

# The Newcastle Upon Tyne Hospitals NHS Foundation Trust

## Risk Register – Policy for Management and Use

Effective: August 2010

Review: August 2013

### 1. Introduction

- 1.1. The Trust recognises that identifying risks and managing these well, provides invaluable opportunities to improve on our corporate performance, patient and staff safety. These aims are consistent with sustaining our corporate identity as a health care provider associated with excellence.
- 1.2. As part of the strategy for the management of risk the Trust uses a Risk Register to create a portfolio of hazards that may affect the efficient running of the organisation, and ensure that action plans are developed, implemented and monitored. This practice supports the Department of Health documents *Assurance: The Board Agenda (2002)* and *Building the Assurance Framework: A Practical Guide for NHS Trusts (2003)*.
- 1.3. This policy document is directed at all Directorate Managers and other relevant senior staff with access to the Risk Register.

### 2. Purpose of the Risk Register

- 2.1. The purpose of the Risk Register is to:
  - Promote the process for assessing all types of risk across the Trust
  - Allow local managers to maintain information of all the hazards / threats that exist in their area of control that present an unacceptable level of risk, following the risk identification exercise and in accordance with the Trust risk tolerance matrix
  - Promote the ongoing management of risk by ensuring a continual systematic approach to all risk assessments across the Trust.
  - Allow the Board to have ongoing access to all risks identified within the organisation. This takes the form of regular reporting to the Trust Board's delegated sub-committees for Governance, Risk and Safety
  - Enable the Board to identify all strategic and cross-cutting risks and ensure that they are managed appropriately.
- 2.2. The Risk Register is a web based programme which, following training and the provision of a password, is available to all Corporate and Directorate Managers and other senior managerial staff identified by departmental heads within the organisation. The Risk Register runs using a commercial application "DatixWeb" which is managed by the DATIX Administrator, Clinical Governance and Risk Department. The programme has the facility to provide formal reports on all of the risks contained in the Register.

### 3. Risk Management Process and the use of the Risk Register

- 3.1 *The Risk Management Process*

Directorate strategies and objectives must concentrate on maximising the opportunities arising from contributing to achievement of the Trust's corporate objectives. In part, this involves identifying threats (hazards) to that goal, assessing the likelihood and consequences and prioritising plans for institution of controls or other risk reduction measures. Where appropriate, risk assessments should be used in conjunction with strategic decision making and for the development of business plans, procurement initiatives and service developments through the completion of, and integration with, risk action plans.

In particular, any proposals for service development or capital bids must be supported by risk assessments which demonstrate the need for them and which address the risks to, or arising from, the proposed action.

### 3.1.1 *Risk Identification*

A Hazard or threat is a source or issue of potential harm or damage to the organisation achieving its objectives, and the potential measured in levels of risk. In order to identify sources of uncertainty and opportunity, risks should be systematically identified from a number of sources, such as:

#### *Internal sources*

- Risk assessments
- Directorate risk registers
- Business process planning
- Performance reviews
- Complaints
- Litigation
- Accident and incident / Near-miss incident' reports
- Aggregated data analysis
- Staff meetings/workshops
- Risk profile analysis
- SWOT analysis
- Training

#### *External sources*

- National risk alerts / health and safety requirements
- Local and national targets
- Clinical audit
- NICE guidance / other guidance from national bodies
- Regulatory body requirements
- Legislation
- Inspections / reports from external bodies.

The above list is not exhaustive, and managers should ensure that they are able to evidence the identification of risks through a thorough and inclusive methodology. Managers must ensure that their risk registers are reviewed monthly, and where new sources of risk are identified that these are documented. Health and Safety risk assessments must be completed as outlined in the Health and Safety Operational Policy and included in the Directorate Risk Register.

### 3.1.2 *Risk Analysis and evaluation*

Where this cannot happen, an analysis is then carried out to establish the **grading** of each risk by assessing both the **likelihood** of the hazard causing a problem and the **consequences** if it did occur. The Trust has introduced its Risk Grading Matrix which incorporates a risk tolerance measure for identifying hazards, the level of risk arising from these and for the grading of these risks (Appendix 1). This process aims to ensure that risks are assessed consistently across the Trust. Once the grading is known and recorded in the Risk Register, the risk can be compared with other risks facing the Trust and prioritised according to significance. The list of all risks facing the Trust, in order of significance, makes up the Trust-wide Risk Register.

It is the responsibility of the Directorate or Corporate Manager to ensure that appropriate risk assessments are carried out. Health and Safety Risk Assessments will be carried out at least annually or after any changes to procedures, processes, equipment, staff, and environment or in the event of an accident/incident. Where identified risks cannot be resolved immediately they should be incorporated into the Risk Register.

Risk assessment is an integral part of the business planning process. Therefore, significant strategic risks will be identified by the Trust Board and managed through the Assurance Framework process.

### 3.1.3 *Risk Monitoring and review*

The risk assessments must be reviewed in accordance with this policy and whenever circumstances change. In addition, the Trust Health and Safety Operational Policy should be referenced and adhered to. When there are changes to the risk, the control measures, contingency plans or action plans recorded on the DatixWeb risk register must be updated.

Risk assessment reviews should be done on a monthly basis by the Directorate Manager and form part of the discussion at Directorate Management Team /Directorate Governance Group meetings.

#### *Action plans*

The Risk Register will be used as a live record of each Directorate's response to an individual hazard. Directorates have a duty to develop and record action plans to eliminate or mitigate each risk and progress in relation to these plans should be recorded such that they are amenable to audit and scrutiny.

When the threat/hazard has been removed or lowered to a manageable level, the entry on the Risk Register may be closed or kept open as a low level constant threat/hazard and monitored as a contingent. As long as the hazard is recognised as a risk it must have an identifiable and ongoing date for review.

Closed risks will remain on the risk register when completed though can be re-opened at any time.

#### 4. Responsibilities relating to the Risk Register

##### *Chief Executive*

As accountable officer, the Chief Executive is responsible for ensuring that the Trust Board

- Understands the threats to the achievement of corporate objectives
- Discusses the risks and decides on appropriate action.

##### *Trust Board*

The Trust Board is responsible for identifying significant strategic risks and for ensuring that they are managed through the Assurance Framework process and the Trust Risk Management Strategy. The board will receive regular updates of the high level and cross-cutting risks. Duties for monitoring the high risks will be delegated to the Corporate Governance Committee and the Trust Audit Committee.

*Corporate Governance Committee* (CGC) is a delegated sub-committee of the Trust Board with responsibility for Risk Management, Patient Safety and Quality. The CGC is responsible for reviewing the high profile organisational risks, the formulation of action plans as appropriate and the provision of exception reporting to the Trust Board.

##### *Trust Audit Committee*

The Trust Audit Committee is a delegated sub-committee of the Trust Board with responsibility for the audit and scrutiny functions relating to corporate governance including risk management and internal controls assurance. It is the Committee's responsibility to ensure probity and scrutiny of all high level and strategic risks.

##### *Corporate/Clinical Directors and Directorate Managers*

Corporate and Clinical Directors through their Directorate Managers and Matrons have the responsibility of ensuring that risks are identified and added to the Risk Register for Directorate and Trust wide risks, and are responsible for:

- implementation of the Trust's strategy insofar as it relates to their area of responsibility
- achieving their own objectives, linked to that target
- ensuring that action plans/work programmes are in place that detail who (or which groups) within the department has the responsibility for identifying risks, and how often the departmental risk profile will be scrutinized
- ensure that all sources of risk have been considered as potential contributors to the risk profile of that department/directorate
- ensuring that any threats/hazards to those objectives, operational continuity or to compliance with relevant standards, are assessed in accordance with current guidance
- ensuring that appropriate action is taken where necessary
- nominating a senior staff member to oversee compliance with this policy and act as the main contact person for this purpose within the departments in their directorate
- ensuring that appropriate training and support is provided for staff nominated to carry out risk assessments and/or to design and/or implement risk treatment plans
- ensuring that risk assessments are reviewed in accordance with Trust guidance
- ensuring that risk action plans are completed on time.

## *Risk Manager*

The Risk Manager is operationally responsible for the maintenance of the Trust wide risk register including the analysis of the Trust's risk profile, and feedback and dissemination of relevant information to directorates. The Risk Manager will also report to the Trust Board Standing Committees such as the Corporate Governance Committee, the Trust Audit Committee and the Infection Control Committee on:

- Significant risks
- New risks and any risks closed off since the previous reporting period
- On areas of reduced compliance with risk policy
- Changes to reported risks
- Risks identified through the aggregated analysis of incident, complaint and claims data
- Any cross-cutting risks that may potentially impact on the Trust objectives and targets, (these risks may not be individually ranked as significant but together may be deemed significant enough)
- All Directorate risks, and in particular, high level clinical and business risks are reported monthly, at the respective Directorate local governance meetings The Directorate Manager is ultimately responsible for producing these reports to the local meeting, although the preparation of such reports may be delegated to an appropriate senior officer
- Directorate risks, and in particular, high level risks are reported as part of the Directorate performance review process on a quarterly basis. The Directorate Manager is responsible for the preparation of said reports
- In addition, the Risk Manager is responsible for providing a summary report of all high level risks for the relevant Directorate under review, to the performance management team of the relevant Directorate
- Risk reduction measures implemented.

### *All staff*

All staff are expected to co-operate with risk assessments and to provide factual evidence as required. They are also required to bring to the attention of their manager and/or the Risk Manager any risks which arise.

## **5. Training on the Risk Register**

The Trust Risk Manager will provide relevant training and support to staff nominated and approved by their Directorate Management teams in line with this guidance.

## **6. Monitoring**

- The Trust Infection Prevention and Control Committee receives quarterly risk reports from the Risk Manager on all open risks with a risk rating of 15 and over related to Healthcare Associated Infection (HCAI) hazards.
- The Audit Committee receives quarterly risk reports from the Risk Manager on the significant risks with a risk rating of 20 and over.
- The Trust Corporate Governance Committee receives quarterly risk reports from the Risk Manager of the top 20 risks and/or with a risk rating of 20 or over and an

overview of the approved organisation wide risk register. The Committee is responsible for reviewing the reports, developing action plans to correct identified deficiencies and monitoring these through to completion.

- The Director of Quality and Effectiveness will have responsibility for coordination of action plans generated from the Trust Audit Committee, Infection Prevention and Control Committee and the Corporate Governance Committee.

### **Associated Policies**

- Management and Reporting of Accidents and Incidents – Operational Policy and Procedure
- Risk Management Strategy and Policy
- Health & Safety Operational Policy
- Fire policy
- Business Continuity Policy
- Trust Security Policy
- Moving & Handling Policy
- NICE Guidelines Implementation
- Implementation of National Confidential Enquiries, National Service Frameworks and High Level Enquiries
- An Organisation wide document for Aggregating data and Learning from incidents, complaints and claims
- Concerns and Complaints policy
- Claims policy

### **References**

Assurance: The Board Agenda. Draft Version 5, (2002). Dept. of Health Publishers

Building and Assurance Framework: A practical guide for NHS Boards (2003). Dept. of Health Publishers

NHSLA Risk Management Standards for Acute Trusts, 2009/ 2010

Management of Risk: Guidance for Practitioners, (2002). Office of Government Commerce (OGC).

A risk matrix for risk managers. (2008). National Patient Safety Agency (NPSA)

Author: Risk Manager

**RISK GRADING MATRICES**

The Matrices below are not exhaustive, but are intended as a broad guide to interpretation of the consequence and likelihood scores. They are intended to support the application of professional judgement in relation to specific risk issues.

**Step 1.**

Choose the most appropriate descriptor row for the risk issue from the categories below. Using the descriptors estimate the potential consequence. Where the consequence spans more than one subject area the **consequence** for the risk should be graded at the most severe. The consequence level relates to the highest row identified.

	<b>Consequence scores (severity levels) and qualitative measure of consequence or impact:</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Domain</b>	<b>Insignificant/Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Impact on the safety of patients, staff or public (physical/psychological harm)</b>	Minimal injury requiring no / minimal intervention or treatment  No time off work required	Minor injury or illness requiring minor intervention  Requiring time off work for <3 days  Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention  Requiring time off work for 4 – 14 days  Increase in length of hospital stay by 4-15 days  RIDDOR / agency reportable incident  An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability  Requiring time off work for >14 days  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects	Incident leading to death  Multiple permanent injuries or irreversible health effects  An event which impacts on a large number of patients
<b>Quality / complaints / audit</b>	Peripheral element of treatment or service sub-optimal  Informal complaint / inquiry	Overall treatment or service sub-optimal  Formal complaint (stage 1)  Local resolution  Single failure to meet internal standards  Minor implications for patient safety if unresolved  Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness  Formal complaint (stage 2)  Local resolution (with potential to go to independent review)  Repeated failure to meet internal standards  Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risks to patients if unresolved  Multiple complaints / independent review  Low performance rating  Critical report	Incident leading to totally unacceptable level or quality of treatment / service  Gross failure of patient safety if findings not acted on  Inquest / ombudsman inquiry  Gross failure to meet national standards

	<b>Consequence scores (severity levels) and qualitative measure of consequence or impact:</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Domain</b>	<b>Insignificant/Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Human resources / organisational development/ staffing competence</b>	Short-term low staffing level that temporarily reduces service quality <1 day	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff (sickness absence, recruitment, retention)  Unsafe staffing level or competence (>1 day)  Ongoing unsafe staffing level  Low staff morale  Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff  Unsafe staffing level or competence (>5 days)  Loss of key staff  Very low staff morale  No staff attendance for mandatory / key training	Non-delivery of key objective / service due to lack of staff  Ongoing unsafe staffing levels of competence  Loss of several key staff  No staff attending mandatory training / key training on an ongoing basis
<b>Statutory duty / Inspections</b>	No or minimal impact or breach or guidance / statutory duty	Breach of statutory legislation  Reduced performance rating if unresolved	Single breach in statutory duty  Challenging external recommendations / improvement notice	Enforcement action  Multiple breaches in statutory duty  Improvement notices  Low performance rating  Critical report	Multiple breaches in statutory duty  Prosecution  Complete systems change required  Zero performance rating  Severely critical report
<b>Adverse publicity / reputation</b>	Rumours  Potential for public concern	Local media coverage – short term reduction in public confidence  Elements of public expectation not being met	Local media coverage - long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions in the House)  Total loss of public confidence
<b>Business objectives / projects</b>	Insignificant cost increase / schedule slippage  Noticeable reduction in quality / scope	<5% over project budget  Schedule slippage  Minor reduction in quality / scope	5 – 10% over project budget  Schedule slippage  Reduction in scope or quality requiring client approval	Non-compliance with national 10-25% over project budget  Schedule slippage  Key objectives not met / secondary objectives	Incident leading >25% over project budget  Schedule slippage  Key objectives not met / primary objectives
<b>Finance including claims</b>	Small loss  Risk of claim remote	Loss of 0.1-0.25% of budget  Claim of less than £10,000  Absorbable unplanned expenditure or loss of income	Loss of 0.25 – 0.5% of budget  Claim(s) between £10,000 and £100,000  Significant effect on departmental budget	Uncertain delivery of key objective / loss of 0.5 – 1.0% of budget  Claim(s) between £100,000 and £1 million  Purchasers /commissioners failing to pay on time  Impact on Directorate's financial position	Non-delivery of key objectives / loss of >1% of budget  Failure to meet specification / slippage  Loss of contract / payment by results  Claim(s) >£1 million  Impact on Trust's financial position

	<b>Consequence scores (severity levels) and qualitative measure of consequence or impact:</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Domain</b>	<b>Insignificant/Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
Information Governance	None	<p>Loss of system for short period causing delays to appointments or patient activity</p> <p>Equipment found in exposed or inappropriate locations which may result in theft or damage</p> <p>Discovery of inadequate records which could have resulted in treatment being appropriate</p> <p>Inappropriate or unauthorised access to sensitive data by staff due to accident or human error</p> <p>Unauthorised use of trust computer equipment for personal activities</p> <p>Computer virus incidents resulting in loss of staff time for recovery but no data loss</p>	<p>Loss of system for up to 24 hours resulting in delay or cancellation of patient appointments or treatment</p> <p>Actual or attempted deliberate unauthorised access to hospital information systems</p> <p>Loss of system resulting in inability to fulfil financial commitments in short term</p> <p>Inaccurate data which was acted upon and created minor recoverable injury to patient</p> <p>Theft of PC equipment not involving the loss of sensitive patient data</p> <p>Failure to recover system data (back-up) resulting in loss of one day staff time</p> <p>Storage of inappropriate or pornographic material on computer systems</p> <p>Unauthorised use of personal hardware or software on Trust computer systems</p> <p>Deliberate copying or theft of Trust computer software in breach of appropriate copyright or licensing agreements</p> <p>Unauthorised disclosure of patient data</p>	<p>Misuse or abuse of Trust computer systems for the purpose of financial gain (fraud/theft)</p> <p>Computer virus incidents which destroy essential or medical information or results in the loss of clinical systems for over 24 hours</p> <p>Malicious hacking incident resulting in systems being compromised</p> <p>Theft of a server(s) containing application programmes and/or data, theft of computer storage media containing medical records or personal data</p> <p>Loss of computer system for up to one week</p> <p>Loss of patient data which may result in embarrassment to the Trust or financial litigation</p> <p>Irrecoverable loss of archive data or back-up media</p> <p>Loss of supplier support contracts relating to essential data systems or services</p> <p>Unauthorised use of personal hardware or software on Trust computer systems resulting in loss of computer services or data</p>	<p>Major loss of systems resulting in the invocation of disaster recovery procedures</p> <p>Loss of patient related system resulting in major loss to service</p> <p>Network security compromised for over 24 hours</p> <p>Unrecoverable loss of patient data or archive material</p> <p>Personal data confidentially compromised in such a way as to bring the Trust into disrepute</p> <p>Inaccurate computer records resulting in application of treatment which results in death or injury</p>
Inspection / Audit / Investigation	<p>Small number of recommendations focussing on minor quality improvement issues</p> <p>Minor non-compliance with standards</p>	<p>Non-compliance with standards</p> <p>Minor recommendations given that can be addressed by low levels of management actions</p>	<p>Challenging recommendations</p> <p>Reduced ratings</p> <p>Non-compliance with core standards</p>	<p>Enforcement action, low ratings in critical report by CQC, HSE, NHSLA, SHA</p> <p>Multiple challenging recommendations</p> <p>Major non-compliance with core standards</p>	<p>Prosecution</p> <p>Zero rating; severely critical report</p> <p>CQC suspension of Trust business</p>

	<b>Consequence scores (severity levels) and qualitative measure of consequence or impact:</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Domain</b>	<b>Insignificant/Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Environment</b>	Minimal environmental impact	Emission of non-toxic materials	Small emission of toxic material	Large emission of toxic material	Environmental impact such that the Trust Major Incident plan would be triggered
<b>Loss or damage (assets)</b>	Minimal loss / damage	Requires replacement or repair	Work area unusable	Areas beyond the department affected	Physical plant destroyed
<b>Service / business interruption / environmental impact</b>	Loss / interruption of > 1 hour; no noticeable effect on functional capacity  Minimal or no impact on the environment	Loss / interruption of >8 hours  Service disruption causing operational inconvenience  Minor impact on environment	Loss / interruption of >1 day  Services interrupted necessitating temporary working arrangements for up to 24 hours  Moderate impact on environment	Loss / interruption of >1 week  Services curtailed for up to 48 hours; patient care compromised  Major impact on environment	Permanent loss of service or facility  Services curtailed for more than 48 hours; patient care impossible  Catastrophic impact on environment
<b>Patient experience</b>	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience

### Step 2.

Estimate the **Likelihood** of this level of consequence/adverse outcome occurring, on a scale of one to five by assigning a predicted frequency of the adverse outcome occurring, or by assigning a probability of it occurring in a given timeframe.

Table 2 Qualitative measure of **likelihood**:

<b>Likelihood of occurrence</b>	<b>Descriptor</b>	<b>Level</b>
Likely to occur on many occasions, e.g. at least once a month	Almost Certain	5
Will probably occur, but not an everyday event, e.g. at least quarterly	Likely	4
May occur occasionally, e.g. at least annually	Possible	3
Unlikely to occur, but possible, e.g. once in every 5 years	Unlikely	2
Unlikely to occur, e.g. once every decade or not at all	Rare	1

### Step 3.

Multiply the **Consequence** by the **Likelihood** to give the Risk Rating.

Table 3 Overall risk rating (generated automatically by Datix)

<b>Likelihood</b>	<b>Consequence</b>				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**  
**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Risk Register – Policy for Management and Use	Policy Author:	Mrs N Croft, Risk Manager
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against any individual or group on the basis of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If "yes", please answer sections 4(b) to 4(d)).</i>	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d).	Can we reduce the impact by taking different action?	N/A	

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b>  <b>Not applicable</b>
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Name and Designation of Person responsible for completion of this form: Mrs N Croft ..... Date: October 2010 .....

Names & Designations of those involved in the impact assessment screening process: Corporate Governance Committee .....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)