Western Health and Social Care Trust

RISK MANAGEMENT POLICY

March 2014

RISK MANAGEMENT POLICY

POLICY NUMBER: MED08/02

ORIGINAL IMPLEMENTATION DATE: MARCH 2008

FIRST REVISION: May 2011

SECOND REVISION: September 2012 (Governance Structure up-dated following approval by Governance Committee, 26 September 2012)

THIRD REVISION: March 2014 (approved by Trust Board, 13 March 2014)

REVIEW DATE: March 2017

NAME OF RESPONSIBLE OFFICER: Medical Director

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WESTERN HEALTH AND SOCIAL CARE TRUST

RISK MANAGEMENT POLICY

1.0 INTRODUCTION

The Western Health and Social Care Trust ("the Trust") is committed to providing high quality, safe and accessible patient and client focused health and social care services. This is achieved by promoting a culture of openness and accountability and by effective communication.

The Trust recognises that the identification and effective management of risks provide invaluable opportunities to improve patient/client care.

The Trust will strive to place an active awareness of risk and knowledge of how to manage it at the core of its activities. The Trust recognises that it is vital to develop and maintain systems and procedures which identify and minimise risks to patients, clients, visitors, staff and others if it is to achieve its commitment to providing high quality care.

2.0 DEFINITIONS

The following definitions are used for the purpose of this Policy:-

Risk - *'The chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood.'*[1]

Risk management - *'The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects'.*[2]

[1] Australian/New Zealand Risk Management Standard 4360/2004
[2] Australian/New Zealand Risk Management Standard 4360/2004

3.0 AIMS & OBJECTIVES

The aim of the Trust's Risk Management Policy is:

To develop and maintain a clear and effective structure of responsibility and accountability across the Trust, together with clear systems for identifying and controlling risks, so that all Trust employees will play a role in managing risk, leading to measurable improvements in patient/client and staff safety.

This will involve:

- Developing a culture which secures the involvement and participation of all staff in patient/client safety, risk assessment, incident reporting, health & safety, complaints, and management of financial, information and reputational risk;
- Securing the commitment of management at all levels to promote risk management and provide the necessary leadership and direction;
- Ensuring that staff have the right knowledge and skills for the assessment and appropriate management of risk by providing appropriate training;
- Developing and promoting policies and procedures which facilitate positive and effective risk management;
- Monitoring and reviewing risk management performance at all levels of the organisation (i.e. Corporate, Directorate, Sub-Directorate, Ward/Departmental levels) to ensure that corrective action is taken where necessary;
- Using opportunities for learning from complaints, incidents, litigation, inspections and audit and gaining assurance that appropriate action has been implemented;
- Having in place effective systems of communication to ensure the dissemination of information on risk management matters;
- Complying with national and regional standards and requirements in relation to risk management.

4.0 CLINICAL, SOCIAL CARE, FINANCIAL AND ORGANISATIONAL GOVERNANCE

From 1 April 2003, a statutory duty of quality was placed on Health & Social Services (now Health & Social Care) Trusts. Under this duty, a Trust is required "to put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal social services which it provides to individuals and the environment in which it provides them".

Robust risk management systems and clear accountability arrangements will allow the Trust to demonstrate its commitment to providing safe and high quality services and will contribute towards the Trust's integrated clinical, social care, financial and organisational governance arrangements and its aims set out in the Quality & Safety Strategy 2011-2016.
http://whsct/IntranetNew/Documents/Quality%20Safety%20Strategy%20FinalVersion%20Mar11.pdf

5.0 RISK MANAGEMENT ACCOUNTABILITY ARRANGEMENTS

Trust Board - is responsible for ensuring that appropriate risk management and governance structures and arrangements are in place and for receiving assurances that these are operating satisfactorily.

Chief Executive - is accountable to the **Trust Board** for ensuring that appropriate systems are implemented throughout the organisation to eliminate and control risks to the Trust.

Medical Director - has executive responsibility for Risk Management, both clinical and non-clinical.

Director of Women & Children's Services - has executive responsibility for the statutory duty quality of care in relation to social services.

All **Directors, Assistant Directors, Divisional Clinical Directors, Clinical Leads, Senior Managers, Facility/Ward Managers and Heads of Department** must ensure that risks within their area of responsibility are managed appropriately. Management of risk is one of their key operational and day-to-day responsibilities.

The **Head of Clinical Quality & Safety** has responsibility for ensuring that robust systems for the identification and management of risk are in place and that trends are monitored and reported on.

The **Corporate Risk Manager** is the Trust-wide operational lead for risk management (including risk registers, incident reporting and management, health and safety and litigation). He/she is charged with management responsibility to provide advice to the Directorates, to develop all aspects of risk management and to encourage a Trust-wide risk management culture with the co-ordination of risk identification, analysis and control. The Corporate Risk Manager also has responsibility for ensuring that the Trust's risk management database (Datix) is maintained and for ensuring that the Corporate Risk Register and Board Assurance Framework is regularly up-dated and produced for appropriate Trust meetings.

Individual staff members have a personal responsibility for maintaining a safe environment, notifying line managers of any identified risk and complying with relevant risk management policies and procedures. In addition they are accountable to their individual professional bodies and must adhere to their codes of professional conduct. In particular, staff must ensure that any serious risks which have not been addressed appropriately or in a timely basis by the relevant manager, are brought to the attention of the appropriate Director.

In accordance with Section 21 of the NHS Terms and Conditions of Service Handbook and the Trust's Public Interest Disclosure (Whistle-blowing) Policy http://whsct/IntranetNew/Documents/Public%20Interest%20Disclosure%20(Whistleblowing)%20pdf.pdf, all employees working within the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.

The right of Trust staff to "whistleblow" has also been reiterated in a letter to HSCB staff by the Minister of Health which is available on the Trust's intranet at http://whsct/intranetnew/Documents/SUB.325.2012.pdf.

6.0 GOVERNANCE COMMITTEE STRUCTURE

The governance committee structure and accountability arrangements within the Trust are outlined below and in Appendix 1.

Governance Committee (chaired by the Chairman of the Trust) provides assurance to the Trust Board that appropriate governance arrangements are in place and working effectively.

The following Trust groups report directly to the Governance Committee:-

- **Quality & Safety Accountability Forum** (chaired by the Chief Executive)
- **Risk Management Sub-Committee** (chaired by the Medical Director)
- **Quality & Standards Sub-Committee** (chaired by Director of Women & Children's Services)
- **Directorate Governance Groups** – these groups will provide an assurance to the Governance Committee on the risk management arrangements within each Directorate.
- **Complaints Forum** (chaired by a Non-Executive Director)
- **Personal & Public Involvement** (chaired by a Non-Executive Director)
- **Patient/Client Experience** (chaired by the Director of Primary Care & Older People/Executive Director of Nursing)

Risk Management Sub-Committee will seek reports and assurances from the Working Groups that report to the Sub-Committee (see Appendix 1) on the management of risk within their remit. The chair of the Sub-Committee will then advise the Governance Committee of any significant risks reported by the Working Groups. The Terms of Reference of the Risk Management Sub-Committee are set out at Appendix 2.

The Risk Management Sub-Committee will also review the Corporate Risk Register at each quarterly meeting.

In accordance with National Institute for Clinical Excellence (NICE) Guidance re The Interventional Procedures Programme (Circular PPMD(NICE)1/07), where a new activity or practice is being considered the Risk Management Sub-Committee is required to review the proposal to ensure that it has been properly assessed for risk prior to approval. Consideration should also be given to including the activity on the Risk Register (see point 7.0 below).

7.0 RISK MANAGEMENT PROCESS

The Trust will ensure that the risks to be managed are identified using a comprehensive, systematic process linked to the organisation's corporate objectives as set out in the Trust's Corporate Plan, which is available on the Trust intranet at http://whsct/IntranetNew/intranet%20documents/Useful%20documents/Corporate%20Plan%202014-15%20to%202015-16.pdf. These are as follows:-

No	Corporate Objective
CO1	To provide safe, high quality and accessible patient and client-focused services.
CO2	To improve and modernise our services in line with evidence-based practice and research.
CO3	To ensure the probity and safety of our processes and systems through active governance arrangements.
CO4	To promote public confidence in our services.
CO5	To create a culture and an environment which will attract and retain high quality staff.
CO6	To build effective relationships with service users, communities and our strategic partners to promote the health and social wellbeing of our population.
CO7	To secure and manage resources effectively and efficiently in order to achieve best outcomes, demonstrate value for money and ensure financial viability.

Trust Board, having identified the overall Trust corporate objectives, is then in a position to identify the key corporate risks which may prevent the Trust meeting its objectives.

The Trust is committed to ensuring that risk management arrangements are based on the principles of the Australian/New Zealand Risk Management Standard and recognises that risk management should be an integral part of the organisation's culture..

The Risk Management process has four key components:

1. Risk identification
2. Risk analysis / evaluation
3. Risk control
4. Risk review

7.1 IDENTIFYING RISKS

Risks must be identified at all levels of the organisation using a variety of means including the risk assessment process, learning from incidents, serious adverse incidents, complaints, claims, inspections, audit, monitoring of performance and financial management systems, regulatory and legislative requirements. Individual Directorates / Wards / Departments / Specialties and Service Areas will be required to identify and prioritise their risks. The range of risks to be identified will be broad and depends on the area or service to be assessed, the key objectives of the Directorate and the risks which can impact to prevent the objectives being met.

Consideration must also be given to risks which are managed from outside the Trust and are owned elsewhere (e.g. by the DHSSPSNI, HSCB, Contractors or other public service/voluntary organisations) that may impact on objectives. Managers must ensure that appropriate governance and contractual arrangements are in place to reduce and monitor risks which are outside of the Trust's direct control.

7.2 ANALYSING RISKS

Risks will be analysed by considering the consequences/severity of the risk and the likelihood/frequency that those consequences may occur. The risk criteria contained

within the regionally agreed Risk Rating Matrix and Impact Assessment Table (Appendix 3) will provide a guide for analysis. Risk analysis will involve consideration of the sources of risk, their consequences and likelihood that those consequences will occur (based on quantitative/qualitative data) bearing in mind existing control measures. The outcome will be a prioritised list of risks (extreme, high, medium or low) requiring further action.

7.3 RISK CONTROL / ACCEPTABLE RISK

It is not possible to eliminate all risks from the organisation and therefore the Trust will have to agree that some risks have to be deemed acceptable. Acceptable risks are those that fall into the low category and have adequate control mechanisms in place. All identified risks will be analysed to separate low/acceptable risks from more serious and major risks. Low/acceptable risks will be monitored and reviewed on a quarterly basis to ensure that they remain acceptable to the organisation.

Where control measures fail and lead to a material realisation of risk a systematic review of the treatment plans should be undertaken to ensure that the controls are appropriate to manage the identified risk.

Where it is not possible to completely eliminate risk, all necessary steps will be taken to control the frequency and severity of the risk. The Head of Quality and Safety, Corporate Risk Manager and senior/specialist managers will provide advice and assistance to managers in identifying appropriate actions. It is essential that the process is kept under regular review. Risks and the effectiveness of control measures need to be monitored to ensure changing circumstances do not alter risk priorities.

7.4 RISK REVIEW

Risks must be reviewed on regular basis (at least quarterly) to ensure that action plans remain effective and that where the level of risk is increasing, appropriate action is taken to reduce the level of risk and escalate the risk to a higher level within the Trust, as per the process outlined at Appendix 4. Risk Registers will be a standing item on

Trust Committees/Sub-Committees/Working Groups and Directorate/Sub-Directorate governance groups. Discussion regarding risks and action agreed must be recorded within the minutes of each meeting.

8.0 RISK REGISTERS

The Trust will maintain a database of **Corporate, Directorate and Sub-Directorate** level risks. Each risk record will include a description of the risk, current control measures in place to manage the risk, an assessment of the impact and likelihood of realisation of the risk (initial, current and target risk levels) as well as action necessary to treat/remove the risk. The corporate objectives that may be affected should the risk materialise must also be identified.

The Corporate Risk Manager will have responsibility for ensuring that the database is maintained and used appropriately and will provide training to identified Directorate staff in its use.

The database will enable the Corporate Risk Register and individual Directorate/Sub-Directorate risk registers to be developed, maintained and produced, thus ensuring that significant risks are recorded, action plans are developed and their implementation is monitored.

The process for identifying risks for inclusion on the Risk Register and recording these on Datix is attached at Appendix 4. A “new risk” form is provided at Appendix 5 and is also available in Word format on the Trust intranet at http://whsct/intranetnew/documents/Appendix 5 - New Risk Form January 2014.doc

Risks which can be managed at **Ward/Department** level will not be recorded on Datix. An Excel spreadsheet to enable Ward/Department managers to record local risks is provided at Appendix 6. This is available on the Trust intranet at http://whsct/intranetnew/documents/Appendix 6 - Risk Register spreadsheet for use by Wards Depts - Blank Version.xls

Consideration must be given to risks which are cross-Directorate in nature. Such risks will be categorised as “Trust-wide” and an appropriate Director must be nominated to take the lead in its management.

Corporate Risks are risks which, due to the high/extreme level of risk involved or Trust-wide implications, have been recommended by CMT and accepted by Governance Committee for inclusion on the Corporate Risk Register. These “principal risks” require continual monitoring by CMT, Governance Committee and Trust Board to ensure all necessary action is being taken to reduce the level of risk to patients, staff, the organisation and other stakeholders.

The Corporate Risk Register will also be a standing item on the Agenda of the following meetings:-

- Corporate Management Team – for discussion each month and to approve in principle any additions to, or deletions from, the register.
- Governance Committee - for discussion at each quarterly meeting and to approve any additions to, or deletions from, the register.
- Trust Board – for noting at the Trust Board meeting immediately following quarterly Governance Committee meetings. Trust Board will also be advised of any significant changes to Corporate Risks in the intervening period as necessary.
- Risk Management Sub-Committee – for noting. Directorate representatives and Chairs of Working Groups will also be reminded to ensure that any significant risks within their area of responsibility are escalated to corporate level as required.

The Corporate Risk Register will also be posted on the Trust intranet following each Governance Committee meeting.

Risk registers will also be a standing item on Directorate/Sub-Directorate Governance meetings and quarterly updates on key risks will be provided at these meetings. Information on key risks will also be included in Directorate reports to the Governance Committee.

Each risk on the database should be reviewed and up-dated **at least quarterly** to reflect the position regarding its current risk rating and implementation/progression of action plans. Staff at Directorate and Sub-Directorate level have been given access to the database to enable this requirement to be met.

9.0 RISK APPETITE STATEMENT

The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits.

The Trust endeavours to establish a positive risk culture where unsafe practice is not tolerated and where every member of staff feels committed and able to identify and correct/escalate control weaknesses.

The Trust Board is committed to ensuring a robust risk management system is in place to manage risk throughout all levels of the organisation and that should risks materialise, learning is identified and improvements are implemented.

The Trust will routinely assess the initial, current and target risk levels for all risks recorded on the risk management database, whilst acknowledging that it is impossible to eradicate all risk within a health & social care environment.

Managers will be required to consider the Trust's risk appetite by answering the following questions when developing Action Plans for new risks, or escalating existing risks to corporate level:-

1. Does the proposed Action Plan actively manage this risk to ensure that the level of risk can be reduced to the target level?

2. Does the proposed Action Plan take account of any opportunities that could be exploited whilst managing this risk?

3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?

4. How will the proposed actions be monitored to ensure they are completed within identified timescales?

5. At what point should the decision regarding the management of this risk be escalated to a higher level?

The “new risk” form at Appendix 5 incorporates these questions.

10.0 BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework will be utilised by Trust Board as a planned and systematic approach to the identification, assessment and mitigation of risks that could compromise achievement of the Trust’s Corporate Objectives. Corporate risks will be evaluated to determine assurance on the effectiveness of controls in place to manage risks and identify any gaps. Action must then be put in place to address gaps in controls and/or sources of assurance.

The Assurance Framework will be provided to each quarterly meeting of the Governance Committee for review, and then forwarded to the following Trust Board meeting for noting.

The Board Assurance Framework and risk registers will be referred to as part of the Audit planning process.

11.0 CONTROLS ASSURANCE

Controls assurance is a process designed to provide evidence that HSC bodies are doing their reasonable best to manage key risk areas so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds.

The Governance, Financial Management and Risk Management Controls Assurance Standards set out the core requirements for an effective risk management system. The Department of Health Social Services & Public Safety for Northern Ireland (DHSSPSNI) requires Trusts to report on compliance against these and other specific organisational standards. The Business Service Organisation's (BSO) Internal Audit Department provide the Western Trust with verification against the scores submitted. Deficiencies identified by the relevant standards will be reported to the Risk Management Sub-Committee together with action plans aimed at improving compliance. The action plans will be approved by the relevant Working Group. Progress against action plans will be reported to the Controls Assurance Working Group, Risk Management Sub-Committee and Governance Committee.

Compliance with Controls Assurance Standards is also monitored as part of Accountability Review meetings between the Trust and the DHSSPSNI.

12.0 GOVERNANCE STATEMENT

The assurance provided by the above arrangements enables the Chief Executive to sign the mid-year and end of year "Governance Statement" which confirms that the Trust has in place, and is constantly reviewing, a comprehensive risk management and control framework that is built on sound risk management practice. The Chief Internal Auditor also provides assurances to the Audit Committee and the Governance Committee that there is sufficient evidence to support statements on internal control and governance.

13.0 POLICY REVIEW

The Risk Management Sub-Committee will be required to assure the Governance Committee that the Policy remains relevant to the business of the organisation. The Policy will be reviewed every three years, or sooner if necessary.

14.0 OTHER ASSOCIATED POLICIES AND PROCEDURES

The following policies and procedures are relevant to the Risk Management Policy:

- Complaints
  http://whsct/IntranetNew/Documents/Policy%20for%20Management%20of%20Complaints.pdf

- Claims Management Policy
  http://whsct/IntranetNew/Documents/Claims.pdf

- Control of Substances Hazardous to Health Policy
  http://whsct/IntranetNew/Documents/Control%20of%20Substances%20Hazardous%20to%20Health%20Policy.pdf

- Emergency Planning Policy
  http://whsct/IntranetNew/Documents/Emergency%20Planning%20Policy.pdf

- Health and Safety Policy
  http://whsct/IntranetNew/Documents/WHSCT%20Revised%20Health%20and%20Safety%20Policy%20as%20at%2010-12%20-%20Approved%20Version.pdf

- Infection Prevention and Control Guidelines http://whsct/intranetnew/ (available at Menu to left-hand of screen (Infection Prevention Control Guidelines)

- Incident Reporting Policy
  http://whsct/IntranetNew/Documents/Revised%20Incident%20Policy%20with%20effect%201%20October%202013%20(inc%20new%20matrix).pdf

- Manual Handling Policy
  http://whsct/IntranetNew/Documents/Manual%20Handling%20Policy%20August%202012.pdf

- Manual Handling of the Bariatric Patient
  http://whsct/IntranetNew/Documents/Manual%20Handling%20of%20the%20Bariatric%20Patient.pdf

- Medicines related policies and procedures
  http://wta-spwfe-01/sites/acute/Pharmacy/Medicines/SitePages/Home.aspx

- Public Interest Disclosure ("Whistleblowing") Policy
  http://whsct/IntranetNew/Documents/Public%20Interest%20Disclosure%20(Whistleblowing)%20pdf.pdf

- Zero Tolerance and Security Policy
  http://whsct/IntranetNew/Documents/Zero%20Tolerance%20and%20Security%20Policy.pdf

The above list is not exhaustive.

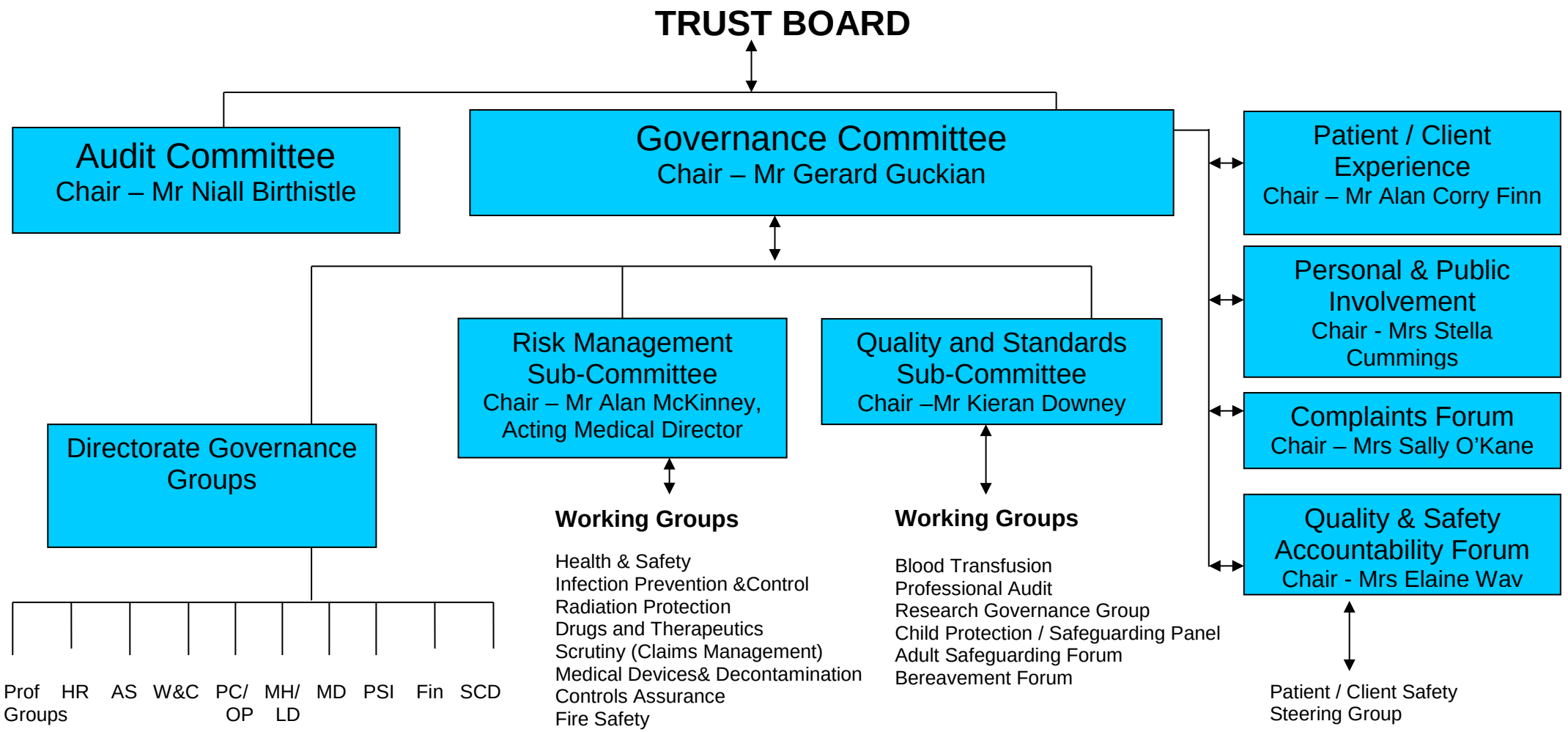
15.0 EQUALITY & HUMAN RIGHTS STATEMENT

The Trust's equality and human rights statutory obligations have been considered during the development of this policy.

Signed: _____ (Chairman)

Date: _____ 20_____

Governance – Western Health & Social Care Trust



September 2012

Final Version Approved by Risk Management Sub-Committee on 01/10/08
Membership amended following Risk Management Sub-Committee 20/02/2013
Reviewed January 2014.

WESTERN HEALTH & SOCIAL SERVICES TRUST

RISK MANAGEMENT SUB-COMMITTEE

TERMS OF REFERENCE

1. NAME OF SUB-COMMITTEE

The Sub-Committee will be known as the Risk Management Sub-Committee.

2. MEMBERSHIP OF GROUP

Membership of the Group will consist of:

Medical Director (Chair)
Associate Medical Director (Deputy Chair)
Director of Adult Mental Health & Disability Services
Director of Primary Care & Older People
Director of Acute Services
Assistant Director of Planning & Service Improvement
Director of Human Resources
Head of Clinical Quality and Safety Governance
Corporate Risk Manager
Assistant Director Women and Children's Quality
Director of Pharmacy
Directorate Nominations

In attendance:

Chairs from reporting Risk Management Working Groups
Clinical Risk Midwife
Risk Management Officer

If a member or attendee is unavailable, they should nominate an appropriate member of staff to attend on their behalf.

3. QUORUM

A quorum will be achieved if the following members of the Sub-Committee are present.

Chair or Deputy Chair, plus one representative from
CMT
Medical
Social Care

Final Version Approved by Risk Management Sub-Committee on 01/10/08
Membership amended following Risk Management Sub-Committee 20/02/2013
Reviewed January 2014.

Nursing
Risk Management

In the unavoidable absence of both the medical Director and Associate Medical Director, the meeting will be chaired by a member of the Sub-Committee who is a Director of the Trust.

4. FREQUENCY OF MEETINGS

Meetings will take place on a quarterly basis.

5. RECORD OF MEETINGS

A record of all Sub-Committee meetings shall be formally recorded by the Risk Management Officer and made available to each member as soon as possible after each meeting.

Responsibility for any action required shall be clearly defined.

The Minutes of each meeting shall be formally approved at the following meeting. Minutes of each meeting will be submitted to the next meeting of the Integrated Governance Committee.

6. ACCOUNTABILITY OF THE SUB-COMMITTEE

The Sub-Committee will report to the Governance Committee.

7. ROLE AND RESPONSIBILITIES OF SUB-COMMITTEE

The overall objectives of the Sub-Committee are to

- provide strategic direction and oversight of Risk Management arrangements in the Trust;
- ensure effective implementation of the Risk Management Strategy;
- provide assurance to the Integrated Governance Committee that risk management arrangements within the Trust are effective and are contributing real value to the delivery of safe and effective services.

To achieve these objectives the Sub-Committee will:-

a) Advise the Trust on all Risk Management issues, and agree a method of reporting and escalating strategic risks and their management, as well as any major actions that are required to rectify an unacceptable risk.

b) Receive Business Services Organisation Internal Audit reports on Risk Management/Board Assurance Framework and ensure that accepted recommendations are implemented on a timely basis.

Final Version Approved by Risk Management Sub-Committee on 01/10/08
Membership amended following Risk Management Sub-Committee 20/02/2013
Reviewed January 2014.

c) Regularly review progress against the Risk Management Controls Assurance Action Plan.

d) Review the Trust's Corporate Risk Register and recommend risks for inclusion within it and Directorate Risk Registers.

e) Review associated monitoring arrangements, to ensure that risk registers remain relevant and complete for all levels of the organisation.

f) Ensure that Risk Management becomes an integral part of the business function.

g) Develop an operational plan to ensure the effective implementation of the Risk Management Policy and associated Policies and Procedures.

h) Agree Action Plans on the development of Clinical & Non-Clinical Risk Management and ensure ongoing monitoring of same.

i) Promote the reporting of incidents in a culture of openness and monitor timely investigation and closure.

j) Ensure that there are adequate arrangements for the identification, implementation and sharing of learning across the Trust.

k) Assist with the identification of areas of risk shared with external stakeholders.

l) Receive reports from Risk Management Working groups and advise the Governance Committee of pertinent corporate issues arising from the reports including the action required/taken to address the issues.

m) To provide quarterly and annual Risk Management reports to the Governance Committee.

8. REVIEW OF TERMS OF REFERENCE

These Terms of Reference will be reviewed on an annual basis and if necessary, more frequently, to ensure that they continue to reflect the Trust's obligations and requirements in respect of risk management.

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

WH&SCT RISK REGISTER PROCESS – JANUARY 2014

Risk Assessment carried out or reviewed.

New Risk or increase in level of risk Identified

At Ward/Departmental level - Ward/Department manager to consider whether the risk can be managed locally?
NB: If the Risk is of a serious nature which requires urgent attention, the appropriate Director should be notified so they may ensure that the risk is escalated to Directorate/Corporate level as necessary

YES – Take appropriate action and record at Ward/Department level on Risk Register spreadsheet (Appendix 6 of Risk Management Policy). Communicate risk to staff, monitor effectiveness of controls and regularly review risk assessment annually or if circumstances change)

If risk becomes unmanageable by Ward/Dept

NO – Ask Business Services Officer or Business Manager to check whether risk is already recorded on DATIX. If not, appropriate Manager to complete New Risk Form (Appendix 4). New Risk Form to be approved by "Lead Officer" and submitted to Sub-Directorate Governance Group for consideration. Take appropriate action and document at Ward/Department level. Communicate to staff and continue to monitor.

Sub-Directorate Governance Group to consider risk:
- Does Sub-Directorate Governance Group accept and approve risk description and grade?
- Does risk need to be managed at Sub-Directorate level?
- Does risk have implications for other Directorates (i.e. "Trust-wide")?

YES - Risk to be managed at Sub-Directorate level – submit approved New Risk Form to appropriate Business Services Officer for inputting onto DATIX.

Agree Action Plan and deadlines for implementation and record in "Actions" section of DATIX.

BSO to up-date and produce Sub-Directorate Risk Register **at least quarterly** for consideration at Sub-Directorate Governance meetings. Lead Officer to monitor and review risk.

Once actions and/or resources are implemented, risk can now be managed at Ward/Department level. Re-grade accordingly and close if appropriate. Regularly review risk assessment and re-open if level of risk increases.

NO – Return to Ward/Departmental Level and provide explanation.

OR, if necessary,

Escalate risk to Directorate Level – BSO to log risk on DATIX and advise relevant Business Manager of request for escalation to Directorate level. Directorate Business Manager to place on Agenda of Directorate Governance Group for consideration.

Directorate Governance Group to consider risk:
- Does Directorate accept and approve risk description and grade?
- Does risk need to be managed at Directorate level?
- Does risk have implications for other Directorates (i.e. "Trust – wide")?

YES - Risk to be managed at Directorate level: Business Manager (or other appropriate officer at Directorate level) to up-date DATIX ("Risk-Type" to be amended to "Directorate Risk"). Agree Action Plan and record in "Actions" section of DATIX.

Business Services Manager to up-date and produce Directorate Risk Register at least quarterly for consideration at Sub-Directorate Governance meetings. Lead Officer to monitor and review risk.

Once actions are implemented, risk can be managed at appropriate lower level. Regrade and amend "Risk Type" accordingly. Close if appropriate and re-open if level of risk increases

NO – Return to Sub-Directorate Level OR

Escalate risk to Corporate Level – Directorate Business Manager to advise Corporate Risk Manager of request for escalation to Corporate level. Corporate Risk Manager to submit new risk to CMT for consideration.

Corporate Management Team (CMT) to consider risk:
- Does CMT approve risk description and grade?
- Does CMT accept risk needs to be managed at Corporate level?
- Is the risk "Trust-wide" ? If so, identify Lead Director to manage risk.

YES - Risk to be managed at Corporate level. Corporate Risk Manager (CRM) to record as Corporate Risk on DATIX. Lead Director to agree Action Plan and record in "Actions" section of DATIX. Ensure that all Controls, Assurances and Gaps in Controls/Assurances are recorded on Datix. Lead Director to inform Commissioner if risk not manageable within the Trust resources. CRM to produce Corporate Risk Register and Assurance Framework document for Governance Committee on quarterly basis for discussion. **All additions/deletions to Corporate Risks must be approved by Governance Committee (CMT and Non-Executive Directors).** Corporate Risk Register to be considered by CMT each month and by Goverance Committee on a quarterly basis. Trust Board will be advised of any amendments.

NO – Return to Directorate Level for management and provide explanation

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

Please complete this form if you have identified a risk which needs to be considered for inclusion on the Trust's Risk Register database (Datix). Appendix 3 of the Trust's Risk Management Policy sets out the process that must be followed. The Policy is available on the intranet, web-link http://whsct/intranetnew/Documents/Risk%20Management%20Strategy.pdf.

The information requested below is required for completion of fields within Datix and is in the order that fields appear on screen. Sections marked with an asterisk (*) are mandatory and must be completed. The completed form should then be considered at the appropriate Sub-Directorate/Divisional/Department Governance meeting. If the risk is approved for inclusion, please then forward the form to the relevant Business Services Officer/Business Services Manager for inputting on Datix. A list of BSOs/BSMs with access to Datix within each Directorate and Sub-Directorate is posted on the intranet – click here.

No	Datix Field Name	Data to be included in this Field		
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**			
2.	**Facility** **(only necessary if risk relates to one specific facility)**			
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**			
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**			
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**			
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**			
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**		Corporate	
			Directorate	
			Sub- Directorate/Divisional	
8.	**Risk Sub-type*** Please tick most appropriate category:	• Clinical Risk • Staff Competence • Compliance with Professional/Clinical/Non-Clinical Standards • Education & Training • Emergency/Contingency Planning Arrangements • Equipment • Financial • Fire Safety • Health & Safety • Independent Sector • Infection Control • Organisational • Professional Issues • Patient/Client Safety • Staffing Issues/Levels		

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	To provide safe, high quality and accessible patient and client focused services	
	C02	To improve and modernise our services in line with evidence-based practice and research	
	C03	To ensure the probity and safety of our processes and systems through active governance arrangements	
	C04	To promote public confidence in our services	
	C05	To create a culture and an environment which will attract and retain high quality staff	
	C06	To build effective relationships with service users, communities and our strategic partners to promote the health and social wellbeing of our population	
	C07	To secure and manage resources effectively and efficiently in order to achieve best outcomes, demonstrate value for money and ensure financial viability	

10.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	
11.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	
12.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters	
13.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	
14.	**Please list all identified gaps in Controls.***	.
15.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	
15.	**Please list all identified gaps in Assurances.**	

16.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate		Possible	
	Major		Likely	
	Catastrophic		Very Likely/ Almost Certain	

17.	**Target/Acceptable level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate		Possible	
	Major		Likely	
	Catastrophic		Very Likely/ Almost Certain	

NB: Datix will automatically calculate the level of risk (i.e. Red/Extreme, Amber/High, Yellow/Medium, Low/Green).

18. Action Plan to reduce Level of Risk

When developing an action plan to reduce the level of risk to the target level, Managers should take the Trust's Risk Appetite Statement into consideration, as set out in the Risk Management Policy, as follows:-

"The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits."

Managers must consider the following questions when developing an action plan to manage the identified risk:-

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	

Please set out below the key actions that will be taken to reduce the level of risk (e.g. develop business case, service redesign, develop policy/procedures, provide training, recruitment of staff, etc):-

Action Required	Start Date	Due Date	Lead Officer

Once the new risk has been approved, these key actions should be recorded within the "Actions" section of Datix.

Once each action has been completed, the date of completion should be recorded. Each completed action should then be listed within the “Controls” section of Datix.

If you require advice with regard to completion of this form, or on the use of Datix Risk Register module, please contact the Corporate Risk Manager on extension 214129.

Meeting where risk was approved: **Date of Meeting:**	**For use by BSO/BSM only**	**Risk ID No:** (automatically generated by Datix)

Risk Register for use at Ward/Department Level

No	Date added to Register	Has this Risk been escalated to a higher level?	If escalated to a higher level, insert Datix ID No	Description of Risk (maximum no of characters is 1024)	Corporate Objectives Affected by this Risk (choose most appropriate)	Control Measures In Place (please list - max no of characters is 1024)	Domain of Impact (as per Risk Impact Table)	Impact Score	Likelihood Score	Risk Grade	Action Plan to reduce level of risk (Max no of characters is 1024)	Lead Officer	Target Date	Up-date on Progress (Risks to be reviewed and up-dated at least quarterly)	Date Closed
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