South Central Ambulance Service
NHS Foundation Trust

RISK MANAGEMENT POLICY

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

TABLE OF CONTENTS

DOCUMENT INFORMATION

Author: Corporate Risk Manager

Consultation & approval: Consultation

This document replaces: Risk Management Strategy V12 (a combined strategy and policy)

Notification of release: Staff Matters, Staff Notice Boards, Intranet Publication, Internet Publication

Equality impact assessment: August 2021

Date of issue: September 2021

Reviewed: N/A

Next review: September 2023

Version: Version 0.3 [Draft]

Monitoring and review: The effectiveness of this Strategy will be monitored regularly by the Quality & Safety Committee and the Audit Committee

1. INTRODUCTION

1.1 South Central Ambulance Service NHS Foundation Trust [SCAS] provides emergency and urgent care along with other non-emergency business such as patient transport services and NHS 111. The Trust provides these services across Hampshire, Berkshire, Oxfordshire, Buckinghamshire, Surrey and Sussex.

1.2 The Trust is a large organisation; with over 3,000 staff delivering a complex mix of assessment, treatment and transport, across a large geographical footprint, to over 8,000 patients a day. An organisation of this size needs a robust approach to risk management to ensure that services are delivered safely and sustainably.

1.3 The risks the Trust is required to manage are wide ranging and varied and at a high level can be summarised as things that could delay, interfere with or prevent the delivery of the Trust strategy;

- Clinical Excellence – improving clinical outcomes, ensuring patient safety, and providing a positive patient experience.
- Operational Excellence – achieving response time performance standards, resilience and efficiency
- Effective Stakeholder Relationships – developing whole system solutions and seamless pathways of care
- Sound governance, value for money and a strong financial standing
- Leadership, Staff Engagement and a Learning Culture – developing the workforce, motivating and enabling our people to deliver excellence
- A network of profitable and high quality non-emergency contracts
- Effective management of the health and safety of patients and staff and others who are affected by the activities of the Trust.

1.4 The Risk management policy provides a basis for a well-managed process to ensure safe services and an accurate record of risks. It will be reviewed on a biennial basis and approved by the Trust Board. It will be published and made available to the Public and Stakeholders via the Trust's website.

2. SCOPE

2.1 This Risk Management policy applies to all staff who work on behalf of or for the Trust. Roles and responsibilities are set out in further detail below, but broadly;

- Executives and the Board will **LEAD** the organisations approach to risk management and seek **ASSURANCE** on the execution and management of the Risk Management Policy
- Directorate Leads and Managers will **ASSESS, RECORD** and **RESPOND** to identified risks and, where necessary, carry out risk assesments to provide assurance or escalate as appropriate to the Executive team.

- All staff will, by use of the appropriate systems (e.g. Datix, ESR) or processes (Departmental meetings, Reports, Staff Survey) help **IDENTIFY** risks and **SUPPORT** remedial action as required (as shared through Directives, Memo's, Policy changes etc)

3. AIMS

3.1 The delivery of health care and in particular the provision of Ambulance services will always involve a degree of risk, potentially such risks may be heightened during periods of demand and change management. The aim of this policy is to ensure that such risks are identified, assessed, evaluated and minimised, and to ensure that when making decisions those doing so are deliberately choosing to make judgements from a range of fully detailed and understood options.

4. ROLES AND RESPONSIBILITIES

4.1.1 The **Trust Board** has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidelines issued by the Department of Health (or other central bodies, such as NHS England) in respect of governance.

4.1.2 To assist the Board in fulfilling its duties, the Board will receive;

- Assurances on the strategic risks facing the Trust through the continued development of the Board Assurance Framework (BAF) document
- Summary upwards reports from the Quality & Safety Committee, the Audit Committee and the Risk, Assurance and Compliance Committee
- Detailed assessment of very high risks and their mitigation, escalated as necessary through the committee structures or by request
- Monthly reports from the Director of Patient Care and Transformation and other Executive Directors as required
- Assurance reports on regulatory body interaction with the Trust, including but not limited to the Care Quality Commission and the Health & Safety Executive.
- Compliance reports on key standards the Trust is obliged to meet, including but not limited to NHS Pathways, NHS Resolution, NHS Digital, Counter Fraud Services
- Internal and External Audit reports
- Integrated Performance Reports (IPR) and other Key Performance Indicator (KPI) reports

4.2.1 The **Chief Executive** has overall accountability for the corporate governance of risk management.

4.2.2 The Chief Executive will delegate specific areas of risk management responsibility to Executive Directors.

4.2.3 The Chief Executive is required to maintain the Trust's registration with the Care Quality Commission and provide an annual governance statement in the Trust annual report stating their confidence in the systems of control within the organisation.

4.3.1 The **Executive Directors** have delegated responsibility for risk management across their portfolios and will;

- Champion and encourage participation in the risk management processes within their directorates and support staff to develop their knowledge and skills in management of risk

- Ensure that risk management is integrated throughout their directorates and forms part of the strategic and operational planning and decision making

- Assess and agree the level of risk appetite for each of the Trust's strategic objectives

- Ensure that the key risks for each of the directorates are recorded in directorate level risk registers, are subject to regular review and escalated to the Board as required

- Participate in Risk, Assurance and Compliance Committee meetings and attend Quality & Safety Committee and Audit Committee meetings as required

- Provide the Board assurance on management of key risks and escalate risks of concern as necessary

4.4.1 The **Director of Patient Care and Transformation** has delegated responsibility for the strategic development and implementation of organisational risk management, including;

- Developing and implementing a risk management strategy, agreed with the board and providing assurance on its progress through the Board committee structures.

- Developing and maintain a risk management policy and the systems and processes that support it, including the Trust digital risk reporting and management tool (Currently Datix)

- Identify opportunities for developing the risk management agenda in the Trust and promoting the continued development of skills and knowledge across all directorates

- Identifying and interpreting new legislation, central NHS policy and guidance in relation to risk management and developing the corporate response to any relevant changes to Trust policy, systems or processes

- Providing support to other Executive Directors and their wider teams as required to help ensure their risks across the Trust are identified, recorded and progress on mitigations documented

- Ensure the BAF and corporate risk register are updated regularly and made available for the Board papers and committees by the cut off dates with supporting papers as required

4.5.1 The **Chairperson** will work with the **Non-Executive Directors** to ensure the management of risks is afforded sufficient scrutiny and challenge to be assured that the Trust has robust systems of risk management in place and that risks are well understood and being mitigated against appropriately.

4.5.2 Through the Board committee structures, ensure that key risks and associated assurance on their management is upward reported to the full Board.

4.6.1 The **Company Secretary** will work closely with the Chair, Chief Executive and Executive Directors to ensure that risk management policy and processes are in place and reviewed as required, in line with the Trust constitution.

4.6.2 The Company Secretary will coordinate the agenda of Trust Board and its Committees to ensure that risk management is appropriately discussed and scrutinised, including access to the BAF and Corporate Risk Registers in line with the published schedule of meetings each year.

4.7.1 The **Corporate Risk Manager** is responsible for supporting Directors and Managers in assessing and articulating risks for entry into risk registers and will act as a 'critical friend' by highlighting risks that need reviewing, or where there is insufficient evidence recorded to demonstrate effective management of risk.

4.7.2 The corporate risk manager will collate risks from different risk registers around the Trust and provide analysis to Directors and Committee members to help their understanding of risks facing the Trust and how they are being managed.

4.7.3 The Head of Risk and Safety will advise and support managers in the carrying out of risk assessments and provide risk assessment training.

4.7.4 The head of risk and safety is also the 'competent person' to advise the Trust on matters of health and safety and is a subject matter expect.

4.7.5 The head of risk and safety will also work with managers to develop and escalate risks on the health and safety risk register.

4.8.1 **Managers and Supervisors** are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated areas and scope of responsibility.

4.8.2 In situations where significant risks have been identified and/ or where local control measures are considered to be potentially inadequate, managers and supervisors are responsible for escalating these risks through their line management, reporting on the Trusts risk management system (Datix) and seeking advice from the Trust risk department as necessary.

4.8.3 All managers and supervisors have a responsibility to respond to risks they discover or that are raised to them (through the Trust risk management tool (Datix) or directly). They will need to carry out suitable and sufficient risk assessments using the most appropriate risk assessment form depending on the type of risk assessment required, for instance, generic, stress, display screen equipment, new or expectant mother (the generic risk assessment template is in the appendices below) and where necessary, implement appropriate further control measures to minimize that risk.

4.8.4 All managers and supervisors are required to record the risks, their assessments and any controls implemented; this might be through the Trust risk management tool (Datix), entry onto a directorate risk register or other agreed method.

4.9.1 **All Staff** will participate, whenever required in risk assessment and cooperate with risk management processes.

4.9.2 Report and identified areas of risk immediately or within 24 hours in accordance with the Trusts risk and incident reporting procedures, using the Datix reporting system.

4.9.3 Where necessary, carry out dynamic risk assessments to help ensure their safety and that of patients and others affected by their work.

5. RISK REGISTERS

5.1 The Trust has a **Corporate Risk Register** that contains all the high level risks, identified through Directorate level risk registers and/or committee meetings.

5.2 Risks on the corporate risk register will be owned agreed by a named Executive Director and they will be responsible for assessing the risks at regular intervals and updating actions and mitigations to demonstrate management of the risks.

5.3 Risks on the Corporate Risk Register will be linked to the Trust Strategic aims and will inform the high level Board Assurance Framework.

5.4 Each directorate will have an overarching risk register, supported by subordinate risk registers as required and agreed with the Executive Director. These will overseen and managed by the manager(s) nominated by the Executive Director and will be subject to a minimum of quarterly review.

5.5 There are a number of working groups that maintain a risk register and they will escalate key risks through upward reporting to their agreed committee, these include;

- Health, Safety and Risk Group
- Equipment and Vehicle Review Group
- Patient Safety Group
- Project Management Office
- Risk and Resilience Office
- Clinical Transformation Board
- IT Board
- Audit and research Team

5.6 Risks will be assessed on the both their **Impact** and **Likelihood** using the guidance and risk descriptor matrix available in the Risk Register templates and at appendix one.

5.7 Methods of identifying risks across the Trust include, but are not limited to the following;

- Issues raised by staff/managers and/or from discussions at meetings
- Incident reporting and analysis of incidents
- Patient experience and professional feedback
- Investigations and patient safety incident reviews

- Audit
- Project start up and scoping
- Advice from subject matter experts
- National, Regional and local intelligence

6 TRAINING AND EDUCATION

6.1 It is essential that all staff and managers receive such training and awareness of health and safety and risk management and how to carry out risk assessments as is relevant to their area of work. Such training may take place in a formal environment i.e. a classroom or be work-based and also through technology enhanced learning e.g. e learning, podcasts and videos.

6.2 Satisfactory completion of training will be recorded in the member of staff's learning record. Training records will be held on the member of staff's training file.

6.3 The Trust provides Root cause analysis/Serious Incident investigation training using some of the National Patient Safety Agency (NPSA) programme and Leading Safety training (for Directors and Assistant Directors) and Managing Safely Training (for Heads of Operations/Clinical Operations managers and other managers) accredited through the Institute of Occupational Safety and Health (IOSH) to all its managers as part of individual performance development Training (IPD).

6.4 The Trust also provides the following risk assessment training courses:

- How to carry out a 'task' based risk assessment
- How to carry out a stress risk assessment
- How to carry out a display screen equipment risk assessment

6.5 The Education Review Group will work with Executive Directors and Managers to understand the Trust's key risks, informing their programmes of learning and session content.

7. EQUALITY STATEMENT

7.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy / maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the aforementioned protected characteristics, whether full or part time or employed under a permanent or a fixed term contract or any other irrelevant factor.

7.2 By committing to guidance encouraging equality of opportunity and diversity, The Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service.

The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence. A copy of the equality impact assessment is available form the author if required.

7.3 Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

8 MONITORING AND REVIEW

8.1 The effectiveness of this policy will be monitored regularly by the Quality & Safety Committee and the Audit Committee.

9 REFERENCES

9.1 This policy underpins the effective management of risk and supports the Trust in meeting its regulatory and licence obligations, in particular;

- The Health and Social Care Act 2012
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations)
- Health and Safety at Work Act 1974
- NHS Improvement Provider Licence Requirements
- NHS Resolution Requirements

10 LINKED DOCUMENTS

10.1 The policy supports and is supported by the following documents which support the both intelligence gathering on risks and how they are managed;

- Adverse Incident Reporting and Investigation Policy
- Board Assurance Framework
- Health & Safety Policy and Procedures
- Infection Prevention, Control and Decontamination Policy and Procedures
- Statutory and Mandatory Training Policy
- Patient and Public Experience Policy
- Duty of Candour policy
- Claims Management Policy
- Whistleblowing Policy
- Corporate Risk Register
- Terms of Reference: Quality and Safety Committee
- Terms of Reference: Audit Committee
- Terms of Reference: Risk, Assurance and Compliance Committee
- Terms of Reference: Health, Safety and Risk Group
- Terms of Reference: Patient Experience Review Group
- Terms of Reference: Patient Safety Incident Group
- Terms of Reference: Patient Safety Group

Appendix One – Risk assessment matrix

The Trust uses a standard assessment matrix for (next page) identifying the level of risk associated with an activity or situation. It was designed by the now disbanded National Patient Safety Agency and is widely used and recognised across the NHS.

It has a number of descriptors to help users decide between the levels of risk; because it is not possible to describe every scenario an organisation may face, these are indicative only. The user will have to apply a level of judgement when deciding on a risk score. Sometimes it will be better to have a discussion on the level of risk, for example in a team or committee meeting, so that everyone understands the risk fully and agrees on the scoring applied to it. It is also useful to ‘sense check’ a score with those already on a risk register – for example; if the agreed score has a likelihood of 3 and impact of 3 (3 x 3 = 9) then does another risk that also scores 9 seem similar, or if another score is 6 then is it appropriate that this this carries more weight?

Probability Impact	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Coding risk scores	1 to 3	4 to 7	8 to 14	15 to 25

South Central Ambulance Service NHS Foundation Trust – Risk Scoring System

Likelihood Score

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	< 1%	1 – 5%	6 – 25%	26 – 60%	> 60%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Consequence/Impact Score

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury **(Physical & Mental)** **to anyone**	Minor injury (not requiring first aid)	Minor injury or illness (first aid treatment needed)	Reportable to external agencies/statutory bodies (e.g. RIDDOR, HSE, NPSA, Police, MHRA, SHA)	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience no injury	Unsatisfactory patient experience and or involving first aid treatment – readily resolvable	Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover (breach of working practices)	Serious mismanagement of patient care (major permanent harm) (breach of working practices)	Totally unsatisfactory patient care (breach of working practices)
Complaint / Claim Potential	Locally resolved complaint	Justifiable complaint peripheral to clinical care / management	Justifiable complaint involving lack of appropriate care / management Claim below excess	Multiple justifiable complaints. Claim above excess	Multiple claims or single major claim
Objectives / Projects	Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage Minor reduction in quality or scope	5 – 10% over budget / schedule slippage Reduction in scope or quality requiring client approval	10 – 30% over budget / schedule slippage Does not meet secondary objective(s)	> 30% over budget / schedule slippage Does not meet primary objective(s)
Service / Business Interruption	Loss / interruption < 1 hour	Loss / interruption >1 hour and < 8 hours	Loss / interruption > 8 hours and < 24 hours	Loss / interruption > 24 hours and < 1 week	Loss / interruption > 1 week

Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality < 1 day	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training
Financial	<0.1% of budgeted income	>0.1% and <0.25% of budgeted income	>0.25% and <0.5% of budgeted income	>0.5% and<1.5% of budgeted income	>1.5% of budgeted income
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards	Reduced rating Challenging recommendations. Non-compliance with core standards Reportable to associated external / statutory agencies	Enforcement action Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with standards	Prosecution Zero rating. Severely critical reports.
Adverse Publicity / Reputation	Rumours	Local Media interest (short term)	Local Media interest (long term)	National Media interest < 3 days. Local MP concern	National Media interest > 3 days. National MP concern (questions in the House)