUCTURE

The Risk Management structure is based on committees and groups (Appendix A), which have key roles in the management of risk. This provides the assurance required by the Board that all areas of risk are being adequately managed. Appendix B demonstrates the organisational structure and lines of reporting with individual duties of key individuals detailed in Appendix C.

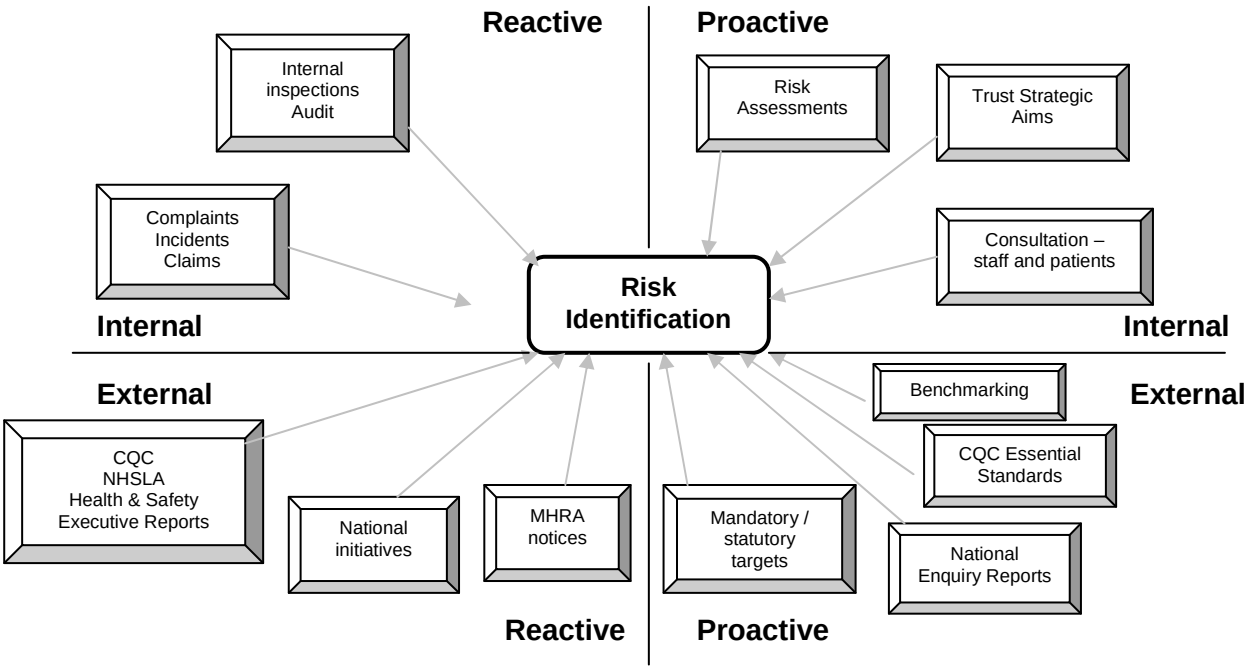
6. THE MANAGEMENT OF RISK

The management of risk, locally or centrally, is underpinned by the following key components:

- The Risk Management Cycle:
  - ❖ Risk Identification
  - ❖ Risk Assessment
  - ❖ Risk Treatment
  - ❖ Risk Review
- Risk Registers
- Assurance Framework
- Risk Management Training
- Review of Effectiveness

6.1 The Risk Management Cycle

Risk Identification: A risk can be identified through a variety of external and internal sources and can be proactive or reactive.



Risk Assessment
A risk assessment is simply a systematic process for identifying the level of risk associated with an activity, event or service area, the main purpose of which is to help prioritise the organisation's risks. Risks are assessed using a standard risk assessment tool/rating matrix which maps the likelihood of the risk occurring against the impact/consequence of its occurrence and recorded on a standard risk assessment form.

The process of risk assessment is clearly outlined in the Trust's Risk Assessment Policy.

Risk Treatment
For any identified risk, an action plan is agreed and implemented at the appropriate level, to manage and control the risk, using the following approaches:

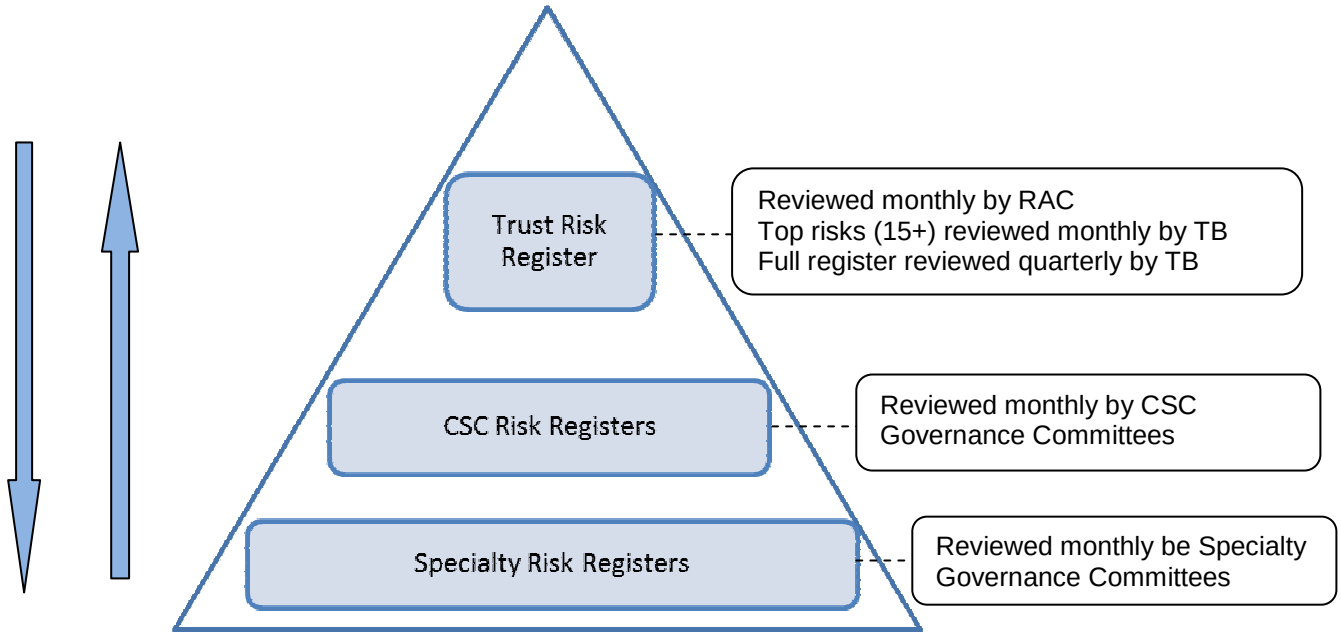
- **Avoidance:** undertaking the activity in a different way to prevent the risk occurring
- **Reduction:** taking action to reduce the risk
- **Transfer:** movement of the risk to another individual / organisation
- **Acceptance:** all of the above options are not possible and a contingency plan is developed

Risk Review
All identified risks that cannot be addressed immediately are placed on a risk register, held and managed at the appropriate level within the Trust. As a minimum, all levels of the organisation will review their registers and the associated action plans on a quarterly basis. See section 6.2 below

6.2 Risk Registers

Managing risk, locally or centrally, is a part of everyday management in the NHS. Whilst some aspects of risks can be addressed immediately, there are occasions when time is required to implement solutions. Risk registers have been developed to provide ongoing logs of those risks and to monitor implementation of the action plans necessary for mitigation. Risk registers are primarily internal management tools to support Clinical Service Centres (CSCs) and Specialties in managing their risks, whilst offering an opportunity to escalate particular risks to the Trust Risk Register. All risk registers are maintained in the same format to aid monitoring and escalation

Management of Risk Registers



Local Management

Specialty Risk Registers

All specialties are required to maintain a local register of risks. It is the responsibility of the specialties to monitor their registers on a monthly basis. Any risks that cannot be managed at specialty level, or have the potential to affect the whole of the CSC, are escalated to the relevant CSC Governance Committee for consideration and potential inclusion on the CSC Risk Register.

Clinical Service Centre Risk Registers

Each CSC maintains a risk register. The risks held on these registers may be those which cannot be managed at specialty level or have the potential to affect the CSC as a whole. It is the responsibility of the CSC Governance Committees to monitor their registers monthly and to escalate any risk that cannot be managed at CSC level or may have a trust-wide impact to the Risk Assurance Committee (RAC) for consideration and possible escalation to the Trust Risk Register.

Corporate Management

Trust Risk Register

Risks managed through the Trust Risk Register are those which cannot be managed by the CSCs and/or have the potential to impair or affect the operational or financial ability of the Trust to deliver core services, or those which may adversely affect the Trust's profile or reputation.

The Trust Risk Register is reviewed monthly by RAC and any risks RAC deems appropriate are escalated to the Assurance Framework for consideration by the Trust Board.

The Trust Board reviews the top risks (those rated 15+) on a monthly basis. The complete register is reviewed by the Trust Board quarterly, and by the Audit Committee and the Senior Management Team bi-monthly. This provides these high level groups with a comprehensive picture of the risks facing the organisation and enables them to consider any further actions or assurance which may be required.

The Trust Risk Register can be accessed on the Risk Management webpage on the Trust Intranet.

6.3 Board Assurance Framework

The Assurance Framework provides the Trust with a comprehensive method for managing the high level risks identified as having the potential to prevent the achievement of the Trust's strategic aims.

The Assurance Framework is reviewed by the:

- Trust Board: monthly
- Risk Assurance Committee: monthly.
- Audit Committee: bi-monthly.

The Assurance Framework/Risk Register Protocol flowchart is at Appendix D.

6.4 Risk Management Training

The Trust Board recognises that training is central to the successful implementation of this strategy and to staff understanding their roles and responsibilities for risk management across the organisation.

Risk Management training for staff forms part of the Trust's Essential Skills and Training requirements; as identified by the Training Needs Analysis. It is included in mandatory Corporate

Induction and in Essential Updates. Staff attend classroom delivered Essential Update training every three years and undertake refresher training via ESR in the intervening years.

The uptake of training is monitored by the Learning and Development Team, via ESR and reports on compliance are provided monthly to the CSCs. Review of compliance then forms part of the CSC monthly performance reviews.

Specific risk management awareness training will be held on a two yearly basis for all Board members. Attendance at this training will be monitored by the Company Secretary who will follow up on non-attendance.

6.5 Review of Effectiveness of the Risk Management Process

Corporate

This includes:

- Monthly receipt of the Quality Exception Report and Business Intelligence by the Trust Board;
- Quarterly receipt of the Quality Report which provides an aggregated view of issues concerning patient safety, patient experience and clinical effectiveness;
- Monthly review of top risks (15+) on the Trust Risk Register by Trust Board;
- Monthly review of Assurance Framework by Trust Board and RAC;
- Quarterly review of the full Trust Risk Register by Trust Board;
- Monthly review of the full Trust Risk Register by RAC
- Bi-monthly review of Assurance Framework by the Audit Committee;
- Receipt of independent sources of assurance e.g. External / Internal Audit reports, National Surveys, reports of external inspection/assessment bodies such as the CQC, NHSLA;
- Receipt of CSC reports by Governance and Quality Committee and RAC, in accordance with reporting schedules;
- Monthly CSC performance reviews with the Executive Team; and
- Monthly contract meetings with Commissioners

Local

Whilst all specialties and wards have local level responsibility for reviewing and managing their risks, the CSC Governance Committees have an overarching responsibility to ensure that all relevant risks within their CSCs are monitored, managed and escalated appropriately. This will include:

- Receipt of reports from their CSC specialties;
- Review of clinical dashboards/heat maps;
- Review of Risk Registers;
- Review of all incidents, complaints and claims;
- Review of action plans relevant to their sphere of activity; and
- Monthly CSC performance reviews with Executive Team

7. EQUALITY IMPACT STATEMENT

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This Strategy has been assessed accordingly

8. MONITORING COMPLIANCE WITH THE RISK MANAGEMENT STRATEGY

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Leads for Acting on Recommendations
All	Head of Risk Management and Legal Services	• Internal Audit	Annually	Reported to: • Trust Board • Audit Committee • Risk Assurance Committee	Head of Risk Management and Legal Services

9. ASSOCIATED DOCUMENTATION

The following internal and external documents support the implementation of the Risk Management Strategy

Internal – these can be found on the Trust's Intranet site.

- *Being Open Policy*
- *Claims Policy for Clinical Negligence, Employer, Public Liability and Property Claims*
- *Fire Policy*
- *Major Incident Response Policy*
- *Maternity Risk Management Strategy*
- *Maternity Policy for the Management of Adverse Events and Near Misses*
- *Policy for Analysing and Learning from Aggregated Incidents, Complaints and Claims*
- *Policy for the Management of Adverse Events and Near Misses*
- *Policy for the Investigation of Incidents, Complaints and Claims*
- *Policy for the Management of Serious Incidents Requiring Investigation*
- *Policy for the Management of Complaints and Plaudits*
- *Risk Assessment Policy*
- *Security Operational Policy*
- *Whistleblowing Policy*
- *Business Intelligence Report*
- *Quality Exception Report*

If, for any reason, a member of staff does not have access to the Trust Intranet a hard copy can be made available by their line manager or the Risk Management Department

External

- An Organisation with a Memory: *Department of Health 2000* *www.dh.gov.uk*
- Building a Safer NHS: *Department of Health (2002)* *www.dh.gov.uk*
- Building a Memory: preventing harm, reducing risks and improving patient safety: *National Patient Safety Agency (2005)* *www.npsa.nhs.uk*
- Being Open: *National Patient Safety Agency (2005)* *www.npsa.nhs.uk*
- National Standards, Local Action, Health and Social Care Standards and Planning Framework: *Department of Health (2004)* *www.dh.gov.uk*
- NHSLA Risk Management Standards: *NHSLA (20011)* *www.nhsla.com*
- Essential Standards *Care Quality Commission (March 2010)* www.cqc.org.uk
- Assurance: The Board Agenda: *Department of Health*. *(2002)* www.dh.gov.uk
- The Handbook to the NHS Constitution www.dh.gov.uk

10. REVIEW

This Strategy will be reviewed in 2013, unless requirements change.

Appendix A

Responsibilities of Key Committees/Groups in the Management of Risk

Trust Board
The Board has ultimate responsibility and accountability for the quality and safety of services provided by the Trust. Risk management, as part of the overarching framework of governance is, therefore, a principle role of the Board.

The Board reviews all high levels risks (15+) and the Assurance Framework monthly and the full risk register quarterly.

Audit Committee
The purpose of the Audit Committee is to provide the Trust Board with an independent and objective review of internal control. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), to support the achievement of the Trust's objectives.

Senior Management Team
The purpose of the Team is to manage generally the business of the Trust below the level of the Board.

Governance and Quality Committee
The Committee, which reports directly to the Trust Board, has overarching responsibility for ensuring that there is continuous and measurable improvement in the quality of services provided and for ensuring the Trust Board receives assurance that the risks associated with its activities are managed appropriately.

Risk Assurance Committee
The purpose of the Committee, which reports to the Governance and Quality Committee, is to promote effective risk management and to establish and maintain an Assurance Framework and a Risk Register, through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality. The Committee will promote local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

Health and Safety Committee
The purpose of the committee, which reports to the Governance and Quality Committee, is to effectively identify and review health and safety risks within the organisation and contribute to the risk register through which the Trust Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality. The Committee will promote local level responsibility and accountability and will challenge risk assessment and the risk control measures in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

Clinical Effectiveness Steering Group
The purpose of the Clinical Group is to provide direction and formally report on progress against the key work-streams relating to clinical effectiveness across the Trust. It will take into account national best practice guidance to ensure standards across the Trust. CESG will also consider the clinical effectiveness implications arising out of national reports and enquiries, making recommendations as required to the Governance and Quality Committee.

Patient Experience Steering Group
The purpose Group is to provide direction and formally report on progress against the key work-streams relating to patient experience across the Trust. It will take into account national best practice guidelines and patient feedback to ensure standards across the Trust. PESG will also consider the patient experience implications arising from national reports and enquiries, making recommendations as required to the Governance and Quality Committee

Patient Safety Working Group
The purpose of the Group, which reports directly to the Governance and Quality Committee, is to demonstrate improved patient safety levels within the Trust, which builds on our good clinical reputation and differentiates us not only in terms of quality but also influences Patient Choice and Commissioning.

Information Governance Steering Group
The purpose of the group, which reports directly to the Governance and Quality Committee, is to promote effective information governance and to establish and maintain a framework which ensures that all information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care and services.

Serious Incident Review Group
The Group will provide a high level forum in which to oversee and monitor the effective reporting and review of internal serious incidents requiring investigation (SIRIs) and will receive details of any external enquiry reports and associated recommendations in relation to incidents of relevance to the Trust, as and when appropriate.

The Group will promote local level responsibility and accountability and will challenge untoward serious incident investigation arrangements in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

Clinical Service Centre (CSC) Governance Committees
Each CSC is required to have a Governance Committee, which oversees the delivery of the governance agenda. The Committee provides the monitoring, assurance and reporting function on all aspects of the governance agenda with the CSC. Reports are provided to the Governance and Quality Committee and the Risk Assurance Committee as per the committee reporting schedules.

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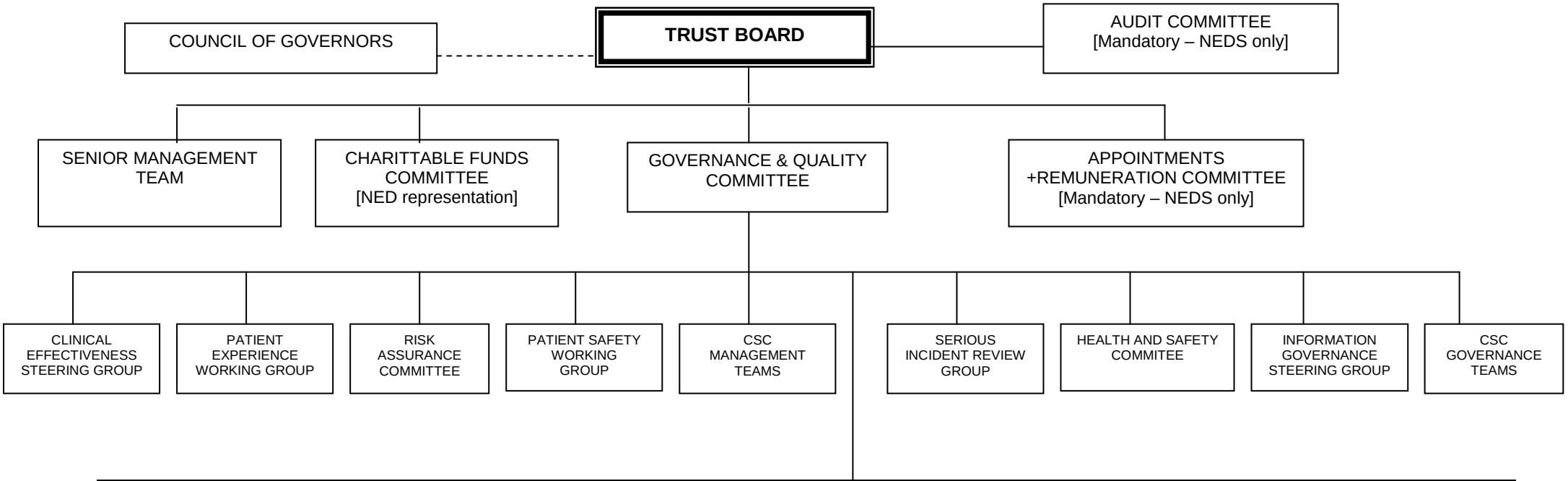
Appendix B

ORGANISATIONAL RISK MANAGEMENT REPORTING STRUCTURE



Area Prescribing Committee	Facilities Management	Medical Devices	Patient Environment Action Group
District Resuscitation Committee	Hospital Transfusion Committee	Medical Radiation Committee	Research and Development
Equality and Diversity Committee	Human Resources (workforce)	NPSA Alerts	Safeguarding Children
Formulary and Medicines Group	Infection Control Committee	Paediatric Standards Committee	Vulnerable Adults

Appendix C

Duty of Key Individuals in the Risk Management Framework

Chief Executive: is the Accountable Officer for the Trust and has overall responsibility for the management of risk.

Director of Nursing: is the Executive lead for governance and patient safety. In partnership with the Medical Director, the postholder ensures organisational arrangements are in place, which satisfy the legal requirements of the Trust with regard to the quality and safety arrangements or patients and staff; including delivery of processes to enable effective risk management and clinical standards.

Chief Operating Officer: has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation.

Director of Finance: has executive responsibility for the financial governance arrangements throughout the organisation, including overseeing financial performance management at corporate and CSC level

Company Secretary: is responsible for the work of the Board and its Committees and for ensuring integration of their activities with respect particularly to their governance and regulatory responsibilities.

Non-Executive Directors: have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

Head of Governance and Patient Safety: supports the Director of Nursing and the Medical Director with regard to their governance, safety, quality and risk management responsibilities. In particular the postholder has responsibility for compliance with the Care Quality Commission and PCT Quality Contract requirements. This includes overseeing the risk management function, encompassing the Assurance Framework, Trust Risk Register, Statement on Internal Control and compliance with the requirements of the National Health Service Litigation Authority.

Responsibility of the Head of Risk Management and Legal Services: has management responsibility for the operational delivery and implementation of the Risk Management Strategy and associated processes.

CSC Senior Management Teams: the teams comprise a General Manager, Chief of Service and Head of Nursing and have delegated authority and responsibility for: directing governance activity; managing risk and developing monitoring systems for providing assurance that activity is being carried out appropriately. The Teams are also responsible for escalating any issues up through the governance structure.

Senior Managers: have delegated responsibility and authority with regard to the management of quality, risk and performance within their specific spheres of activity included in their job descriptions. Senior Managers are also responsible for escalating issues up through the designated governance structures.

Managers: have delegated responsibility and authority with regard to the management of quality, risk and performance within their specific spheres of activity included in their job descriptions. Managers are also responsible for escalating issues up through their designated governance structures.

All Staff: are responsible for their own and others health and safety within their immediate workplace and for participating in the wider governance, quality and risk management activities, as appropriate and have this included in their job descriptions. Staff are also responsible for escalating issues up through their designated line management structures.

Appendix D

ASSURANCE FRAMEWORK/RISK REGISTER PROTOCOL FLOWCHART