

RISK MANAGEMENT STRATEGY 2016 - 2019

Policy Author	David Tita, Corporate Risk Manager Susan Simpson, Head of Corporate Affairs & Company Secretary.
Version	14
Impact Assessment Date	1st June 2009
Ratifying Committee	Trust Board
Date Approved	
Review date	January 2017

CONTENTS

Section	Page N°
1. Introduction	3
2. Definitions.....	4
3. Strategic Aims	5
4. Individual Roles and Responsibilities for Risk Management.....	5
5. Governance Structure for Risk Management.....	10
6. Key Principles of Risk Management at Kingston Hospital NHS Foundation Trust.....	13
7. Recording risk	15
8. Implementation.....	17
9. Communication / Dissemination	18
10. Monitoring.....	18
11. Review.....	19
12. Archive Arrangements.....	20
13. References.....	20
14. Version Control	20
Appendix A - Corporate Framework	24
Appendix B - Board assurance and escalation framework	25
Appendix C - Governance Committee Structure.....	36
Appendix C1 – Service Line Risk Management Structure	37
Appendix D - List of Trust Policies and Guidelines Relevant to Risk Management	38

1. Introduction

Kingston Hospital NHS Foundation Trust is committed to a Risk Management Strategy which minimises risk to all of its stakeholders through a comprehensive system of internal controls, whilst maintaining the potential for flexibility, innovation and best practice in delivery of its strategic objectives around delivering high quality care. The Risk Management Strategy provides a framework for taking this forward through internal controls and procedures which encompass strategic, financial, quality, reputational, compliance and health & safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centred services that achieve excellent results and promote the best possible use of public resources, through an integrated approach to managing risks from all sources. ***The strategy also seeks to support consistency and standardisation through the gathering and dissemination of intelligence on risks and mitigation control measures amongst all staff.***

The Risk Management Strategy should be read in conjunction with the Risk Identification, Assessment and Risk Register Procedure which includes the process to identify and manage local risks and the systematic means by which these local risks are escalated to Board level attention through the Corporate Risk Register and how risks are controlled and monitored. Linked to the strategy are a number of operational procedures for risk and incident management which are referenced in the Corporate Framework attached at **Appendix A**.

The Trust also has a Board Assurance Escalation Framework in place which demonstrates how the Trust's policies, systems and processes work together to provide an effective and robust governance structure enabling the identification of emerging issues and their monitoring, escalation and management at appropriate levels and in a timely way. This is attached at **Appendix B**

~~***In October 2013 a number of changes to the Divisional and Board governance structures were made. The new structures are attached at Appendix C. These recent governance changes will need time to become embedded. To ensure that this Strategy remains accurate and reflects the Trust's processes and Risk Management approach it is reviewed every year. Some further elements of the restructure are still being embedded and will reflect in future reviews.***~~

The Trust has identified three key risks to the achievement of its strategic objectives over the next five years which are outlined in the Trust's 5 year Integrated Business Plan (IBP). These risks are reflected in the Corporate Risk Register and Board Assurance Framework, and are:

- That financial and productivity plans are not delivered
- Fluidity in the external environment
- Insufficient organisational capacity and delivery of cultural change to deliver our vision

The following document therefore sets the aims and objectives for risk management and the assurance mechanisms for measuring progress.

Trust Policy Equality Statement

This Strategy forms part of Kingston Hospital NHS Foundation Trust's commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

2. Definitions

Risk is defined as ‘the chance of something happening, or a hazard being realised that will have an impact upon objectives’ (NPSA). It is measured in terms of consequence and likelihood.

Risk management therefore encompasses;

the process of minimizing risk to an organization by developing systems to identify and analyze potential hazards to prevent accidents, injuries and other adverse occurrences, and by attempting to handle events and incidents which do occur in such a manner that their effect and cost are minimized.

(MeSH 2009 cited in Dückers 2009, p.1)

Effective risk management can therefore be described as a systematic process for proactively identifying risks and opportunities by assessing and removing the uncertainty they pose while minimising their potential consequences, likelihood and impact on the achievement of strategic objectives.

Effective management of operational risks is very important here as this refers to the robust mitigation of risks associated with the delivery of key business processes and high quality patient-centred care within a safe environment. Operational risks may include:

- *Clinical Risks: These are risks which relate to the provision of high quality patient-centred care e.g. Medication Errors, Patient Falls, and Patient Safety Risks.*
- *Non-clinical Risks: These are risks associated with the environment in which patient care takes place including the use of facilities by staff, patients, contractors and other visitors e.g. Health and Safety Risks, Financial Risks, Reputational Risks, Information Governance Risks etc.*

The Trust uses effective risk management as a tool for improving the quality of patient care and safety of its patients, staff, visitors and contractors while further identifying and mitigating risks which could compromise the achievement of strategic objectives.

Risk can mean different things in different contexts. For the purposes of this Strategy and the associated operational procedures, the risks faced by the Trust have been refined into 4 categories, which are reflected in the Risk Registers. Boundaries between the categories are not always clear and some risks may fall into more than one category:-

Quality	<p>These relate to risks which would impact on;</p> <ul style="list-style-type: none"> • Patient safety and experience, • Clinical outcomes • Compliance issues, for example, meeting statutory and non-statutory standards set by the care quality commission, NICE, the NHS litigation authority and other regulatory or enforcement bodies. • Reputational risks for example events which may damage the credibility or good name of the Trust
Health & Safety	<ul style="list-style-type: none"> • Infrastructure, • Employee safety, • The safety of visitors to the trust’s premises • Compliance issues, for example, meeting statutory and non-statutory standards set by health and safety executive and

	other regulatory or enforcement bodies such as the information commissioner and local fire authority
Strategic	These relate to risks which would impact on; the long term strategic objectives of the Trust, which may be affected by legal and regulatory changes and changes in the business environment
Financial	These relate to risks which would impact on;: <ul style="list-style-type: none"> • Income, • Expenditure, • Fulfillment of contracts • The correct application of standing orders, standing financial instructions and the scheme of delegation

3. Strategic Aims

The Trust's key aims are to manage risks where they occur as part of normal line management responsibilities, and appropriately prioritise resources to address risk issues through the operational management and business planning processes.

Strategic aims for the Risk Management Strategy are;

- Compliance with relevant statutory, mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission (CQC)
- Consistent and effective risk management processes at all levels of the organisation
- Open culture where people feel encouraged to take responsibility for minimising risks
- The development of a learning culture to support improvements to the safety of services
- Integration of risk management into business processes, such as ensuring service developments do not adversely impact on safety

Specific measurable objectives for **2016 to 2019** are set out below. These objectives will be reviewed annually by the Quality Assurance Committee and Audit Committee and progress against them will be assessed six monthly by the **Executive Management Committee**;

- To maintain compliance with regulatory requirements
- To ensure robust governance arrangements as we change management structures
- To strengthen the incident and SI investigation process so that investigations and actions are more robust

4. Individual Roles and Responsibilities for Risk Management

The Chief Executive

The Chief Executive, as Accountable Officer has overall responsibility for risk management and for ensuring the Trust has a Risk Management Strategy and infrastructure in place to provide a comprehensive system of internal control and systematic and consistent management of risk. S/He will delegate specific roles and responsibilities to the appointed Executive Directors/Senior Managers to ensure risk management is co-ordinated and implemented equitably to meet the Trust objectives safely without detriment to patient care. ~~The Chief Executive line manages the Divisional Directors and chairs the Clinical Quality Improvement Committee.~~

Chief Operating Officer

The **Chief Operating Officer** is responsible for ensuring that risks related to the delivery of the quality, performance and finances of the clinical directorates are identified and controlled through the Performance Management Review meetings between the Divisional Directors

and the Service Line structures. ~~*The Deputy Chief Executive chairs the Compliance and Risk Committee.*~~

Head of Corporate Affairs/Company Secretary

The Head of Corporate Affairs/Company Secretary has operational responsibility for the governance and risk management processes across the Trust and leads on the development of governance processes, the Board Assurance Framework and the Corporate Risk Register.

Director of Nursing and Patient Experience

The Director of Nursing and Patient Experience has responsibility for ensuring risks related to quality are identified and controlled and for Patient Experience and safeguarding agendas and is the Director of Infection Prevention and Control.

Medical Director

The Medical Director has the overall responsibility for leading on, and the delivery of, the patient safety agenda and for ensuring quality and the best possible clinical outcomes, as well as enabling medical staff to achieve better outcomes and a safe service. As part of this s/he will ensure that there are processes in place for sharing learning between departments. S/he is also the Caldicott Guardian, *the lead for duty of candour* and responsible for Medical Revalidation. The Medical Director has overall responsibility for the Serious Incident policy and processes.

Director of Finance

The Director of Finance is responsible for ensuring that proper systems are in place and operated correctly to minimise financial risk. In addition the Director of Finance has a responsibility for ensuring that proper reporting exists and for advising the Board on financial strategy. The Director of Finance is the Senior Information Risk Officer (SIRO) and has a role in minimising information governance risk. *S/he has specific responsibility for the leadership and delivery of the Health and Safety agenda and Estates Strategy [subject to confirmation of Executive Director portfolios]. ~~She/he Chairs the Compliance and Risk Working Group which operationally manages the processes around the Corporate Risk Register (CRR) and the BAF and other operational work on behalf of the Compliance and Risk Committee.~~*

Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development is responsible for delivery of the Workforce Strategy and objectives, and is the lead for ensuring compliance with equality and diversity requirements. She/he is responsible for ensuring that risks related to the delivery of the strategy and of the learning and development agenda are identified and controlled.

Director of Estates and Facilities

The Director of Estates and Facilities is responsible for ensuring that;

- A comprehensive programme of risk assessments exists in relation to the estate.
- The estate complies with statutory standards and best practice guidance in infrastructure and maintenance including waste management.
- Adequate provision is made in terms of specialist advice and training including in relation to fire.
- The *Director of Finance* is notified if there are insufficient resources to control the risks or no risk treatment plan can be identified.

Director of Information Management and Technology

The Director of Information Management and Technology (IM&T) is responsible for delivery of the IM&T Strategy. She/he is responsible for ensuring that risks related to the delivery of the strategy and the operational running of IM&T services are identified and controlled.

All Executive Directors

Executive Directors are accountable for the delivery of quality services in the areas within their remit whether clinical or operational, lead on the delivery of the Trust's Strategy and are responsible for ensuring risks are appropriately identified and controlled. They will ensure the quality agenda is effectively co-ordinated, resourced and implemented across the Trust in an integrated way. They will ensure actions taken to improve the quality of service delivery are completed, measured and shared to promote learning. Executive Directors are accountable for ensuring that the potential effect on the quality of service delivery is risk assessed prior to approval of any new business proposal. They will ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility is in place.

Service Lines and Corporate Departments

Each service line and corporate department has inclusive systems in place to ensure that all aspects of their work are subject to regular review across all specialties and teams. This will be identified within their documented governance structure and reflect the Trust requirement for specified outcomes for each aspect of service provision.

Divisional Directors, Clinical Directors, Service Line Managers, Service Line Risk Leads and other Managers with an operational role

All Senior Managers are responsible for ensuring systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust's priorities.

Divisional and Clinical Directors, with support from Associate Directors and Service Line Managers, are accountable for managing the strategic development and implementation of integrated risk and governance within their Divisions and Service Lines. This includes ensuring:

- Systems are in place to identify, assess and manage risks through implementation and review of the Service Line Risk Register.
- Effective systems are employed for reporting, recording and investigation of all adverse events, such as serious incidents, incidents, near misses, complaints and claims.

They will identify risks within the service line, will ensure appropriate actions are taken to mitigate these risks, and will comply with the reporting and governance requirements to ensure learning is shared across the organisation. They will monitor their staff and service compliance against identified standards and safe systems of work whether set nationally or locally and will facilitate and act upon regular user feedback.

Corporate Risk Manager

Reporting to the Head of Corporate Affairs **and Company Secretary**, it is the responsibility of the Corporate Risk Manager to ensure that:

- The Risk Management Strategy is being implemented at an operational level.
- The Risk Management Programme is coordinated and monitored across the Trust.

- To maintain the Corporate Risk Register as an active document and monitor treatment plans.
- To monitor that the risk and safety requirements of external agencies, such as the MHRA, NHSLA, Health and Safety Executive and Care Quality Commission are being implemented.
- To implement the process to ensure that risks highlighted in external reviews and reports are addressed by the Trust.
- Co-ordinating the risk management training programme
- **Accredited Service Lines, Non-Accredited Service Lines and Corporate Departments continually and regularly review their risk registers.**

Head of Clinical Audit and Effectiveness

The Head of Clinical Audit and Effectiveness, reporting to the Medical Director is responsible for ensuring that:

- Arrangements are in place to enable prioritisation of topics related to risk, for inclusion in the annual clinical audit programme.
- Guidance is provided through the Clinical Audit group to ensure that action plans are developed and their implementation is monitored.

Head of Procurement

The Head of Procurement, reporting to the Director of Finance, is responsible for:

- Providing advice and guidance on purchasing strategies, to enable the minimisation of risk.
- Working with the Corporate Risk Manager to maintain an effective response to MHRA guidance.

Quality Improvement Leads for Patient Safety

The Quality Improvement Leads for Patient Safety are responsible for:

- Providing specialist clinical safety advice and support to managers within their Service Lines as required.
- Being a source of expertise and training for root cause analysis techniques.
- Developing and implementing risk management training programmes.
- Providing guidance for those undertaking risk assessments and other local risk management functions.
- Supporting the analysis of trends obtained from incidents, with the Head of Litigation, Complaints and PALS triangulating the data with complaints and litigation, providing information and recommendations to relevant committees and service line groups.
- Acting as the link between their Service Lines and the corporate functions on risk management issues.
- Supporting and advising on the continued development of Service Line risk registers and assisting in the development of risk mitigation plans.
- Leading, and supporting, the coordination of the Serious Incident (SI) investigation process, acting as advisors on root cause analysis methodology and the delivery of the SI Procedure.
- Reviewing all reported Patient Safety incidents.

Health and Safety Advisor

The Health and Safety Advisor, reporting to the Head of Corporate Affairs and accountable to the **Director of Finance** as Board lead on health and safety, is responsible for:

- Acting as a Specialist Advisor (competent person) to the Trust on compliance with health and safety legislation, standards, policies and procedures.
- Ensuring adequate investigation and follow up to health and safety incidents, providing reports, analysis and identifying trends.

- Identifying specific health and safety risks and ensuring that they are adequately assessed and recorded and mitigated.
- Responding to health and safety issues identified through complaints, legal claims, and medical device alerts.
- Providing a comprehensive training programme for health and safety to staff.

Head of Litigation, Complaints and PALS

The Head of Litigation, Complaints and PALS, reporting to the Director of Nursing and Patient Experience, is responsible for the following areas in respect of risk:

As the lead for claims he/she is responsible for ensuring that any risk management issues or remedial action identified during the course of a claim, or during the review process on closure, is referred appropriately for action.

As the lead for complaints he/she is responsible for ensuring proper arrangements are in place for:

- Managing and Co-ordinating the investigation of formal complaints.
- Ensuring that the Trust Complaints Procedure is adhered to.
- Ensuring that investigations are completed by Service Lines in accordance with identified standards and that required follow up action is implemented in order to prevent recurrence.
- Providing information on a quarterly basis, in relation to complaints for inclusion in the aggregated risk management reports.

Information Governance Manager

The Information Governance Manager, reporting to the Director of Finance, is responsible for:

- Ensuring that the Trust meets statutory obligations in relation to information governance and freedom of information and that risks are identified and managed and where necessary drawn to the attention of the SIRO.
- Ensuring that the Trust complies with the requirements of the Information Governance Toolkit.
- Analysing and identifying trends in information governance from incidents, complaints or claims data.
- Providing training in information governance issues for staff.

All staff, including medical, nursing, allied health professionals, administrative and support staff (clinical and non-clinical)

All staff are accountable for the quality of services they deliver and complying with, and participating in, risk assessment processes as required. They will comply with identified standards and safe systems of work specific to their roles, whether identified in national, professional or Trust policy, procedures, and guidelines. They will report quality issues, however caused, through identified channels to ensure prompt action can be taken using existing reporting systems within the Trust.

As outlined above, all managers and staff have responsibility for managing risks within the services within which they work. The Table below outlines levels of specific responsibility.

1. All staff	Risk/hazards/complaints are reported in line with the appropriate policy, comply with policies, standard operating procedures and instructions to enable control of risks
2. Risk Assessors	Perform risk assessment and report findings in accordance with the process for managing risk
3. Quality Improvement Leads for Patient Safety	Ensure that risk assessments are included on the Service Line Risk Registers, ensure treatment plans are in place and monitored. Analyse incident information supporting the Service Lines in the identification of trends Support the investigation of serious incidents and monitoring of changes arising from investigations.
4. Service Line Managers	Review and prepare their Service Line Risk Register. Ensure treatment plans for risks, incidents and complaints are in place. Ensure there are arrangements to monitor the treatment plans.

5. Governance Structure for Risk Management

The Committee structure set out below is designed to ensure that all risks are being effectively identified and managed.

The current Service Line risk management structures and their inter-relationship with the Trust-wide committees are outlined in **Appendix C1**.

Terms of reference for all these Committees and the local Risk or Governance Groups are available on the Trust intranet (Our Hospital/Structure/Committee Structure).

5.1 High Level Committees with Overarching Responsibility for Risk Management

The high level committees with overarching responsibility for risk management are:

- **The Trust Board** is responsible for establishing principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and through the Corporate Risk Register.
- **The Audit Committee**, on behalf of the Board, reviews the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives and also ensures effective internal and external audit.
- **The Quality Assurance Committee (QAC)** provides assurance to the Trust Board that there are adequate controls in place to ensure high quality care is provided to the patients using the services provided by Kingston Hospital NHS Foundation Trust.
- **The Finance and Investment Committee** is responsible for scrutinising aspects of financial performance as requested by the Board. It will conduct detailed scrutiny of major business cases and proposed investment decisions on behalf of the Board and will regularly review contracts with key partners.
- **The Executive Management Committee (EMC)** is the core leadership team for the Trust, and is responsible for developing, maintaining and supporting appropriate leadership behaviours and visibility within the Trust. It is responsible for ensuring the fullest clinical contribution to determining the strategic direction and its operational

delivery. The Committee monitors the delivery of the organisation's operational, quality, financial and performance targets, ensuring corrective strategies are agreed where required.

- **Implement this strategy and in doing so encourage and foster greater awareness of risk management throughout the Trust**
 - **Routinely review the Corporate Risk Register.**
 - **Ensure systems are in place to support delivery of compliance with legislation, mandatory NHS Standards, Monitor, CQC, NHSLA and other relevant bodies.**
 - **Identify risks to compliance with the various statutory bodies.**
 - **Monitor past and future external visits and any action plans in place to respond to any risks.**
 - **Oversee implementation of the Trust wide policy management process and review and ratify risk and non-clinical policies in accordance with the Policy on Trust wide Procedural Documents.**
- **The Clinical Quality Improvement Committee (CQIC)** leads the Trust strategy for the delivery of high quality clinical care ensuring that quality standards are maintained and constantly improved.
Specifically it will:

- Develop and implement the Trust Quality Strategy.
- Develop the annual Quality Account
- Use information derived from the analysis of adverse incidents, complaints and clinical data and audit to identify risks to quality and make improvements.
- Ensure the Trust utilises national and international best practice information to innovate and improve.
- Identify the key quality improvement projects for the Trust annually and ensure they are successfully delivered.
- Oversee quality assurance (QEIA) elements of the productivity programme.
- Inform **EMC** of risks to quality and ensure risks are described in the CRR.
- Support QAC in the delivery of its role.

5.2 Sub Committees and Groups with Specific Responsibility for Risk

The Sub Committees and Groups with specific responsibility for risk are summarised below. Terms of reference for all these Committees are available on the Trust intranet (Our Hospital/Structure/Committee Structure).

- **The Health & Safety Committee** is responsible for:
 - Overseeing the Trust's health and safety processes and systems.
 - Ensuring compliance with health and safety legislation.
 - Reviewing incidents and other sources of information, e.g. staff surveys, to identify trends.
- **The Patient Experience Committee** is responsible for:
 - Overseeing the Trust Patient experience processes and systems.
 - Ensuring delivery of the Patient Experience Strategy and annual work plan.
 - Reviewing complaints performance, identifying any trends and action to be taken.
- **The Information Governance Committee** is responsible for:
 - Overseeing the Trust Information Governance processes and systems.
 - Ensuring delivery of the Annual work plan.
 - Monitoring compliance with the Information Governance Toolkit.

- Reviewing relevant incidents, complaints and litigation, identifying any trends and action to be taken.
- Leading and co-ordinating improvements in data quality
- **The Audit and Clinical Effectiveness Committee** is responsible for:
 - Overseeing the Trust's clinical audit and effectiveness processes and systems.
 - Ensuring delivery of the annual work plan.
 - Monitoring the progress of red flagged actions resulting from clinical audits.
 - Identifying any risk issues highlighted in audit reports for follow up through Performance Review Meetings.
- **The Workforce Committee** is responsible for:
 - Providing leadership and oversight for the Trust on workforce issues that supports the delivery of the Board approved Workforce objectives.
 - Monitoring the operational performance of the Trust and Human Resources functions in people management, recruitment and retention, and employee wellbeing
- **The Equality and Diversity Committee** is responsible for:
 - Overseeing the Trust's diversity processes and systems.
 - Ensuring delivery of the annual work plan.
- ~~**The Compliance and Risk Working Group** is responsible for:~~
 - ~~Supporting the Compliance and Risk Committee in ensuring the organisation complies with relevant legislation and requirements to practice.~~
 - ~~Ensure that there are effective risk management systems in place.~~
- ~~**The Quality Working Group** is responsible for:~~
 - ~~Supporting the Clinical Quality Improvement Committee with analysed data and trends.~~
 - ~~Ensure that quality standards are maintained and constantly improved.~~
- **Service Line Performance Review Meetings** are responsible for:
 - Receiving and agreeing risk assessments from service areas within the Service Line
 - Ensuring that all risks relevant to the Service Line have been identified and assessed accurately
 - That the Service Line Risk Register is comprehensive
 - Monitoring the implementation of treatments plans
 - Reviewing incidents, complaints and claims trends as sources of risk intelligence.
 - Agreeing serious incident action plans and monitoring implementation of actions.
- **The Serious Incident Review Group** is responsible for:
 - Scrutinising and reviewing Serious Incident Root Cause Analysis (RCA) reports and Post Infection Reviews.

- Signing off Serious Incident RCA reports ahead of the submission to Kingston Clinical Commissioning Group
- Monitoring the SI Action Plan Tracker

- **Others**

There will be occasions when specialist groups will be required to support the management of specific risk areas. Depending upon the risk issue either the Clinical Quality Improvement Committee or the **EMC** will have overall responsibility for monitoring how those risks are controlled.

6. Key Principles of Risk Management at Kingston Hospital NHS Foundation Trust

Healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances will always involve an inherent degree of risk.

In broad terms, groups or areas that may be affected are;

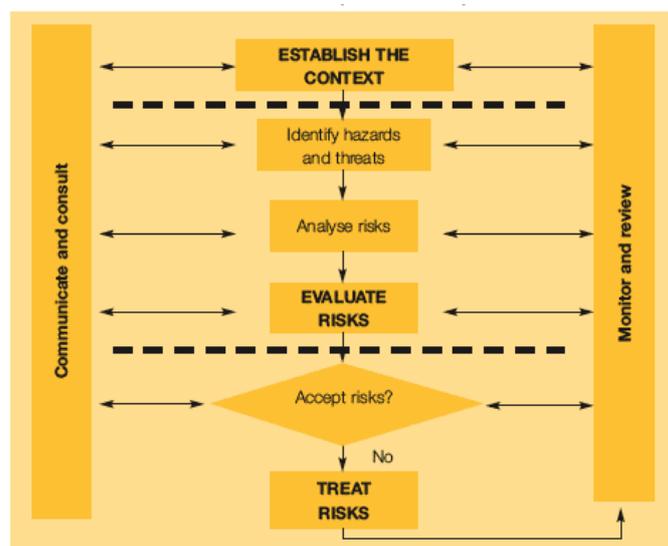
- Patients and visitors
- Staff (including contractors and volunteers)
- Finances
- The business of the Trust
- Compliance with statutory duties
- The Trust's reputation

The key sources of risks to **the above** groups are;

- Acts or omissions by staff
- Information systems and the reports they generate
- Trust estate and environmental impact
- Actions of contractors
- Business continuity i.e. the unexpected failure of a system, which may have a wide impact on delivery of services.
- Changes in the external commissioning environment

6.1 Identification of Risk

The process diagram below demonstrates the risk management identification, evaluation and treatment cycle.



6.2 Identification of Hazards or Threats

Possible risks may be identified through a variety of mechanisms, both reactive and proactive.

Proactive identification may arise from local risk assessments, impact assessments and gap analyses of published reports on healthcare subjects or inspections of other care providers. Reactive identification can be flagged as a result of a serious incident, a trend in incidents or complaints or as a result of an audit, either internal or external. More description of the risk identification process, and the triggers for risk assessment, is provided in the Risk Identification, Assessment and Risk Register Procedure.

6.3 Risk Evaluation

Risks are analysed and scored according to the process outlined in the Risk Identification, Assessment and Risk Register Procedure. As part of this process, current controls on the risks are evaluated. The aim of this process is to decide what further action to control the risk is required (treat the risk), or if the risk must be tolerated at its existing level (accept the risk).

Risk Controls are the available systems and processes which help to minimize risk.

The key controls used to manage risk are;

- Recruitment and training of competent staff
- Clear accountabilities and responsibilities for all levels of staff
- Effective Trust-wide policies
- Standard operating procedures for service areas
- Governance and risk management systems, such as incident reporting
- Performance framework
- Capital Investment programme
- Working with commissioners and partner organisations

6.4 Assurance on controls:

Assurances on controls are the methods by which the organisation measures the effectiveness of the controls in place.

Assurance on the effectiveness of the controls is provided at all levels of the organisation through;

- Internal and external audit of control mechanisms
- Key Performance Indicators
- Benchmarking and Peer reviews
- Performance review processes
- Self-assessment and internal challenge

Robust assurance and oversight on the adequacy and effectiveness of controls for mitigating and efficiently managing risks is also provided through other structures such as:

- ***Service Line and Departmental Clinical Governance Groups***
- ***Service Line and Departmental PRMs***

Comprehensive risk identification, assessment, and control are critical to being a high performing organisation and assuring the Board, Commissioners and regulators that risk is

well managed by the Trust. A separate procedure for the management of risk throughout the organisation, setting out the process for assessing risks, is contained in the Risk Identification, Assessment and Risk Register Procedure and is available to all staff.

6.5. Corporate Risk: A Corporate risk is one that meets any of the following criteria:

- **It is a high level risk that has been scored at ≥ 12 .**
- **It is a risk with Trust-wide implications or one that is viewed as Trust-wide.**
- **It is a risk that is deemed to deserve corporate visibility.**

6.6. Target Date: This is the date by which the risk is supposed to have been treated or reduced to a tolerable level at which its controls will have become embedded in operational practice and have become business as usual.

6.7. Timeframe for Review of Risk Registers:

This Strategy recommends in line with best practice that risk registers should be reviewed and updated at least once quarterly. Key risks should be reviewed more often depending on the perception of the impact of such risks in disrupting the achievement of strategic objectives were they to occur.

7. Recording risk

The two key documents that the Trust uses to record risks and the actions in train to mitigate the identified risks are the Board Assurance Framework and the Corporate Risk Register.

7.1 Board Assurance Framework(BAF)

The Board Assurance Framework (BAF) enables the Board to review its principal objectives to ensure there are sufficient controls in place to manage the risks to their delivery and to understand the assurance there is on the effectiveness of those controls. The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls.

~~**The assessment of risk within the Board Assurance Framework is reviewed at the Compliance & Risk Committee and managed through its working group.**~~ Scrutiny of the Board Assurance Framework is the principal responsibility of the Audit Committee with input from the Quality Assurance Committee in the areas of clinical quality and the Finance and Investment Committee. ~~**It is also reviewed by the Board at each meeting and at an Executive Level by the Executive Management Committee, Clinical Quality Improvement Committee and Patient Experience Committee.**~~

The Board Assurance Framework is closely linked with the Corporate Risk Register (CRR), which reflects significant risks identified at both a corporate department and divisional level. The Head of Corporate Affairs, through the Corporate Risk Manager and Assistant Company Secretary, will ensure that the link between the Corporate Risk Register and the Board Assurance Framework is maintained, and that the Audit Committee is satisfied that this is occurring. The Head of Corporate Affairs is a member of the Quality Assurance ~~**and Compliance and Risk Committees**~~ and attends the Audit Committee.

7.2 Corporate Risk Register (CRR)

The risk register is an active tool through which the Trust manages its risks. Its purpose is to log all risks identified in the high or extreme categories and the controls in place or planned to manage the risk to its lowest possible level (residual risk). The Corporate Risk Register is built up from the Service Line Registers and the organisation-wide and strategic risks identified in the BAF and Integrated Business Plan and from other risks identified by corporate committees and the Executive Team. Regular update and review of the CRR

provides assurance that risks are being managed and progress in controlling risks is maintained. The Trust process for populating a risk register is described in the Risk Identification, Assessment and Risk Register procedure, which is available to all staff. The principles that underpin the approach to the management of the risks identified on the CRR (and service line risk registers) are;

<i>Tolerate</i>	Accept the risk at its current level
<i>Transfer</i>	Transfer the risk to another party, i.e. by outsourcing, the consequences of this action will require risk assessing
<i>Terminate</i>	Stop the activity that presents the risk, the consequences of this action will require risk assessing
<i>Treat</i>	Take action to reduce or mitigate the risk, in terms of reducing the likelihood of its occurrence or reducing the severity of impact if it does occur

The Corporate Risk Manager manages the CRR process. ***The CRR is reviewed by the Executive Management Committee (EMC) quarterly*** and is presented to the Audit Committee who, where required, may request that risks are subject to further review. The CRR is also presented to the Quality Assurance Committee who will review those risks that relate to quality of care. The CRR is provided to the Board for approval on a quarterly basis.

7.3 Service Line and Departmental Risk Registers

The purpose of these local risk registers, including those within corporate departments, is to identify and monitor risks to the achievement of local objectives. All risks of whatever grading will be included so as to ensure comprehensive and regular scrutiny of all levels of risk. ***Risks that score 12 or above will be considered for inclusion in the CRR.*** Where it is agreed that the risk should sit on the CRR the risk will be considered for rescoring to take into account the corporate impact of the risk. ~~***The CRR is monitored by the CRC and the Board in addition to the relevant Service Line Performance Review Meeting. In addition the CRC reviews each Service Line Risk Register twice per year.***~~

Service Line Managers are responsible for the management of Service Line Risk Registers in collaboration with their Clinical Director and supported by the Quality Improvement Leads for Patient Safety.

7.4. Risk Escalation: Service Lines and Corporate Departments are expected to escalate risks which score 12 and above for consideration for inclusion onto the Corporate Risk Register.

7.5. Risk De-escalation: Service Lines and Corporate Departments can recommend that risks be de-escalated where they consider risks to have been mitigated sufficiently or where the risk is considered no longer to be relevant.

7.6. Board Assurance and Escalation Framework

The Board Assurance and Escalation Framework attached at **Appendix B** demonstrates how the Trust's policies, systems and processes work together, providing an effective and robust governance structure enabling the Trust to identify, monitor, escalate and manage emerging issues at the appropriate levels and in a timely way.

Assurance - describes the level of confidence that can be obtained by the Board, based on sufficient evidence that internal controls are in place, operating effectively and objectives are

being achieved. This document explains the key sources of assurance – both internal and external – that inform work of the Trust Board.

Escalation – is the process used within the Trust to ensure decisions are made at the right level to ensure continued quality of care, patient safety and delivery of corporate objectives. This process ensures risks over delegated thresholds and decisions outside delegated authority are escalated through the Trust's governance processes, and that these decisions are systematically and properly recorded.

8. Implementation

The implementation of this Strategy will be achieved through:

- Development of Service Line risk management frameworks to support the Trust Risk Management Strategy
- Providing training and support to managers to enable them to manage risk as part of normal line management responsibilities
- Effective use of the governance system and structures
- Risk assessments are undertaken systematically in all Service Lines and departments to identify risk, assess effectiveness of controls and implement treatment plans, where necessary.
- Delivery of actions plans at corporate, e.g. NHSLA and Organisational Development plans and at local level, e.g. individual risk treatment plans.
- Use of, and compliance with, policies to strengthen the systems of control
- Using information from risk assessment, incidents, complaints, audit and claims and other relevant external sources to improve safety and support organisational learning
- Internal and external audits and assessment to provide assurance of the effectiveness of controls to minimise risk

The corporate framework for monitoring risk management is set out in **Appendix A**.

8.1 Risk Management Training

A programme of Risk Management Training, including Risk Assessment and Root Cause Analysis is in place and is **administered by the Corporate Risk Manager**. Risk Management is also included on the induction programme for new starters.

In line with the Trust's Training Needs Analysis, contained within the Mandatory Training Policy and Procedure, specific Risk Management Awareness sessions are held for Board members and Senior Managers on an annual basis. The Board receives training on specific areas such as Risk Management, Information Governance, Health and Safety, Infection Control and Safeguarding.

The recording of attendance, follow up of non-attendance and monitoring the compliance with training requirements, is covered in the Mandatory Training Policy and Procedure (including Training Needs Analysis).

8.2 Policies and guidelines relevant to Risk Management

The policies and guidelines in place which are specifically relevant to Risk Management are listed in **Appendix D**.

9. Communication / Dissemination

The Risk Management Strategy will be provided to individuals with risk management responsibilities and made available in the Policy section of Trust Intranet for all staff to access. When published, all staff will be informed of its publication.

It is each individual Manager's responsibility to communicate the contents within their departments.

This Strategy recommends that intelligence on the effective mitigation and management of risks should be communicated and disseminated to all staff involved in the provision of services. Such sharing and dissemination of information on risks and the controls in place to mitigate them will strengthen local and shared ownership, empower staff, improve quality and engineer staff engagement in effectively mitigating risks and improving the quality and safety of patient care. Mechanisms such as staff meetings, handovers, targeted campaigns, information leaflets, posters, trainings etc can be used in fostering effective communication and dissemination of intelligence and information on the robust management of risks.

Copies of this Risk Management Strategy will be made available to all staff and Stakeholders, as appropriate.

10. Monitoring

Element to be Monitored	Lead	Tool	Frequency	Reporting	Lead for Actions
Objectives	Chief Executive	Review progress in achieving objectives	6 monthly	Executive Management Committee (EMCj)	Corporate Risk Manager
Governance structure – Risk Management Strategy: <ul style="list-style-type: none"> The organisation's risk management structure, detailing all those committees and groups which have some responsibility for risk How the board or high level risk committee(s) review the organisation-wide risk register How risk is managed locally Duties of the key individuals for risk management activities 	Head of Corporate Affairs	Review of committee structure.	Annual	EMC	Head of Corporate Affairs
Governance structure - TORs for the high level committee(s) with overarching responsibility for risk: <ul style="list-style-type: none"> Duties Who the members are, including nominated deputies where appropriate 	Head of Corporate Affairs	Terms of Reference of Board Committees are reviewed at least annually	Annual	Board	Head of Corporate Affairs

Element to be Monitored	Lead	Tool	Frequency	Reporting	Lead for Actions
<ul style="list-style-type: none"> How often members must attend Requirements for a quorum How often meetings take place Reporting arrangements into the high level risk committee(s) Reporting arrangements into the board from the high level risk committee(s) 		Annual reports for each committee reporting to EMC demonstrate compliance with terms of reference, reporting and attendance.	Annual	EMC	Chairs of Committees
Risk management process: <ul style="list-style-type: none"> How all risks are assessed How risk assessments are conducted consistently Authority levels for managing different levels of risk within the organisation How risks are escalated through the organisation 	Head of Corporate Affairs	Review of risk management process /Audit	Annual	EMC	Corporate Risk Manager
Board Assurance Framework	Head of Corporate Affairs	Review of BAF risks and actions progress/ Audit	Every Board meeting	Board	Assistant Company Secretary

11. Review

This Strategy will be reviewed by the Audit Committee at least on an annual basis to ensure its objectives remain current and relevant. Progress against the objectives will be reported to the Executive Management Committee and the Audit Committee bi annually.

12. Archive Arrangements

This strategy will be added to the Policy Information Management System (PIMS) and will be archived in accordance with the Policy on Procedural Documents.

13. References

National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA March 2010)
 Care Quality Commission Essential Standards (Dec 2010)
 Risk Management in the NHS (DH 1993)
 An Organisation with a Memory (DH 2000)
 Monitor Applying for FT Status: Guide for Applicants (Dec 2008)
 Kingston Hospital NHS Trust Integrated Business Plan (IBP October 2012)

14. Version Control

Version Control Sheet

Version	Date	Author	Status	Comment
V9	Jan 2011	Head of Risk & Safety	Ratified	<ul style="list-style-type: none"> Document is a merger of the previous Risk Management Strategy (V8) and Risk Management Policy (V8) New Strategic aims and objectives Addition of Key Committee's Terms of Reference Updated committee structure included Management & population of Risk Register information added Dissemination section added
V10	Dec 2011	Head of Risk & Safety	Ratified	<ul style="list-style-type: none"> Revised Strategic aims and objectives Revised to reflect amended Board governance structure and functioning, including change of Strategic Risk Committee name New monitoring table in line with NHSLA requirements Removal of procedural guidance to create the 'Risk Identification, Assessment and Risk Register Procedure'
V11	January 2013	Deborah Lawrenson, Head of Corporate Affairs Jacky Bush, Head of Quality & Risk Assurance	Ratified	<ul style="list-style-type: none"> Revised Strategic aims and objectives Refined the Risk Categories Amended structure charts Updated job and committee titles and roles and moved them in to the main document Synergised with the Trust's Integrated Business Plan Updated to ensure compliance with NHSLA Clarification of roles and responsibilities Addition of the Board Assurance and Escalation Framework as an appendix
V12	January 2014	Tam Moorcroft, Corporate Risk	Ratified	<ul style="list-style-type: none"> Revised objectives Health & Safety added as a risk

		<p>Manager Jacky Bush, Head of Quality & Risk Assurance Deborah Lawrenson, Head of Corporate Affairs</p>		<p>category</p> <ul style="list-style-type: none"> • Individual and committee roles and responsibilities updated following re-structure • Reference to Divisions, replaced with Service Lines • Amend the process for risk escalation onto the CRR
V13	November 2014	<p>Tam Moorcroft, Corporate Risk Manager Deborah Lawrenson, Head of Corporate Affairs</p>		<ul style="list-style-type: none"> • Reviewed to ensure a fair reflection of current structure. • Appendix B – the Board Assurance and Escalation Framework will require some updating in relation to references to NMAC and The Matron’s Forum • Appendix C – latest governance structure document to be included • Page 6 – removal of reference to the Associate Director role and addition of reference to local risk leads in supporting the service lines • Addition of responsibilities for the Director of Workforce & OD, Director of IM&T and the Workforce Committee. • Divisional Risk Managers title changed to Quality Improvement Leads for Patient Safety and roles redefined.
V14	December 2015	<p>David Tita, Corporate Risk Manager Susan Simpson, Head of Corporate Affairs and Company Secretary.</p>		<ul style="list-style-type: none"> • Another objective of this Risk Management Strategy added, p.3 • An explanation of Risk Management added for more clarity, p.4. • Description of Operational Risks has been included, p.4 • Addition to role of CRM to ensure that Service Lines regularly review their RRs, p.7-8. • Other structures for oversight and assurance included p.15 • Descriptions of Corporate

				<p><i>Risk (6.5), Target Risk (6.6) added, p.15</i></p> <ul style="list-style-type: none"> • <i>Timeframe for review/update of risk registers (6.7), added, p.15</i> • <i>Threshold at which risks are escalated is raised to 12. p.16</i> • <i>Descriptions of Risk Escalation (7.4) & De-escalation (7.5) p.17</i> • <i>Recommendation for communication & dissemination of intelligence on effective management of risks, p.17</i> • <i>Amendment throughout to remove Compliance & Risk Committee (and working group) but to transfer responsibilities to EMC.</i>
--	--	--	--	---

Appendix A - Corporate Framework

Process	Action	Responsibility	Timeframe
Board Assurance Framework	Review of BAF	Board	Every meeting
		Committees with lead responsibility for a particular section of the BAF	Every meeting
		Audit Committee	Quarterly
Corporate Risk Register	Review of register	Executive Management Committee	Quarterly
		Audit Committee & Quality Assurance Committee	Quarterly Every two months
		Board	Quarterly
Service Line risk registers	Review of Risk Registers	Performance Review Meetings Compliance & Risk Committee	Monthly Bi-annually
Corporate Services Risk Registers	Review of Risk Registers	Performance Review Meetings	Quarterly
Annual Governance Statement	Statement written as part of annual accounts	Chief Executive Director of Finance	Annual
Risk management training and education	Delivery of targeted training programme	Corporate Risk Manager	Monthly induction of new staff Annual programme for all staff
Risk management process	Review of Risk Management policies and associated procedures and guidance	Corporate Risk Manager	Annual
Risk Management Strategy	Review and update	Corporate Risk Manager	Annual