

# Risk Management Strategy

## Reason for development

This Strategy has been developed primarily to set out the Trust's key aims and objectives for risk management. It has also been developed for the following reasons:

- To comply with legal and statutory requirements.
- To assist compliance with National Guidance e.g. National Service Frameworks and National Standards.
- As a result of proactive risk management.
- To improve patient safety and quality care.

## 1 Scope

This Strategy applies Trust-wide to all staff.

## 2 Aims

Risk Management aims to achieve optimum quality care and treatment of patients, and the provision of services which are safe and free of unnecessary risks by making maximum use of available resources and reducing wasteful expenditure.

The Board of Directors will continuously strive to ensure that there are effective Governance and Risk Management systems and arrangements in place and that these are monitored on an ongoing basis.

The Trust's key strategic risk management aims are as follows:

- To adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance.
- To support the achievement of the Trust's objectives as set out in the Performance Management Framework.
- To comply with National Standards and to aid compliance with the NHSLA's new Risk Management Standards.
- To have clearly defined roles and responsibilities for the management of risk.
- To provide a high quality service to patients and continuously strive to improve patient safety.

- To ensure that risks are continuously identified, assessed and minimised.
- To use risk assessments in informing the overall business planning/investment process in the Trust.
- To encourage open and honest reporting of incidents through the use of a single incident reporting system.
- To establish clear and effective communication that enables information sharing.
- To foster an open culture that allows organisation wide learning.

Specific objectives have been set to meet these aims which can be found at Appendix 1.

### **3 Introduction**

Cambridge University Hospitals NHS Foundation Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore involve a degree of risk. These risks are present on a day-to-day basis throughout the Trust.

The continued delivery of high quality healthcare requires identification, management and minimisation of events or activities which could result in unnecessary risks to patients, staff and visitors/members of the public. The management of risk is a key organisational responsibility and is the responsibility of all staff employed by the Trust.

The Trust acknowledges its legal duty to safeguard staff, patients and members of the public. There are also sound moral, financial and good practice reasons for identifying and managing risks. Failure to manage risks effectively can lead to harm/loss/damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation and adverse or unwanted publicity.

Risk Management is an integral part of good Clinical and Corporate Governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial. As well as close links with Clinical and Corporate Governance, Risk Management is also embedded within the Trust's overall Performance Management Framework and links with business planning and investment.

Cambridge University Hospitals NHS Foundation Trust is committed to ensuring the safety of patients, staff and the public through the integrated management of all aspects of governance and risk.

The Trust recognises that this is best achieved through an environment of honesty and openness, where mistakes and adverse events are identified quickly and dealt with in a positive and responsive way.

**Current position**

The Trust already has a number of systems and processes in place to manage risk but also recognises that there is more to do. The Good Practice in Clinical Governance Guide was implemented in April 2006 and this has provided a very useful framework for SDU's to work towards implementing Clinical governance within their areas. An audit has shown that not all areas are yet adhering to Good Practice guidance and this requires more work with individual SDU's.

The Trust has a network of trained Risk Officers and Risk Representatives in place to manage risks at a local level. These individuals receive formal risk management training through the Risk Management Department. With the draft new NHSLA Risk Management standards, the Trust will need to ensure, for example that it has undertaken a training needs analysis to identify the Risk Management training needs of all staff including the Board and senior managers. The Trust is currently working towards implementation of a programme of Root Cause Analysis (RCA) training Trustwide for all managers and staff involved in the investigation of incidents.

In terms of IT/systems support, the Trust has a Risk Management Information System (RMIS) which captures incidents and risk assessments. It also acts as the central register for the capture of all risks Trust-wide and locally. The Risk Register which was in its infancy is now becoming more populated especially in the wake of the Trust-wide clinical risk assessment exercise undertaken as part of the CNST (*Clinical Negligence Scheme for Trusts*) assessment. The Trust has now begun to undertake a similar exercise to capture Trust-wide organisational risks. Once entered on the Risk Register these assessments will form the basis of an information set that will aid each SDU to monitor their organisational risks. The Trust's Risk Management Information System also requires upgrading to allow the capture of Trust-wide generic risk assessments and this work will be completed as part of this year's work programme.

## 4. Implementation of Strategy

The implementation of this strategy will be achieved through:

1. Developing robust arrangements in all directorates for managing Governance and risk as set out in the "Good Practice in Clinical Governance" guide.
2. Providing Risk Management training and support to designated individuals including senior managers to enable them to manage risk as part of normal line management responsibilities.
3. Undertaking risk assessments (*clinical; organisational; financial etc*) using a common methodology in all Directorates to identify, control and minimise risks.
4. Building on the Trust-wide clinical risk assessment that was undertaken as part of achievement of CNST level 2 and continuing with the Trust-wide Organisational risk assessment.
5. Recording the results of risk assessments onto the Trust's Risk Register and in ensuring that all high risks (*risk rating 16-25*) are escalated to the Clinical and Corporate Governance Committee.
6. To encourage a culture of openness in terms of reporting and learning from incidents for both staff and patients.
7. Using National Patient Safety Agency Root Cause Analysis Tools to investigate incidents; identify contributory factors and root causes and inform improvements/changes required to improve patient safety.
8. Ensuring that the lessons learnt from incidents are shared and disseminated across the Trust to foster Trust-wide learning.
9. Learning from incidents, claims, complaints, audit results and other national reports/guidelines to improve patient safety.
10. Implementing the recommendations from the National Patient Safety Agency (NPSA) and other SABS (Safety Alerts and Broadcasting System) Alert Notices and communicating changes to all staff across the Trust.
11. Benchmark the Trust's current compliance against Levels 1 and 2 of the draft new NHSLA Risk Management Standards.

See Appendix 1 for specific objectives set for this financial year in order to implement the Strategy.

## 5. Monitoring and Assurance

As part of the process for managing risk consideration will be given to the level of assurance for monitoring the effectiveness of identified controls. The level of assurance expected will be influenced by the level of risk for the objective or activity.

The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed through the following:

- The Statement on Internal Control and the Board Assurance Framework and the Trust's progress against its strategic and operational objectives as set out in the framework.
- Receipt of quarterly Performance Management Reports outlining achievement against key performance and quality indicators
- Compliance levels with National Standards.
- Compliance levels with the NHSLA's Risk Management Standards.
- The annual Statement of Internal Control (SIC).
- Receiving assurance from Internal and External Audit that the Trust's Risk Management systems are being implemented.
- Commissioning of specific Internal and External Audit reports and opinions by the Audit Committee; priorities driven by the assurance framework and the Risk Register.
- Receipt and review by the Clinical and Corporate Governance Committee of the minutes and annual reports of the Specialist Advisory Committees that feed directly into it.
- Audit on compliance of each SDU (Service Delivery Unit) with the Trust's Good Practice in Clinical Governance Guide.
- Receipt by the Clinical and Corporate Governance Committee of an Annual Risk Management Report outlining progress against implementation of the Trust's Risk Management Strategy. The Committee will also ensure that this strategy is reviewed on an annual basis.
- Compliance with the Trust's Health and Safety Policy and arrangements for the management of health and safety via completion of an annual programme of workplace inspections and health and safety audits.

## 6 Dissemination and Communication

This Strategy is available on the intranet and communicated to all staff at corporate induction via the staff handbook.

## 7 Other related Strategies, Policies and Procedures

Other key related documents include:

- Maternity Services Risk Management Strategy
- Trust Risk Management Policy
- Trust Risk Assessment Policy and Procedure
- Trust Incident Reporting and Investigation Policy and Procedure
- Health and Safety Policies
- Clinical Negligence and Personal Injury Claims Policy & Procedure
- Complaints Procedure
- Consent Policy

The above and additional Trust Policies and Procedures can be found on the Trust's intranet.

## Equality and Diversity Statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service Equality and Diversity statement.

## Disclaimer

It is your responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.

<b>Document ratification and history</b>	
Approved by:	Governance and Risk Management Department
Date approved:	8 September 2006
Date placed on electronic library:	October 2006
Ratified by:	Clinical and Corporate Governance Committee
Date ratified:	21 September 2006
Review date:	September 2008 (or earlier in the light of new evidence)
Authors:	Clinical Risk Manager, Organisational Risk Manager
Owning Department:	Governance and Risk Management Department

**Appendix 1: Risk Management Objectives and Key Performance Indicators 2006/07**

<b>1. Ensure robust arrangements in all Directorates for managing Governance and Risk</b>					
	<b>Objective</b>	<b>Action</b>	<b>Criteria for Achievement</b>	<b>Action by</b>	<b>Target Date</b>
	(a) To ensure that all SDU's are adhering to the Clinical Governance Good Practice Guide	To undertake an audit of all SDU Governance meetings to assess compliance with the Good Practice guide	(a) Audit undertaken. 90% of all SDU's holding quarterly Governance meetings  90% of all SDU's adhering to the Good Practice in Clinical Governance Guide	Governance Manager and Clinical Audit Manager  Governance Manager and Clinical Audit Manager	March 31st 2007  March 31 <sup>st</sup> 2007
	(b) To ensure that all Directorates have designated risk representatives and risk officers	(1) Liaise with all Directorates to identify key individuals  (2) Maintain a database of up-to-date risk representatives and risk officers  Make the list of designated risk reps and risk officers available on the intranet	(b) 90% of Directorates have designated persons in place for risk  Database in place and up-to-date  Database available on the intranet	Organisational Risk Manager  Organisational Risk Manager  Organisational Risk Manager	March 31 <sup>st</sup> 2007  December 2006  December 2006

<b>2. Undertake a Training Needs Analysis to identify the Risk Management training needs of all staff and provide risk management training accordingly.</b>					
	<b>Objective</b>	<b>Action</b>	<b>Indicator of Achievement</b>	<b>Action by</b>	<b>Target Date</b>
	(a) To ensure that a training needs analysis to identify the Risk Management training needs for all staff groups has been carried out ( <i>draft new NHSLA risk management standards</i> )	To undertake a training needs analysis to identify the risk management training needs for all staff groups and volunteers.	(a) Training needs analysis carried out.  Training records	Organisational Risk Manager	March 31 <sup>st</sup> 2007

	(b) To ensure that the Board and senior management receive Risk Management training	Develop a risk management awareness training programme for Board members and senior managers. Provide Risk Management training sessions quarterly	(b) Training programme in place	Governance Manager	March 31 <sup>st</sup> 2007
			Records of attendance		
	(c) To ensure that designated individuals ( <i>risk representatives/risk officers</i> ) and area managers have received formal risk management training.		(c) 90% of designated risk reps/ risk officers and area managers have received initial risk management training	Organisational Risk Manager	March 31 <sup>st</sup> 2007
			Training programme content reviewed	Organisational Risk Manager	December 2006
	(d) To ensure that existing risk reps and risk officers have had a refresher session within the last 2 years	Review training programme on an annual basis and make any changes necessary  Develop and implement update sessions bi-annually	(d) Update/refresher training sessions in place	Organisational Risk Manager	December 2006
			25% of existing risk reps and risk officers have had an update session in the past year	Organisational Risk Manager	March 31 <sup>st</sup> 2007

<b>3 &amp; 4.</b>	<b>Ensuring that risk assessments (<i>clinical; organisational; financial etc</i>) are undertaken in all Directorates to identify, evaluate and minimise risks and that risk assessments are recorded and reviewed in line with Trust Risk Assessment Policy.</b>				
	<b>Objective</b>	<b>Action</b>	<b>Indicator of Achievement</b>	<b>Action by</b>	<b>Target Date</b>
	(a) Ensure Trust Risk Assessment Policy and Procedure in place, up-to-date and available to all staff	Review of Trust's Risk Assessment Policy & Procedure	(a) Updated Risk Assessment Policy & Procedure	Organisational/Clinical Risk Manager	September 30 <sup>th</sup> 2006
	(b) To ensure that all areas and individuals with responsibility for undertaking risk assessments have access to the Trust's Risk Register.	Ensure that key individuals locally have had training and access to RMIS ( <i>Risk Management Information System</i> ).	(b) 80% of all SDU's have access to and have received training on the Trust's Risk Register (via RMIS)	Organisational Risk Manager	March 31st 2007

	<p>(c) To ensure that all areas have undertaken risk assessments both clinical and non-clinical and that these risks have been entered on the Trust's Risk Register.</p>	<p>Review the Risk Register for all SDU's to ensure that risk assessments both clinical and non-clinical undertaken.</p>	<p>(c) 80% of SDU's have clinical and non-clinical risks on the register.</p>	<p>Organisational/Clinical Risk Manager</p>	<p>March 31<sup>st</sup> 2007</p>
	<p>(d) To ensure that all SDU's are reviewing their risks in line with the Trust's Risk Assessment Policy and in a/c with the Good Practice in Clinical Governance Guide.</p>	<p>Review SDU Governance minutes to ensure that key risks identified are being reviewed quarterly and that their register of risks is being updated accordingly.</p>	<p>(d) SDU Governance minutes reviewed indicate a review of identified risks undertaken.  Risk Register indicates a review of the risks undertaken  Attendance by Risk Management at SDU Governance meetings</p>	<p>Clinical Audit Manager/Governance Manager  Clinical Risk Manager/Asst. Clinical Risk Manager  Clinical/Asst Clinical Risk Managers</p>	<p>March 31<sup>st</sup> 2007  Ongoing End of year review March 31<sup>st</sup> 2007 March 31<sup>st</sup> 2007</p>
	<p>(e) Build on the work undertaken as part of the Trust-wide clinical risk assessment exercise ensuring all risks identified are on the register and that appropriate action is being taken to address the risks.</p>	<p>(1) Work with and support Directorates to ensure that the risks identified at an SDU level are on the Risk Register; and being reviewed at their SDU governance meetings.</p>	<p>(e) 6 monthly review of progress against the Trust-wide risks identified undertaken at Clinical &amp; Corporate Governance Committee (CCGC).</p>	<p>Governance Manager/Clinical Audit Manager</p>	<p>Ongoing</p>
		<p>(2) Ensure that the relevant Directors designated with responsibility for actioning the Trust-wide risks are taking appropriate action on the risks.</p>	<p>Clinical and Corporate Governance Committee minutes reviewed indicate a review/discussion and actions planned against the Trust's high risks on a quarterly basis.</p>	<p>Governance Manager</p>	<p>Ongoing</p>
	<p>(f) Ensure that a Trust-wide Organisational risk assessment has been undertaken</p>	<p>(1) Undertake a Trust-wide organisational risk assessment</p>	<p>(f) Risk assessments for all the organisational risks identified on Trust Risk Register.</p>	<p>Organisational Risk Manager</p>	<p>March 2007</p>

	(g) To ensure that the Risk Register is up-to-date and can allow for the entry of generic risk assessments.	(1) Approve modifications to RMIS to allow for generic risk assessments to be entered.  (2) "Cleanse" the current Risk Register to ensure that it is up-to-date.	Individual area reports and/or a Trust-wide report on the organisational risks identified.  Review of report and risks at CCGC.  (g) Risk Register upgraded.  Risk Register cleansed and up-to-date.  Generic risk assessments available on the register.	Organisational Risk Manager   Organisational Risk Manager ( <i>funding</i> )  Clinical Risk Manager/Organisational Risk Manager  Organisational Risk Manager/Clinical Risk Manager	March 2007  Ongoing and quarterly  September 2006  March 31 <sup>st</sup> 2007  March 31 <sup>st</sup> 2007
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<b>5. To encourage a culture of openness in terms of reporting and learning from incidents/complaints/claims.</b>					
	<b>Objective</b>	<b>Action</b>	<b>Indicator of Achievement</b>	<b>Action by</b>	<b>Target Date</b>
	Ensure that all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.	Develop and implement a Being Open Policy including Patient Information in line with the NPSA recommendations and NHSLA Risk Management Standards.	Being Open Policy developed.  Being Open policy disseminated and communicated to all staff.  Training in place for staff	Clinical/Assistant Clinical Risk Manager   Risk Management/Patient Information Team/PALS/Complaints Team	October 2006   March 31 <sup>st</sup> 2007

6. Using National Patient Safety Agency Root Cause Analysis Tools to investigate incidents; identify contributory factors and root causes and inform changes required to improve patient safety.					
Objective	Action	Indicator of Achievement	Action by	Target Date	
To deliver Root Cause Analysis Training to key individuals in each Directorate.	Develop and implement a Root Cause Analysis Training Programme	Root Cause Analysis Training Programme developed	Claims Manager/ Clinical Risk Manager	01 <sup>st</sup> June 2006	
	Train key individuals in each Directorate.	100% of all Directorates have an individual(s) trained in Root Cause Analysis.	Each Directorate/Risk Management	March 31 <sup>st</sup> 2007	

7. Ensuring that the lessons learnt from incidents are shared and disseminated across the Trust to foster Trust-wide learning.					
Objective	Action	Indicator of Achievement	Action by	Target Date	
To ensure that lessons from incidents are shared and disseminated to all staff.	(1) Develop a Clinical Risk Newsletter to focus specifically on sharing the lessons from clinical incidents.	Clinical Risk Bulletin developed	Clinical/Assistant Clinical Risk Manager	August 2006	
	(2) Distribute the Clinical Risk Bulletin quarterly to all SDU's.	80% of SDU's audited indicate awareness and receipt of Clinical Risk Bulletin	Governance/Clinical Audit Manager	March 31 <sup>st</sup> 2007	
	(3) Review the Risk Matters Bulletin to incorporate the lessons from organisational and health and safety incidents.	Risk Matters Bulletin reviewed	Organisational Risk Manager	October 2006	
	(4) Distribute the Risk Matters/Health and Safety bulletin twice a year.	Risk Matters Bulletin distributed twice a year	Organisational Risk Manager	March 31 <sup>st</sup> 2007	

			Evidence from 80% of health and safety audits that staff are aware of and have received/read the Bulletin.	Organisational Risk Manager	March 31 <sup>st</sup> 2007
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**8. Learning from incidents, claims, complaints, audit results and other national reports/guidelines to improve patient safety in line with the draft new NHSLA Risk Management standards (Standard 5)**

Objective	Action	Indicator of Achievement	Action by	Target Date
(a) To ensure the Trust has clear procedures/processes in place for the reporting of; investigating and learning from incidents, complaints and claims.	(1) Review the Trust's Incident Reporting and Investigation Policy and procedure	(a) Incident Reporting and Investigation Policy and Procedure in place and up-to-date.	Organisational Risk Manager	March 31 <sup>st</sup> 2007
	(2) Ensure that serious incidents are reviewed at the Critical Incidents, Complaints and Claims Committee/Group	Review of Critical Incidents, Complaints & Claims Committee/group minutes indicate a review of serious incidents and monitoring of actions.	Governance Manager/Complaints; Claims & Incidents Review Group.	March 31 <sup>st</sup> 2007
	(3) Implement changes in systems/practice as a result of incidents, complaints & claims.	Examples/evidence of changes implemented as a result of incidents; complaints & claims seen.	Governance Manager/Clinical Audit Manager	March 31 <sup>st</sup> 2007
(b) Ensure that lessons to be learned from incidents, complaints and claims both locally and Trust-wide are disseminated through the Clinical Risk Newsletter quarterly.	(1) Develop Clinical Risk Newsletter and circulate quarterly.	Minutes of SDU Governance meetings indicate a review of incidents; sharing the lessons from incidents locally and Trust-wide.	Clinical/Assistant Clinical Risk Manager.	March 31 <sup>st</sup> 2007
		(b) Clinical Risk Newsletter in place	Clinical Audit Manager/Clinical Risk Manager	March 31 <sup>st</sup> 2007
		Evidence from SDU Governance meetings that Clinical Risk Newsletter received and discussed ( <i>Audit of SDU Governance</i> )		December 2006

	(c) To ensure there is a process in place for implementing and monitoring the recommendations/best practice from NSF's; NCE's NICE and other nationally agreed guidance.	Develop a Policy/process for the management and implementation of agreed best practice.	(c) Policy/Process in place	Clinical Audit/Clinical Risk Manager	March 31 <sup>st</sup> 2007
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**9. Implementing the recommendations from Safety Alert Notices (including NPSA & SABS) and communicating changes to all staff across the Trust.**

	Objective	Action	Indicator of Achievement	Action by	Target Date
	Implement the recommendations from Safety Alert Notices and communicate changes as a result to all staff.	Set up a central system for the review, monitoring and implementation of the recommendations from Safety Alerts.	System in place	Clinical/Organisational Risk Manager	September 2006
		Set up Project Groups as required to implement the recommendations.	Evidence of Project Groups/meetings having taken place	Clinical /Organisational Risk Manager	March 31 <sup>st</sup> 2007
		Communicate changes in practice/systems etc implemented to all Trust staff.	Evidence of communication in Clinical Risk/Health and Safety Newsletters.	Clinical /Organisational Risk Manager	March 31 <sup>st</sup> 2007

**10. Work towards the draft new NHSLA Risk Management Standards and contribute towards compliance with the Patient Safety standards of the Healthcare Commission's (HCC) Standards for Better Health.**

	Objective	Action	Indicator of Achievement	Action by	Target Date
	(a) To ensure that the Trust is working towards levels 1 & 2 of the draft new NHSLA Risk Management Standards	(1) Identify key leads for each standard	(a) Key leads identified	Clinical/Organisational Risk Manager	October 2006

	(b) Ensure that the Trust is compliant with the HCC's Patient Safety Standards.	(2) Convene a Project Group with all relevant personnel	Project Group in place. Schedule of meetings available.	Clinical Risk/Org Risk Manager	October 2006
		(3) Undertake a benchmarking exercise against levels 1 & 2 of the new draft standards	Benchmarking exercise undertaken.	Clinical Risk/Org Risk Manager	October 2006
		(4) Work towards level 2 of the new draft standards	Evidence of progress towards the new Standards.	Clinical Risk/Org Risk Manager	Ongoing End of year review – March 31 <sup>st</sup> 2007
		(5) Keep up-to-date with developments from the pilot Trusts and any amendments to the standards	Liaise and network with pilot sites in the region	Clinical Risk/Org Risk Manager	Ongoing
		(1) To achieve compliance with the core standard on Patient safety	Compliance with the Core standard on Patient Safety.	Governance Manager	Ongoing