GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**Reference Number: RM02** **Version Number: 3** **Next Review Date: February 2020**

Risk Management Policy

Introduction

Cwm Taf University Health Board (CTUHB / the Board) has significant responsibilities around ensuring that patients and staff exist in an environment that is as free of risk as possible, and where this is not possible, that the risks are managed appropriately and to a high standard.

This document looks in detail at the issues raised by the management of risk and makes recommendations for colleagues.

Objectives

- Provides advice on the management of risk – supported by the Risk Assessment Procedure;
- Outlines where the key responsibilities lie in the management of risk;
- Prescribes what staff need to do – and should not be deviated from.

Operational Date	**Expiry date**
2 February 2017	Informal – one year Formal – three years

Scope

This Policy must be adhered to by all employees within the UHB, including locum staff and contractors.

Equality Impact Assessment	An Equality Impact Assessment has not been completed. This is because the UHB's policy is being reviewed at present. It is unlikely that the Policy will attract any negative impact.

Distribution	All staff via the intranet and staff briefing.
To be read by	All managers and staff who have responsibility for the management of risk.
Documents to read alongside this procedure	• Health & Safety Policy • Incident Reporting Policy
Approved by	Quality Safety and Risk Committee 2 February 2017
Accountable Executive / Lead Director (responsible for formal review every three years)	Board Secretary / Director of Corporate Services & Governance
Author / Management Lead (responsible for informal review annually)	Head of Operational Health Safety and Fire
Freedom of Information status	Open
If the review date of this policy has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Services Department. **To avoid use of out of date policies please do not print and then store hard copy of this document.** **Out of date policies cannot be relied upon.**	

Amendment Record

If a change has been made to the document, the changes must be noted and circulated to appropriate colleagues.

Detail of change	Why change made	Page number(s)	Date of change	Version	Name of Policy Author

Ref: RM02

Summary

Who this document is aimed at:
The document is aimed at all levels of staff, who have to manage risk.

Key issues:
The document will detail specific guidance on the management of risk and is supported by the Risk Assessment Procedure. Advice on the management of specific risks are provided in specific policies and procedures, eg the Management of Stress Policy.

Brief summary of document:
The document will detail the Health Board's approach to the management and identification of risk, outlining key responsibilities.

Policy Definition
A policy is a high level overall statement, which sets the boundaries within which action will take place, and should reflect the philosophy of the organisation or department.

It provides a prescribed plan for staff to follow, which should not be deviated from.

CONTENTS

1. Purpose

The purpose of this Policy is to ensure:

- all risks that could cause harm are identified and that control mechanisms are implemented;
- that satisfactory management arrangements are in place for assessing the risk;
- staff know how to undertake a risk assessment and are able to identify and take action to mitigate risk;
- all legal requirements are met.

This Policy sets out the approach to risk management in Cwm Taf University Health Board and builds on work already underway.

The University Health Board (UHB) has a commitment to the highest level of safety for all patients, staff and visitors. The complexity of healthcare and the ever-growing demands to meet healthcare needs means that there will always be some element of risk.

The management of risk is the responsibility of staff at all levels within the organisation. Patients and the public also have an important part to play by proactively participating in their care and to alert staff to potential risks which may result in harm to others, e.g. water spillages.

For our independent contractor services the responsibility for identifying and managing risk lies with them. Due to the Health Board's contractual relationship with independent contractors, eg. General Practitioners, dentists, optometrist etc the Health Board clinical governance processes will provide assurance to the Board that these services are safe and meet set standards. In order to achieve this, robust processes are in place to identify areas of high risk and the UHB is committed to supporting independent contractor services with their risk management arrangements with issues to be reported via Integrated Governance Groups.

Contractors and Contracted Services: before contracts are finalised, the competence of contractors will be assessed in relation to health and safety as detailed in the HB's Control of Contractors Policy. All hazards on UHB sites that could affect contractor personnel should be clearly defined and controlled. The interests of staff, patients and visitors must be protected before and during contracted work.

The challenge for the Health Board is to:

- ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the '***risk taker is the risk manager'*** and that risks are owned and managed appropriately;
- utilise the agreed approach to risk when developing and reviewing the Integrated three year medium term plan;
- embed both the principles and mechanisms of risk management into the organisation;

- involve staff at all levels in the process;
- revitalise its approach to risk management, including health and safety.

The University Health Board is committed to the principle that risk must be managed, and to ensure that:

- there is compliance with statutory legislation;
- all sources and consequences of risk are identified;
- risks are either eliminated or minimised;
- damage and injuries are reduced, and people's health and well-being is optimised;
- resources diverted away from patient care to fund risk reduction are minimised;
- lessons are learnt from concerns (incidents, complaints and claims) in order to share best practise and prevent reoccurrence;
- sentinel risks are reported through the UHB committee structures and reported to the Welsh Government via the sentinel reporting system;
- statutory reporting requirements are met.

The implementation of the Knowledge and Skills Framework (KSF) has the potential to support staff development, knowledge and competence in relation to risk and ensure that the individual's role in risk management is linked to their job profile. The KSF and its associated development review process will apply across the whole organisation for all staff (except medical). Medical staff will participate through appraisal and medical revalidation via existing processes and those being developed to meet the requirements of medical revalidation.

2. Policy Statement

The University Health Board recognises its responsibility to introduce risk management systems within the workplace. It accepts that at the heart of the risk management process is risk assessment. Risk assessments are essential in identifying areas where the Heath Board's staff, patients, visitors, premises and the business are exposed to risk. The preparation of action plans / risk profiles and risk registers are required for the prevention, reduction and prioritisation of risks to the organisation. The Health Board recognises the need to ensure high level management commitment; professional competence and adequate resources are available.

Good risk management awareness and practice at all levels is a critical success factor for any organisation. The aim is to ensure that risk is managed continuously and addressed in a systematic and consistent manner.

It is the policy of the Health Board to integrate health and safety into risk management and risk management into day to day operational management through having in place measures and processes to enable continuous improvements relating to identification and treatment of risk. In order to achieve this, it is necessary to bring together the various governance processes

in order to help to create the environment necessary to identify and then manage the risks that are inherent in the everyday life of the organisation.

3. Principles

The following suggest the breadth of the Policy and what is required for success to be achieved:

- open and honest reporting in any situation that may threaten the quality and safety of the patient experience or staff / visitor safety;
- a thorough understanding of the needs of patients and stakeholders;
- a thorough understanding of the environment in which the Health Board operates and how to achieve effective partnership working;
- a clear sense of risk issues that need to be addressed via robust risk assessment and captured on appropriate risk registers: this information can then be utilised within the UHB's service planning activities;
- the maintenance and development of corporate level systems and arrangements, e.g. Datix, the COSHH database (Sypol), undertaking of audits (as part of the assurance arrangements) by either in house advisors and/or specialists or external / internal auditor(s);
- a well structured operational programme with clearly assigned responsibilities, led from the centre but appropriately delegated to Directorates;
- managers and leaders (clinical and non-clinical) who understand and take forward the key risk management priorities within each service delivery area;
- the provision of high quality Clinical and Non Clinical Risk Management advice and support to Directorates;
- managers and staff across the organisation who work well together to lead all aspects of risk management;
- all staff demonstrate competence and appropriate standards of performance;
- adequate measurement of strategic and operational performance, and sharing of the information with staff in order to stimulate continuous improvement across the whole organisation;
- performance monitoring mechanisms that are used to bring improvements in workplace safety and the patient experience;
- integration of risk management across the organisation;
- joint working to achieve effective partnership working;
- an innovative and outward looking culture which finds new and innovative ways to improve the quality and value of healthcare and the services customers and stakeholders require;
- where appropriate adopting a 'spend to save' approach e.g. supplying an appropriate ergonomic chair to prevent MSD rather than bear the costs of a personal injury claim;
- knowledge on the extent to which all areas of the organisation comply with statutory, mandatory and professional standards;
- compliance with external requirements will be actioned at the unit, and directorate level and audited at the corporate level.

4. Scope

This Policy complements the Risk Management Strategy and applies to all premises and employees of the Health Board by forming part of the risk management policy file, which includes health and safety policies.

Directors of organisations hosted by Cwm Taf UHB (e.g. Welsh Health Specialised Services Committee and Emergency Ambulance Services Committee) and the staff within the organisations are responsible for ensuring that structures and reporting mechanisms are in place to implement the requirements of this Policy.

All activities that are undertaken must be risk assessed, these will include clinical, business, environmental, security, health and safety and others that are workplace based. Operational or departmental policies should keep faith with the requirements of this Policy.

Independent contractor services are responsible for identifying and managing their own risks, due to the UHB's contractual relationship with them. In order to achieve that, we have robust processes in place to identify areas of high risk and address concerns, and are committed to supporting the independent contractor services with risk management.

4.1 Definitions

Independent Contractors: General Practitioners, Dentists, Community Pharmacists and Opticians together with the Care Homes (with Nursing).

Types of incidents: incidents that have occurred, incidents that have been prevented and incidents that might happen.

Adverse Incident: An event or circumstance that leads to either unintended or intended harm, loss or damage to a patient; member of staff; general public; equipment; building; which may be clinical or non-clinical.

Non-patient safety incident - An event or omission causing physical or psychological injury to a member of staff, visitor, contractor, student etc.

Patient Safety Incident (NPSA definition) - Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care.

Contractors: builders, plumbers, non clinical professionals from outside the NHS, contracted by the Health Board to undertake work on their premises.

Harm: any injury physical or psychological, disease, suffering, disability or death. In most cases harm is unexpected if it’s not related to the natural cause of the individual’s illness or underlying condition. The level (or severity) of harm can be categorised as:

Levels of Harm	Definitions
No harm:	**Impact prevented** – any incident that had the potential to cause harm but was prevented, resulting in no harm. **Impact not prevented** – any incident that ran to completion but no harm occurred.
Low:	Any incident that required **extra observation or minor treatment** and caused minimal harm to one or more persons.
Moderate:	Any incident that resulted in a **moderate increase in treatment** and which caused **significant but not permanent harm** to one or more persons.
Severe:	Any incident that appears to have resulted in **permanent harm** to one or more persons.
Death:	Any incident that directly resulted in the death of one or more persons.

Potential incident or near miss: is defined as an event or circumstance, which could have but did not result in harm to patient, staff, general public, equipment or building. This may be clinical or non-clinical.

Serious incident: an internal event or circumstance, likely to cause harm, and attract significant legal, media or other interest which, if not properly managed, may result in further damage, harm or loss of the organisation's reputation or assets.

Action plan: a list of the risks with the actions needed to eliminate, reduce or control the risk.

Controls: the available systems and processes which help minimise the risk.

Consequence: the impact or outcome component of a risk, on a scale of 1 – 5.

Likelihood: the probability of a risk occurring or recurring, on a scale of 1 – 5.

Hazard: the **potential** of a substance, activity or process to cause harm. Hazards may take many forms such as electricity, fire, equipment, behavioural problems and working methods or practices. The harm can vary in severity, some hazards may cause no harm whereas others may cause serious illness, disability or death. Organisational reputation, finance and quality of care could also apply.

Risk: the likelihood that the harm will be realised eg the chance that somebody could be harmed by the hazard, together with an indication of how serious the harm could be.

Risk Acceptability: the risk grading will identify the appropriate level in the management structure for the acceptability of the risk.

Risk Assessors: competent persons who possess the knowledge, skills and experience to undertake a risk assessment.

Risk Assessment: is a careful and systematic examination of what in your work activity could cause injury, harm or loss to people, the environment or business, so that a decision can be made whether further actions need to be taken or control measures introduced in order to prevent harm or loss. Patients, employees and others have a right to be protected from harm.

Risk Ownership: ownership of the risk is determined by the risk rating.

Reactive Risks: risks that are identified following an event, such as an incident, complaint or audit.

Risk Rating: Each risk is rated as part of the assessment, using a 5 x 5 matrix, which determines both the risk score and whether the risk is graded as green, yellow, amber or red.

Proactive Risks: risks that are realised before they cause an event, or that are being looked for during the audit process.

Residual Risk: the remaining risk that exists following implementation of measures or controls to reduce the risk.

Risk Register: a register of all assessed risks and which contains details of controls in place, the action plan to reduce the risk and the current progress towards the target risk reduction.

Risk Score: the result of multiplying the consequence score x the likelihood score.

4.2 Core elements of managing risk

Risk management is the assessment, analysis and management of risks. It is simply a way of recognising which events (hazards) may lead to harm in the future, and minimising their likelihood of occurrence (how often?) and consequence(s) (how bad).

Acceptable / tolerable risk is defined based on the following principles:

- tolerability does not mean acceptability. It refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk;
- no person should knowingly be exposed to serious risk unless they agree to accept the risk;
- it is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing is even greater;

- financial losses within the budget set aside for such purposes in each financial year equates to 0.33% of total budget.

Given that acceptable risk is defined as:
"A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm."

Identification and reporting of risk: the identification of risk within the University Health Board must be addressed in a proactive as well as a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and comprehensive dynamic organisational risk register and profile, which is developed in conjunction with our Datixweb project. This will enable the Board to prioritise risk and allocate funding accordingly. The organisation relies upon the accurate reporting of incidents by all its staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and lessons learnt from incidents. The use of evaluation, audit, service reviews, complaints and litigation must also be utilised as a source of data for the identification and reporting of risk.

The Health Board must ensure that the processes to identify and report risk are open and accessible to all staff, patients and public. This may result in an increase in the number of incidents identified within the Health Board. Any media interest will be managed in a positive way, by reassuring the public that increased reporting is essential to the prevention of serious incidents and the increase in incident reporting is a major step forward in improving the quality and safety of patient care. It will be important that staff and patients are informed and supported and receive feedback on all incidents reported within the organisation. The degree of feedback being dependent on the nature of the risk reported.

The Risk Assessment Procedure sets out the process to be followed.

<u>Learning lessons from incidents to prevent reoccurrence</u>
The analysis of trends and the development of comprehensive action plans that minimise the likelihood of reoccurrence of incidents are important. The organisation expects the number of reported incidents to rise as methods and systems of reporting are improved. It is anticipated that this should be offset by systems that prevent the incident occurring in the first place, as they continue to be identified via trend analysis of incidents, complaints and litigation. A measure of success will be a reduction in the number of serious incidents within the organisation. A system of sharing and benchmarking issues across directorates and departments will need to be further developed. The further development of the infrastructure to support incident reporting depends upon the success of the Health Board in nurturing an open and fair culture – which is being taken forward as part of the implementation of the Being Open Policy.

This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way. However, occasions may arise when a potentially serious breach of professional practice, or possible criminal activity is revealed, indicating the need for further investigation under the Health Board's Disciplinary or Capability Policies (agreed at an all Wales level). All such cases will be considered individually, however, formal disciplinary action may result where:

- an individual persists in unsafe practice;
- there is a deliberate failure to report, or attempt to cover up an incident;
- there have been repeated unreported errors or violations;
- there is evidence of malicious activities (including malicious reporting of untrue allegations against a colleague);
- there has been an act of gross misconduct (e.g. treating patients whilst under the influence of drugs or alcohol);
- a breach of the criminal law (e.g. theft or assault) or professional conduct has occurred.

The University Health Board will monitor lessons learnt, by improvements in patient care. This will be facilitated by the audit of action plans, trend analysis and compliance with policies and procedures.

Communication with staff, patients and public

It is important that communication relating to risk management is both transparent and effective for staff and patients. The committee infrastructure overseeing clinical / corporate governance, compliance and risk (as documented within the Standing Orders) will be the cornerstone of this communication. The communication of risk management issues will also be shared via the intranet and risk management reports.

The organisation has a large number of external partners including Social Services and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is implemented. Healthcare Inspectorate Wales (HIW), Welsh Risk Pool (WRP), Health and Safety Executive (HSE), South Wales Fire & Rescue Service, Internal Audit and External Audit have a role in the monitoring and evaluation of organisational risk issues. The University Health Board will continue to work collaboratively with these agencies in the continuous improvement of risk management and risk reduction.

Partnership Working

Risk management does not exist in isolation and is one of the enabling systems within Governance frameworks. Risk management processes must continue to enable the organisation to identify unacceptable risks, these can be minimised to meet high quality care for patients.

To facilitate this, the Health Board must work with staff at all levels internally, external partners including Police, Community Partnerships, Local Government including Social Services. The University Health Board will also need to build on the success of its relationship with agencies such as Healthcare Inspectorate

Wales, Health and Safety Executive, South Wales Fire & Rescue Service, the Welsh Risk Pool and Welsh Government.

The public and patients have an important role to play in the identification and reduction of risk. Further work will be undertaken to build on the current involvement of patients and public in service development. Gaining their perspective and involvement in risk management will support the identification and reduction of risk throughout the organisation.

5. Legislative and NHS Requirements

The risk assessment provision of the Management of Health and Safety at Work Regulations (1999) requires employers to assess the risks created by their undertaking, so as to identify the measures they need to have in place to comply with their duties under health and safety legislation.

As such, the assessment provision of the Management of Health and Safety at Work Regulations are superimposed over all other workplace legislation including the general duties in the Health and Safety at Work Etc Act 1974.

This Policy is the governing document for implementing the Risk Management Strategy and is intended to meet all legal and internal requirements.

6. Procedure

The compliance audit and risk assessment procedures will support this Policy and will explain to staff:

- when to undertake a risk assessment;
- how to undertake a risk assessment;
- what is a generic risk assessment;
- the principles of risk assessment; and
- the risk assessment process.

7. Training Implications

The effectiveness of managing risk within the Health Board relies upon the knowledge of staff, patients and public regarding risk identification and reporting. It is important that all staff are aware of their responsibilities regarding risk management. The identification and management of risk must be a core component of the annual personal review and appraisal process and will be reflected in the Knowledge and Skills Framework for Agenda for Change.

A range of training and education relating to risk management will be available within the University Health Board aimed at the specific needs of staff members, this will start at induction. The education and training programmes will also be extended to our independent contractor colleagues to support their responsibilities in the management of risk and safety.

Risk management training or awareness will be provided to all staff, through induction and as part of a regular training programme.

Executive Directors, Clinical Directors, Heads of Nursing / Midwifery, Locality / Directorate Managers, and Line Managers will ensure that all members of staff receive sufficient training to fulfil their individual duties, to ensure compliance with this Policy, and to understand the importance of identifying and controlling risks.

The designated responsible manager(s) for the area concerned (eg Directorate / Locality Managers for wards and department within their remit) will ensure that adequate risk assessment training is given to appropriate members of staff in their specific duties as defined within the Risk Management Strategy, the Governance Framework, Clinical Governance Strategy and Policy and the Workplace Safety and Health Policy. It is essential that risk assessments are completed by competent members of staff, who have sufficient experience of the working procedures and have received the appropriate training.

8. Review, Monitoring and Audit Arrangements

8.1 Operational Date

This Policy will take effect within one month following approval.

8.2 Review of Policies and Procedures

This Policy will be subject to a bi-annual review to ensure its continuing effectiveness within the agreed organisational and consultative arrangements of the organisation.

8.3 Review and Monitoring Arrangements

Directorate managers will regularly monitor to ensure that measures to control risks are being fully implemented and remain effective.

They will arrange for managers to continually review risk assessments and risk profiles, in accordance with the frequency set out in the Risk Assessment Procedure. Risk registers must be regularly reviewed by Integrated Governance Groups at directorate level and will need to be presented when required to the appropriate Committee for corporate consideration, scrutiny and review.

Executive Directors, Clinical Directors, Head of Nursing / Midwifery and Directorate / Locality Managers will ensure that there is a Directorate risk profile, setting out the priorities and action required for managing the risks identified within the directorate.

Executive Directors / Corporate Leads will ensure an organisation-wide risk register is maintained that contains data about all extreme / high risks. The monitoring of the corporate risk register will be appropriately delegated to the Board's sub-committee(s) who will regularly review the organisation-wide risk profile / action plans and present a formal report to the Board for endorsement on an annual basis.

8.4 Audit

The Health Board will monitor the improvement in patient care via the action plans developed following clinical incidents trend analysis.

In some instances the establishment of coordinating groups and 'task and finish groups' will be necessary to address major organisational risks.

The progress of such groups will be reviewed via the appropriate delegated Committees. The Standards for Health Services in Wales and relevant Welsh Risk Management Standards are self assessed on an annual basis, the results will be reported via the agreed reporting structures together with the resulting action plan.

Action plans for specific areas of risk will be developed and monitored following audits at appropriate forums and committees. Line managers will undertake periodic risk management audit inspections to ensure the Policy is being followed and that risk assessments and risk profiles / action plans, detailing the priorities and actions required to manage the risks, have been produced and implemented.

9. Managerial Responsibilities

The Health Board has in existence formal structures and committees, which set the strategic aims and direction of the organisation and monitor progress. Details on the risk management requirements are contained in the Risk Management Strategy.

9.1 Board

The Board is responsible for reviewing the effectiveness of internal controls – financial, organisational and clinical. The Board is required to produce statements of assurance which demonstrate that it is doing its 'reasonable best' to ensure that the Health Board meets its objectives and protects patient, staff, the public and stakeholders against risk of all kinds.

To inform the annual governance statement made by the Chief Executive in the annual accounts, the Board must be able to demonstrate that they have been informed through assurances about all relevant risks and have arrived at their conclusions informed by the organisations risk management arrangements.

9.2 Quality Safety and Risk Committee

To support the Health Board's arrangements the various sub-committees will have a lead role for their respective sphere of responsibilities, whilst at the same time referring specific issues for consideration of another Committee where appropriate. For example, the Quality, Safety & Risk Committee has overall responsibility for coordinating the Health and Care Standards in Wales.

The role of the Committee is to provide the Board with assurances that appropriate arrangements are in place to ensure patient safety and processes

for clinical governance and appropriate arrangements, for the identification and management of risk. The Committee is primarily concerned with patient safety and quality of care and the overall priorities and processes for clinical governance. The Committee also works closely with the Audit Committee in carrying out this role in order to provide assurance to the Board that the Health Board has effective systems of internal control.

The functions and membership of the Committee is set out in the terms of reference and standing orders.

9.3 Audit Committee

The role of the Committee is to provide the Board with assurances that appropriate arrangements for effective internal control, and for the identification and management of risk.

In order to undertake this role the Audit Committee receives the key risks reported to the Quality, Safety & Risk Committee for review.

The functions and membership of the Committee is set out in the terms of reference and standing orders.

9.4 Integrated Governance Committee

The role of the Committee is to provide the Board with assurances that appropriate arrangements for effective internal control, and for the identification and management of risk.

The Committee, comprising the Chairs and Executive Leads of the Boards sub-committees, ensure that the UHB has the necessary systems of internal control in place and is taking appropriate action to address the key risks identified via the organisation's risk arrangements.

The functions and membership of the Committee is set out in the terms of reference and standing orders.

9.5 Chief Executive

The Chief Executive has overall responsibility for health and safety, and ensures that Directors and General Managers accept and can demonstrate a commitment to health and safety. The Chief Executive will ensure that:

- measures for implementing the Health Board's Policy are established and maintained;
- the Policy is kept under review;
- a Corporate Risk / Health and Safety Plan is produced, taking account of Directorates plans;
- policies and procedures are developed to meet relevant legislation, including systems for monitoring and controlling performance and setting objectives;
- competent advice and support will be provided at the strategic, corporate and operational levels;

- so far as is reasonably practicable adequate resources will be provided to meet the requirements;
- the provision and maintenance of:
  - safe and healthy place of work and working environment;
  - safe plant, equipment and working systems;
  - safe labelling, handling, transport and storage of materials and substances;
  - information, instruction, training and supervision;
  - adequate welfare facilities;
  - there is an effective incident reporting system, and provision of information on trends etc;
  - the effective notification and actioning of Hazard Warning and Safety Action Bulletins;
  - the effective operation of the Workplace Safety and Health Committee;
  - the recognition of safety representatives and the provision of sufficient facilities, training and time needed to enable them to carry out their roles and functions;
  - consultation with recognised trade unions on health and safety matters.

9.6 Medical Director and Director of Nursing

The Medical Director and Director of Nursing will ensure:

- that the overall strategy and programme for improving clinical risk management is developed and implemented;
- the Risk Management Policy and assessment procedures are subject to regular reviews in line with the policy document, and that measures for implementing the Policy are established, maintained and monitored;
- risk assessments are prepared and comprehensive risk profiles / action plans developed so that a corporate risk register is maintained;
- every appropriate individual within the patient care and safety team receives training and is competent in providing advice and fulfilling their duties;
- that an effective risk assessment training programme is set up, and training for staff is provided.

9.7 Board Secretary / Corporate Director

The Board Secretary / Corporate Director is the lead for the strategic theme of “compliance with legislation” and will ensure:

- systems are in place to audit compliance with legislation and address any deficits identified;
- that legislative requirements are complied with;
- that effective systems are in place to support the effective coordination of risk management throughout the organisation.

9.8 Chief Operating Officer

The Chief Operating Officer (COO) is accountable for ensuring the effective management of risk within the HBs policies and procedures. The COO may decide to delegate this responsibility to the Assistant Directors at his discretion.

9.9 Directors (Independent Members of the Board, Executive and Clinical)

Independent Members of the Board will chair / be members of the Quality, Safety & Risk Committee.

Executive Directors are instrumental in achieving the risk management strategy. Clinical Directors are accountable for ensuring implementation of the risk assessment policy within their Directorate or Locality. Clinical Directors may identify lead managers / clinicians who will coordinate risk assessments and progress specific issues. Executive Directors and Clinical Directors will also ensure that:

- the Risk Management Strategy, Risk Management Policy, Risk Assessment Procedure and Workplace Safety and Health Policy are implemented;
- all managers are competent to discharge their risk management responsibilities;
- risk assessments and risk profiles / action plans are completed and a directorate risk register is maintained;
- risk assessments and risk profiles / action plans are completed and reviewed, updated via the web based system (Datix). As a result the risk register will be automatically updated. In the interim Directorates / Localities will maintain their risk registers;
- the need for additional funding or other resources within the directorate as a result of undertaking risk assessments is identified;
- reports to the Board in order to confirm that all proposed actions have been fully and effectively implemented are prepared and reviewed regularly;
- practices are reviewed in order to identify areas requiring remedial action;
- staff are provided with safe systems of work, a safe working environment and the necessary equipment to control risks;
- every individual within the directorate is competent in fulfilling their duties, and is aware of their personal responsibility for risk and health and safety, by ensuring staff receive appropriate training and highlighting responsibilities within job descriptions and performance appraisal systems.

9.12 Responsible Managers

Responsible managers, which include any individual involved in the managerial process ranging from a Directorate Manager to a supervisor, are instrumental in achieving the requirements of the Risk Management Policy. They will ensure all staff within their areas of responsibility are aware, and understand the requirements, of the Policy. They will, within their areas of responsibility, ensure that:

- all staff have knowledge of and understand the Risk Management Policy and supporting procedures;
- risk assessments are undertaken and reviewed via Datix;

- the need for additional funding or other resources is, as a result of undertaking risk assessments, identified;
- any action plans arising from the risk assessments are implemented and reviewed. As a result the ward or department risk register will be automatically maintained;
- safe systems of work are developed to protect staff and draw up clearly defined safe operating procedures;
- staff are notified of hazards relating to their job and provided with training in safe methods of working;
- regular inspection and maintenance of equipment and the environment takes place;
- regular monitoring to enable activities to be reviewed and performance improved;
- risk management is on the agenda at ward and department meetings.

9.13 Directorate and Departmental Risk Assessors

Risk assessors will:

- undertake risk assessments and ensure corrective action is implemented;
- support Directorate and/or Locality colleagues with risk assessments, risk profiles / action plans and any corrective action required;
- communicate and facilitate the risk assessment process in their area;
- receive training to undertake risk assessments and provide support to ensure improvement in processes and monitoring within each Directorate or Locality.

9.14 Employees

The Health Board undertakes to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees including doctors, in line with existing legislation. However, all staff must actively participate in this process and accept a responsibility for managing risk. Every member of staff should be able to recognise and report risks through line management structures. If the member of staff does not consider this appropriate, use of the Whistleblowing Policy should be considered.

All staff including doctors will be made aware of their responsibilities and their performance will be part of regular review procedures. Specific responsibilities, where appropriate, must be included in job descriptions and the appropriate level of training and supervision will be provided. Employees have a duty to:

- take reasonable care of their own health and safety at work and of other persons who may be affected by what they do or do not do;
- act with probity and report suspected fraudulent behaviour;
- cooperate with their managers on health and safety and in meeting requirements of the law;
- fully comply with all safety procedures, safe systems of work and approved codes of practice pertaining to their particular work activities;
- carry out user checks of equipment within their control and immediately report any observed defects or potential hazards to their line manager;
- report all incidents, clinical or non-clinical that have led or may lead to injury or damage;

- assist as required in the investigation of incidents and completion of reports with the objective of avoiding recurrence;
- participate in relevant training;
- not to interfere with or misuse anything provided for the control of risk.

9.15 Safety Representatives

Safety representatives are entitled to:

- make representation to managers on general matters affecting the health, safety or welfare at work of any employee;
- represent employees in consultations at the workplace with inspectors of the Health and Safety Executive, or with any other enforcing authority, in relation to health and safety matters affecting any employee;
- undertake training and receive accreditation from the Health Board;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;
- carry out inspections of the workplace in accordance with Regulations 5, 6 and 7 of the Safety Representative and Safety Committee Regulations 1977;
- be represented at, or attend meetings of, the Workplace Safety and Health Committee and Directorate or Locality Integrated Governance Groups.

10. Retention or Archiving

In cases of complaints or claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Corporate Director / Board Secretary must therefore ensure that copies of policies and procedures are archived and stored in line with the HB's Records Management Strategy and are made available for reference purposes should the situation arise.

11. Non Conformance

There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Workforce and Organisational Development policy.

12. Equality Impact Assessment Statement

This Policy has been subject to a full equality assessment and no impact has been identified.

13. References

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Financial controls documentation.
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Health and Safety Executive. (2006) Five Steps to Risk Assessment.
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Health and Safety Executive. (2000) Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance L21. HSE Books.
Health and Safety Executive. (1998) Successful Health and Safety Management HSG65. HSE Books.
Management of Health and Safety at Work Regulations 1999.
Manual Handling Operations Regulations 1992 (as amended).
Medical Devices Agency - Equipment Hazard Notification Requirements.
National Patient Safety Agency. (2008) A Risk Matrix for Risk Managers.
Noise at Work Regulations.
Personnel Protective Equipment Regulations 1992.
Provision and Use of Work Equipment Regulations 1998.
Regulatory Reform Act.
Standards for Health Services in Wales.
Statutory duty of quality in the NHS by meeting the requirements of the Clinical Governance agenda.
Welsh Risk Management Standards.
Workplace (Health, Safety & Welfare Regulations) 1992.

These references are not exhaustive and may be subject to change and amendment.