

# Policy

## Risk Management

### Reason for development

This Policy has been developed for the following reasons:

- To comply with risk management legislation.
- Compliance with National Guidance i.e. National Service Frameworks.
- A result of proactive or reactive risk management.
- Compliance with clinical audit recommendations.
- To incorporate new research/evidence into practice.
- To standardise/improve patient care.

### 1 Scope

This Policy is to be used by all staff and applies Trust-wide.

### 2 Aims

The aim of this Policy is to ensure that appropriate systems and processes are in place to support the implementation of the Trust's Risk Management Strategy.

### 3 Introduction

Risk management is a proactive approach that aims to identify, assess and prioritise risk, so as to minimise its negative consequences. Risk is defined as 'the possibility of incurring misfortune or loss' and may be associated with people (patients, visitors and staff), buildings and estate, equipment and consumables, systems and management. In its broadest sense, risk management applies to all risks and also covers the use of insurance to deal with potential losses.

The Trust has an integrated approach to managing risk and the risk management process deals with all risks regardless of whether they are clinical, organisational, health and safety or financial.

All policies and procedures in place within the Cambridge University Hospitals NHS Foundation Trust are relevant to risk management. Following appropriate standards, national and statutory guidance and best practice identified in policies and procedures will minimise risk.

The Trust has an agreed Risk Assessment Policy and Procedure, which sets out the process for the completion, action and recording of risk assessments. The Policy and Procedure are available on the Risk Management pages on the intranet.

There are a number of systems and data sources that can assist in the management of risk. Key ones include complaints, claims, audits, incident reporting and any other relevant or national information issued to improve patient safety.

## **4 Roles and Responsibilities**

The Trust structure for managing risk is outlined in the chart at Appendix A. The following paragraphs outline key roles and responsibilities of individuals and committees.

### **4.1 Corporate Responsibilities**

#### **4.1.1 The Chief Executive and the Chief Nurse**

The overall responsibility for effective risk management in the Trust, meeting all statutory requirements and adhering to guidance issued in respect of risk lies with the Chief Executive. At an operational level, the Chief Nurse is the Executive Director designated with responsibility for governance and risk management.

#### **4.1.2 Clinical and Corporate Governance Committee**

This Committee is a sub-committee of the Board of Directors and has responsibility for overseeing the management of risk within the Trust

The Committee's key responsibilities include:

- Ensuring the adequacy of systems for assurance, managing risk and the control environment in all areas, excluding those of the Audit Committee, to enable the Chief Executive to complete an Annual Statement on Internal Control.
- Supporting a committee structure of Specialist Advisory Committees in key risk areas and monitoring their activities by regular reporting arrangements.

- Ensuring that all significant risks are properly considered and communicated to the Board.
- A full copy of the committee's terms of reference is available on the Clinical Governance Intranet site.

#### **4.1.3 Specialist Advisory Committees**

The Trust has established a number of Specialist Advisory Committees, each reporting to the Clinical and Corporate Governance Committee.

Each Committee provides a forum for discussing risk and other issues where expert advice can be sought. Issues that individual Committees are unable to resolve are escalated to the Clinical and Corporate Governance Committee.

Each one provides a routine annual report of their activities

- Children's Services Steering Group
- Clinical Audit/Effectiveness
- Complaints, Claims and Incidents
- Control of Infection
- Emergency Planning and Contingency
- Equality and Diversity Steering Group
- Information Governance
- Joint Drugs and Therapeutics
- Medical Equipment Management
- Medical Records
- Patient Involvement and Communications
- Radiation Safety Committee
- Research Governance
- Human Tissue Committee
- Transfusion Committee

#### **4.1.4 The Health, Safety & Welfare Committee**

The function of this committee is primarily focused on staff health, safety and welfare issues. Its reporting line is to the Management Staff Forum. Details of the Committee's membership and terms of reference are to be found in Section 3 of Cambridge University Hospitals NHS Foundation Trust Safety Representatives: Consultation with Employees Policy Statement in the Trust Health and Safety Manual.

## 4.2 Directorate Responsibilities

The Trust has produced a Good Practice in Clinical Governance guide. This provides guidance on the structures, roles and responsibilities, management arrangements within Clinical Directorates, Service Delivery Units and equivalents required to effectively manage Governance and Risk.

Although the focus of the guide is on managing clinical governance, the framework described in the guide is applicable to all Directorates and Departments in the management of risk, both clinical and non-clinical.

The guidance contains clear processes for the escalation of risk or other issues that require resolution at a higher level.

The guidance is aligned with the requirements of the National Healthcare Standards as produced by the Healthcare Commission.

The guide is available on the Connect Intranet

### 4.2.1 Directors (with and without Executive brief)

Directors are responsible for ensuring that risk is managed appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation of the guidance contained in the Good Practice in Clinical Governance Guide.

Risk issues that they are unable to resolve are escalated to the Clinical and Corporate Governance Committee.

### 4.2.2 ADO's / Clinical Directors

Associate Directors of Operations and Clinical Directors are responsible for ensuring that risk is managed appropriately in their area of responsibility. These responsibilities will be discharged by ensuring that Good Practice in Clinical Governance is implemented in SDU's or equivalents in their area of management responsibility.

Key responsibilities include:

- Taking action on risks identified within their area that cannot be resolved at an SDU level by the SDU Director, Senior Clinical Nurse or Service Delivery Manager.

Risk issues that they are unable to resolve are escalated to the appropriate Executive Director.

#### 4.2.3 SDU Directors / SCN's and SDM's

Service Delivery Unit Directors, Senior Clinical Nurses and Service Delivery Managers are responsible for ensuring that risk is managed appropriately in their area(s) of responsibility.

Key responsibilities include:

- Reviewing identified risks.
- Reviewing incidents, complaints, claims within the SDU and identifying lessons that can be learnt.
- Reviewing lessons from incidents, complaints, claims from other SDU's.
- Identifying lessons, changes in practice arising from incidents, complaints and claims that should be shared across the Trust.
- Acting on the results of Audit reports and their recommendations.
- Reviewing training progress (Induction, mandatory training; clinical competencies and skills, specific equipment).

Risk issues that they are unable to resolve are escalated to the appropriate Clinical Director and / or ADO

#### 4.2.4 Managers

All managers are responsible for:

- Managing risk in their area of responsibility. This includes for example, incident investigation and undertaking risk assessments.
- To make this responsibility explicit in terms of health and safety, the Trust has introduced the roles of 'Risk Representative' and 'Risk Officer'. Managers should ensure that they nominate someone to act as Risk Representative/Risk Officer (as appropriate) to cover their area of responsibility. The duties of Risk Representative and Risk Officers are specified in the Trust's Health and Safety Policy, and should be undertaken by those who have had risk management training (**note: the manager's *accountability* cannot be delegated**).
- Implementing and monitoring any identified and appropriate control measures within their areas of management responsibility. Where significant risks are identified and local control measures do not adequately control these, managers are responsible for escalating them via their immediate manager and/or SDU Governance meeting.
- Ensuring that all staff (and others in their area affected by the organisations operations) are made aware of the risks within their work environment and of their personal responsibilities, and that they receive appropriate information, instruction and training to enable them to work safely.

- Undertaking risk assessments using the Trust's agreed procedure ([Risk Assessment Procedure](#)) within their area, in liaison with appropriate advisors as necessary.
- Ensuring that staff within their area are aware of the Trust's strategy for managing risk.

#### 4.2.5 All staff

All staff are expected to:

- Report incidents and near misses using the Trust incident form and in accordance with the Trust's Incident Reporting and Investigation [Policy](#) and [Procedure](#).
- Provide safe clinical practice in diagnosis and treatment.
- Take reasonable care of their own safety and the safety of others
- Comply with all Trust policies and procedures.
- Be familiar with the Trust's Risk Management Strategy and departmental risk issues.
- Be aware of emergency procedures relevant to their area of work.

#### 4.3 Governance / Risk Management Department

Within the Governance and Risk Management Department, the following key posts support the management of risk in the Trust. These are the Governance Manager, Clinical Risk Manager, Organisational Risk Manager, Claims Manager and Clinical Audit Manager. Together these posts are responsible for:

- Communicating and co-ordinating the process of risk management throughout the Trust.
- Supporting the development of SDU (or equivalent) governance meetings to identify and manage risks at local level. This is consistent with the development of clinical governance and builds on the structures in place for the management of non clinical risk.
- Acting as a central reference point for all risk management issues.
- Co-ordinating the management of risk activities throughout the Trust.
- Managing the Trust system for reporting incidents and near-misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, National Patient Safety Agency, the NHS Litigation Authority and the Coroner.

Office of the Chief Nurse

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- Monitoring incident trends and feed back information on incident trends and learning to relevant committees, i.e. the Clinical and Corporate Governance Committee, Complaints, Claims and Incidents Review Committee, and SDU Governance meetings.
- Investigating serious incidents in line with the Trust Incident Reporting and Investigation Policy and where appropriate facilitating or undertaking a Root Cause Analysis.
- Managing claims (clinical negligence, employers and public liability, property losses) quickly, economically and effectively so as to minimise the financial and other potential negative consequences e.g. distress to the claimant, negative publicity etc.
- Managing the clinical audit process by promoting, supporting and facilitating this across the Trust so that that all patient care wherever possible should be evidence based.
- Ensuring through the clinical audit department, that appropriate audit processes are in place and that results and recommendations coming from clinical audit are incorporated into the clinical governance agenda of directorates and are their implementation monitored.
- Through Clinical Audit co-ordinating the implementation of NICE guidance, National Service frameworks (NSFs) and Confidential Enquiries.
- Ensuring that the Trust has appropriate and adequate 'insurance' arrangements with the Clinical Negligence Scheme for Trusts in respect of clinical negligence and the Risk Pooling Scheme for Trusts in respect of third party and professional liability and where appropriate commercial insurers.
- Acting as a central source of information on risk issues and distributing this information as necessary.
- Ensuring that the Trust has appropriate policies and procedures relating to risk/health and safety issues to comply with statutory requirements and good practice guidance.
- Ensuring effective liaison with other organisations with whom there is a shared responsibility for risk management such as the University of Cambridge.
- Developing links with professional organisations concerned with risk management in the Health Service to ensure that the Trust is kept at the forefront of developments in the field.

## 5 Risk Management Education and Training

As part of the Trust's mandatory corporate induction programme all staff are provided with information regarding the management of risk. This covers both clinical and non clinical risk, an explanation of the Trust's approach to managing risk and how individual staff can assist in minimising risk.

All staff are required to attend mandatory education and training on an annual basis and this includes an update on risk management issues. The Trust has defined the scope of mandatory training for all staff groups.

The Risk Management Department delivers Risk Management training in the form of a specific 2 day Risk Management Course for identified risk officers and risk representatives. The Department also provides Root Cause Analysis (RCA) Training to staff involved in the investigation of serious incidents.

Other education and training is also provided to departments and specific groups of staff on a wide range of specific risk related topics.

## 6 Assurance

The Trust will seek assurance that risks are being appropriately identified and managed through the following:

- Receipt by the Clinical and Corporate Governance Committee of an annual risk management report regarding progress against the Risk Management Strategy.
- Receipt by the Clinical and Corporate Governance Committee of annual reports by all its specialist sub committees.
- Commissioning of specific Internal and External Audit reports and opinions by the Clinical and Corporate Governance Committee.
- The annual Statement of Internal Control (SIC) and Board Assurance Framework.
- Compliance levels with the Healthcare Commission's Better Standards.
- Accreditation levels achieved with CNST (Clinical Negligence Scheme for Trusts) and RPST (Risk Pooling Scheme for Trusts)
- Achievement of targets identified in the Trust's Performance Management Framework.
- Completion of annual Risk Audits.
- Compliance with the requirements of the HSE (Health and Safety Executive) and other external regulatory bodies.

## 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>	
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