Kingston Hospital NHS
NHS Foundation Trust

Risk Management Strategy 2014/2016

Trust Board	**Item: 8.4**
29th January 2014	**Enclosure: L**
Purpose of the Report: To present the Trust Board the updated Risk Management Strategy for ratification. The Strategy has been reviewed by the Quality Assurance Committee and was approval by the Audit Committee in December 2013. The key changes are shown in red text in the Strategy.	
FOR: Information ☐ Assurance ☐ Discussion and input ☒ Decision/approval ☒	
Sponsor (Executive Lead):	Deborah Lawrenson, Head of Corporate Affairs / Company Secretary
Authors:	Deborah Lawrenson, Head of Corporate Affairs Jacky Bush, Head of Quality & Risk Assurance Tam Moorcroft, Corporate Risk Manager
Author Contact Details:	Deborah Lawrenson, ext 2522 Jacky Bush, ext 3846 Tam Moorcroft, ext 2536
Risk Implications – Link to Assurance Framework or Corporate Risk Register:	
Legal / Regulatory / Reputation Implications:	
Link to Relevant Corporate Objective:	To deliver quality, patient centered healthcare services with an excellent reputation
Document Previously Considered By:	Objectives considered by RMC and Quality Assurance Committee. Strategy approved by Compliance and Risk Committee for submission to Audit Committee
Recommendation& Action required by the Board : The Board is asked to: a) **Ratify** the revised Risk Management Strategy; and b) **Agree** a mid-year review should take place	

Summary

1. The Risk Management Strategy provides a framework for risk management within Kingston Hospital NHS Foundation Trust. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centered 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 Risk Management Strategy is reviewed and updated every year.

Approval and Ratification process

2. The process of updating and approval is:

    - Revised objectives were agreed by the Risk Management Committee in October 2013, and the Quality Assurance Committee in November 2013, and amended by the Audit Committee in December 2013

    - The updated strategy was signed off by the Compliance & Risk Committee in November 2013

    - The strategy was approved by the Audit Committee in December 2013

    - The updated strategy is being presented to the Trust Board today for ratification.

Revisions to the Strategy

3. Version 11 of the Strategy has been reviewed, by the Corporate Risk Manager, the Head of Quality and Risk Assurance and the Head of Corporate Affairs / Company Secretary. This review has resulted in the following changes (shown in red in the main document);

    - Inclusion of Health and Safety as a risk category. This category had been removed in version 11 of the strategy; however, to ensure that the correct risks are reviewed by the appropriate committees, and to reflect the new governance structure, this category has been reinstated.

    - Updated risk management objectives, these were reduced to three by the Audit Committee prior to approval

    - Updating of individual and committee roles and responsibilities following the October 2013 governance re-structure and the move to Service Line Management

    - References to Divisions have been replaced with Service Lines, to reflect the recent changes

    - Amendment to the process for risk escalation onto the Corporate Risk Register

    - An amended chart showing the local risk management and governance arrangements, as required by the NHSLA standards. It is important to note that as Service Line Management develops these structures will mature and be modified.

Review of the Strategy

4. The Risk Management strategy is routinely subject to an annual review, with a half yearly review of progress against the objectives.

5. As the recent governance changes become embedded, some minor process and structure changes may occur. It is therefore recommended that there is a mid-year review of the Strategy, to ensure that it remains accurate and reflective of the Trust's processes and Risk Management approach.

Recommendations

6. The Board is asked to:
   a) **Ratify** the revised Risk Management Strategy; and
   b) **Agree** a mid-year review should take place

Kingston Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY 2013-2016

Policy Author	**Jacky Bush, Head of Quality & Risk Assurance and Deborah Lawrenson, Head of Corporate Affairs**
Version	**12**
Impact Assessment Date	**1st June 2009**
Ratifying Committee	**Trust Board**
Date Approved	**January 2014**
Review date	**July 2014 (mid-year review due to introduction of SLM)**

CONTENTS

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 is reviewed annually. 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.

It is supported by 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 the Strategy remains accurate and reflective of the Trust's processes and Risk Management approach a mid-year review of the strategy will take place.

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 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 3 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**	These relate to risks which would impact on; • 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**	• 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 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 risks which would impact on;: • 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 2013 to 2016 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 Compliance and Risk 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.

Deputy Chief Executive

The Deputy Chief Executive 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. S/he has specific responsibility for the leadership and delivery of the Health and Safety agenda and Estates Strategy. 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 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. She/he Chairs the Compliance and Risk Working Group which operationally manages the processes around the 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 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 Deputy Chief Executive is notified if there are insufficient resources to control the risks or no risk treatment plan can be identified.

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, Associate Directors, Service Line Managers 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.

The Company Secretary, Head of Corporate Affairs

The Company Secretary and Head of Corporate Affairs is responsible for the governance processes relating to managing risks and for monitoring compliance with the policy framework and for co-coordinating the updating of the CRR for reporting to Trust Board.

Corporate Risk Manager

Reporting to the Head of Corporate Affairs, 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 NPSA, 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 programmes

Head of Clinical Audit and Effectiveness

The Head of Clinical Audit and Effectiveness, reporting into 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 into 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.

Divisional Risk Managers

Divisional Risk Managers are responsible for:

- Providing specialist clinical safety advice and support to managers within their divisions as required.
- To be a source of expertise and training for root cause analysis techniques.
- Guidance for those undertaking risk assessments and other local risk management functions.
- Developing and implement risk management training programs.

- Analysing 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 divisions and the corporate functions on risk management issues.
- Coordinating the generation of Service Line risk registers and assist in the development of risk mitigation plans.

Health and Safety Advisor

The Health and Safety Advisor, reporting into the Head of Corporate Affairs and accountable to the Deputy Chief Executive 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 into 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 into 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. Divisional Risk Managers	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 Divisions 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**. These structures were introduced in October 2013 and will develop further during 2013/14.

Terms of reference for all these Committees and the Divisional 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. It

- **The Compliance and Risk Committee** (CRC) ensures delivery of the organisation's risk management procedures and practice

  Specifically it will;

  o
  - o Develop, review and implement this strategy.
  - o Constantly review the Corporate Risk Register.
  - o Ensure systems are in place to support delivery of compliance with legislation, mandatory NHS Standards, Monitor, CQC, NHSLA and other relevant bodies.
  - o Develop, review and implement the BAF for approval by the Board.
  - o Monitor delivery of BAF action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms.
  - o Lead annual reviews of the Trust's governance processes to take account of current best practice and relevant codes of governance.
  - o Identify risks to compliance with the various statutory bodies.
  - o Encourage and foster greater awareness of risk management throughout the Trust
  - o Monitor past and future external visits and any action plans in place to respond to any risks.
  - o 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 CRC is supported by a number of subject-specific sub committees, which are responsible for risks within a defined area and these are identified in **Appendix B**.

- **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:

  - o Develop and implement the Trust Quality Strategy.
  - o Develop the annual Quality Account
  - o Use information derived from the analysis of adverse incidents, complaints and clinical data and audit to identify risks to quality and make improvements.
  - o 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 CRC 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 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 Compliance and Risk Committee 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

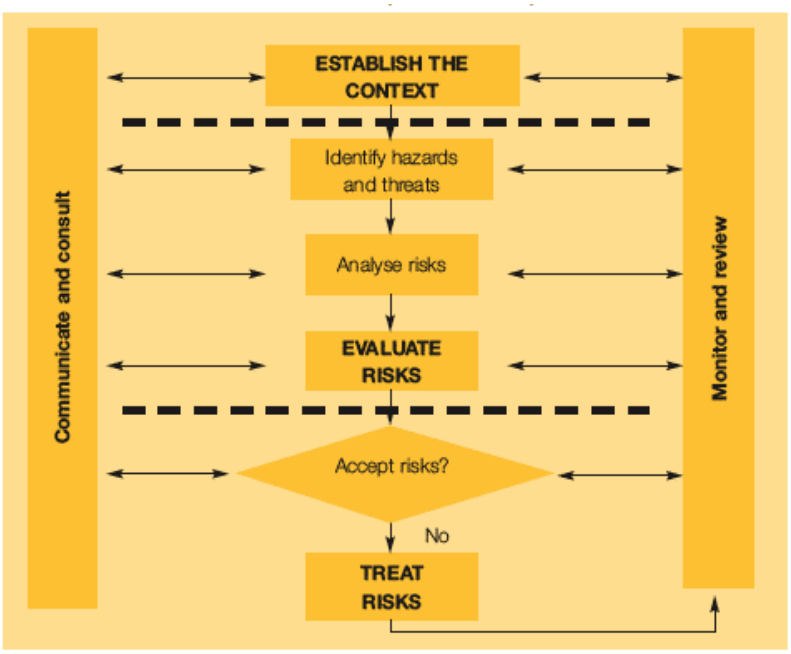
The key sources of risks to those groups are;

- 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

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.

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

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;

Tolerate	Accept the risk at its current level
Transfer	Transfer the risk to another party, i.e. by outsourcing, the consequences of this action will require risk assessing
Terminate	Stop the activity that presents the risk, the consequences of this action will require risk assessing
Treat	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 Compliance and Risk Committee (CRC) and Working Group monthly, working through each risk in detail and through reviewing service line risk registers, any proposals for escalation and de-escalation. The CRR is presented to the Audit Committee who, where required, will request that risks are either subject to further review by the CRC. 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 8 or above will be considered by the Compliance and Risk Committee Working Group 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 Divisional Risk Manager.

7.4 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, Root Cause Analysis, is in place and is delivered by the Risk and Safety Team. 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 at the start of the Trust Board meetings.

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 via the Daily Bulletin.

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

Copies 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	Compliance & Risk Committee (CRC)	Corporate Risk Manager
Governance structure – Risk Management Strategy: • 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 and CRC	Head of Corporate Affairs
Governance structure - TORs for the high level committee(s) with overarching responsibility for risk: • Duties • Who the members are, including nominated deputies where appropriate • 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)	Head of Corporate Affairs	Terms of Reference of Board Sub Committees are reviewed at least annually (5.1) Annual reports for each sub-committee of CRC (5.2) demonstrating compliance with terms of reference, reporting and attendance. TORs are reviewed at least annually as part of these reports	Annual Annual	Board CRC	Head of Corporate Affairs Chairs of CRC sub Committees
Risk management process: • 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	Compliance & Risk Committee (CRC)	Head of Quality and Risk Assurance
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 Compliance & Risk Committee, 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 Compliance and Risk Committee, Quality Assurance 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)
SLM revised structures (October 2013)

14. Version Control

Version Control Sheet

Version	Date	Author	Status	Comment
V9	Jan 2011	Head of Risk & Safety	Ratified	• 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	• 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	• 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 Manager Jacky Bush, Head of Quality & Risk Assurance Deborah Lawrenson, Head of Corporate Affairs		• Revised objectives • Health & Safety added as a risk category • 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

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	Compliance & Risk Committee	Monthly
		Audit Committee & Quality Assurance Committee	Quarterly Every two months
		Board	Quarterly
Service Line risk registers	Review of Risk Registers	Performance Review Meetings	Monthly
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	Head of Quality and Risk Assurance	Monthly induction of new staff Annual programme for all staff
Risk management process	Review of Risk Management policies and associated procedures and guidance	Head of Quality and Risk Assurance	Annual
Risk Management Strategy	Review and update	Head of Quality and Risk Assurance	Annual

Appendix B - Board assurance and escalation framework

Kingston Hospital NHS
NHS Foundation Trust

Board assurance and escalation framework

Updated

November 2013

Version	Description	Date
0.1	Initial outline framework	2 April 2012
0.2	First draft document	26 April 2012
0.3	Following EMT discussion 30 April 2012	
0.4	JB comments	29 May 2012
0.5	Review by Governance Planning Group	20 June 2012
0.6	CM additions re Audit Committee	27 July 2012
0.7	JP and DL amendments – review by Governance Planning Group	4 October 2012
0.8	DL amendments following review by GPG	2 November and 9th November 2012
0.9	DL amendments following review by EMT and GPG	12th November and 15th November 2012 GPG
10.0	DL amendments to fit with review of Risk Management Strategy	November 12th 2013

Contents

Appendices available on request

1. Introduction

1.1. This framework 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. These systems are fundamental to support high quality and safe patient care, underpinning the Trust's vision for local people to choose Kingston Hospital NHS Foundation Trust because they recognise it for delivering consistent and excellent care services.

2. Definitions

2.1. **Quality** – the Quality Strategy explains how the Trust defines quality based upon the three domains described in *High Quality Care for all (Darzi, 2007)* – patient safety, patient experience, and the effectiveness of care. The principles of that strategy are consistent with Monitor's *Quality Governance Framework*, emphasising the importance of processes and structures to:

- Ensure required standards are met;
- Investigate and take action on substandard performance;
- Plan and drive continuous improvement;
- Identify, share and ensure delivery of best practice;
- Identify and manage risks to the delivery of care.

2.2. **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.

2.3. **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.

3. Purpose

3.1. This framework covers quality, financial and other aspects of governance. It explains the Trust's governance structure, as well as the systems and performance indicators through which the Trust Board receives assurance. It describes the processes for escalation of emerging concerns or risks that could threaten delivery of corporate objectives, service delivery or patient safety.

3.2. The escalation framework was first approved by the Board in January 2013 and has been updated to take account of the role of the Council of Governors and to reflect changes to the Risk Management Strategy following the governance review in 2013 and the introduction specifically of service lines.

4. Culture

4.1. Policies, systems and processes are necessary but not sufficient; the Trust recognises these must exist within an organisation whose culture, purpose and values all support good governance. The Trust strives, therefore, to put quality first throughout the organisation, from ward to Board and in all of its supporting and administrative areas. It aims to provide an open and learning culture, encouraging the reporting of all adverse incidents, complaints and concerns by staff, patients, their carers and relatives. This is supported by the work to *Live Our Values Everyday* so we:

- Design and deliver care around each individual patient's needs and wants;
- Make the safety of patients and our staff our prime concern;
- All take responsibility for the hospital, its services and our own actions; and
- All value each other's contribution and the reputation of the hospital.

5. Staff involvement

5.1. The Trust encourages staff at all levels to be involved in performance monitoring and to raise concerns about any risk issues in a systematic way. Working within a strong culture of support and clear accountability delivered through effective line management, the Trust encourages staff involvement through mechanisms including:

- Raising Concerns at Work (Whistleblowing) Policy;
- HR policies such as the Grievance Policy and Procedure;
- Policies on Safeguarding (Vulnerable Adults and Children);
- Risk Management Strategy,
- Risk identification, assessment of Risk Register procedure
- Serious Incidents Procedure;
- Trust Partnership Forum;
- The team briefing system;
- Chief executive open forums;
- Frontline Focus Friday;
- Regular executive and non-executive director walkabouts;
- Staff surveys;
- The induction programme.

6. Patient and carer involvement

6.1. The Quality Strategy approved by the Board describes a range of planned actions designed to ensure patients, their carers and/or representatives are involved, heard from and listened to. Progress will be monitored by the Patient Experience Committee and reported annually in the Quality Account. Ways of obtaining feedback from patients include:

- Patient Advice and Liaison Service (PALS);
- Complaints (informal and formal);
- Patient stories;
- Patient Experience Tracker tools;
- Local Involvement Networks and local Healthwatch;
- Local Authority – Health Overview and Scrutiny Committee.
- Net promoter score

6.2. A refreshed Patient and Public Involvement Strategy was approved by the Board in July 2013

6.3. The Trust has a Council of Governors in place. Governance arrangements are established with committees for Nominations and Remuneration; Membership and Engagement; Quality Scrutiny and Strategy. Further work is taking place in 2013/14 to develop plans for further involvement of the governors and the membership.

7. Internal and external sources of assessment and assurance

7.1 A range of sources of internal and external assessment and assurance cover the Trust's activities. These have been quantified in a 'sources of assurance' document (attached at **appendix 1**) during 2013 these have been monitored through the Governance Planning Group and received by the Quality Assurance Committee, Risk Management Committee and Audit Committee (for their respective assurances). Following the governance review implemented in October 2013, the committee structure has changed and the sources of assurances will be taken to the Clinical Quality Improvement Committee and the Compliance and Risk Committee which have replaced the Risk Management Committee. This document has been updated to reference assurances cited in the 2013/14 BAF and the three levels which have been used in determining assurance:

- Level 1 Provides a high level overview of the sources of assurance

- Level 2 Provides details behind the high level overview of the sources of assurance and lists all external agency visits

since September 2012

- Level 3 Provides much more granular details on sources of assurance; if this approach is to be taken the document would run to many pages. The key to ensuring that this is succinct as well as informative would be to identify the key sources of assurance (ie external visits)

7.2 The types of assurances in place include:

- Internal audit (of internal systems and processes);
- External audit;
- External review of Quality Account;
- Inspection visits, such as CQC;
- Internal quality inspections such as PLACE and peer reviews
- Benchmarking (including Dr Foster and CHKS);
- NHSLA & CNST reports
- Independent reviews (eg Ombudsman reports);
- Clinical audit;
- Annual statements including the Annual Report, Annual Accounts and Quality Account;
- Annual reports from committees reporting to the Board through the sub-committee structure;
- Network reviews;
- Specialty reviews;
- National audits.

7.3 The quality of data and information is of fundamental importance, and during 2013/14 the Trust will continue to build upon the Data Quality Strategy agreed in 2011/12, quarterly data quality reports have been received at Board and are now received at Audit Committee which will request deep dives as required.
If there is a need for additional independent assessment or assurance, the Trust also commissions external reviews of its activities.

7.4 Where possible information is triangulated with patient safety experience to quantify any gaps e.g. ward scorecard and quarterly complaints report. This work is led by the new Clinical Quality Improvement Working Group.

8 Commissioners (NHS South West London, Clinical Commissioning Groups)

8.1 There are formal mechanisms available to commissioners if they wish to raise concerns, including:

- The System Sustainability Board;

- Through appointed governors on the Council of Governors
- Membership of project-specific groups;
- Announced and unannounced inspection visits;
- Monthly SLA meetings;
- Monthly Clinical Quality Review meetings;
- Monthly finance and technical meetings;
- Acute Commissioning Unit;
- PALS (Patient Advice and Liaison Services);
- GP concerns;
- Serious incidents;
- Patient Safety Incidents reported via NRLS (National Patient Safety Agency Reporting and Learning System).
- To Monitor

8.2 Concerns raised by commissioners are logged on a tracker, which is shared with them on a weekly basis to ensure they are monitored and resolved in a timely way.

9 The Trust's performance management processes

9.1 **Key Performance Indicators** The Trust has developed a set of key performance indicators that are used at Board level and below. These include indicators on safety, effectiveness, experience, finance and workforce. They include the key metrics used by Monitor. This set of indicators is supplemented by other key performance data to ensure that areas of adverse performance are picked up.

9.2 **Operational performance meetings.** The Trust has a number of fora where performance is discussed. With the introduction of service line management the approach to this is currently being reviewed.

9.3 Corporate performance meetings. Detailed performance reports are considered at each weekly Executive Management Committee (EMC) meeting, and the content of these reports is reviewed regularly in order to ensure they report on those areas of adverse performance that have been reported through escalation processes and/or are subject to scrutiny by commissioners.

9.4 Performance against the productivity programme, and emerging risks arising, are considered at EMC, and Finance Investment Committee meetings before being reported to Trust Board. Risks are operationally owned within service lines. Reports are received at Quality Assurance Committee (QAC) on impact to quality (which is a process managed through the Clinical Quality Working Group) and at Trust Board.

9.5 Nursing and midwifery quality scorecard. The Trust has developed its nursing and midwifery quality scorecard to: ensure services are monitored for quality and appropriateness of care; establish monitoring and feedback mechanisms for

evaluation and continuous improvement to service delivery, and; to promote evidence-based nursing and midwifery practice. The scorecard integrates workforce key performance indicators (KPIs) and nurse sensitive KPIs, providing a comprehensive picture of the performance of wards and enabling the translation of organisational KPIs to local departmental level. The focus of the scorecard is on:

- Workforce issues (e g nurses/bed, vacancy rates, etc);
- Environment (Hygiene Code);
- Patient safety (falls, pressure ulcers, SIs, observations, MUST, incidents, infection control);
- Patient experience (complaints, NPS, PET tracker);
- Assurance framework and EWTT.

9.6 The scorecard has been reported in Quality and Safety reports to the Quality Assurance Committee, via service lines, Nursing and Midwifery Advisory Committee and the Compliance and Risk Committee. More details on the scorecard, its component KPIs and mechanisms for the performance management mechanisms will be updated following the governance review and move towards service line management in the latter part of 2013/14.

9.7 Frontline Focus Friday. The nursing and midwifery quality scorecard described above enables the Trust to study key quality indicators and plan activity to address emerging concerns. Weekly Frontline Focus Friday sessions, with the Matrons, complement this work by ensuring emerging concerns acted upon.

9.8 Reports to board committees. Finance and productivity programme performance – including achievement of any agreed recovery plans - is reported routinely to each meeting of the Finance and Investment Committee. The Quality Assurance Committee (QAC) receives a Clinical Quality Report. Bi-monthly reports on monitoring the quality impact of the productivity programme are provided to the QAC, . The Audit Committee also received internal audit reports for approval and progress updates on compliance with previous internal audit recommendations as well as regular updates and reports from External Audit. These are reviewed in advance of the Audit Committee by the Compliance and Risk committee. The Audit Committee also receives reports on external inspections and the progress on any follow up actions.

9.9 Board performance reports. The Trust Board receives monthly corporate performance reports which include:

- Monitor's Governance and Financial Risk ratings;
- Key corporate, operational, workforce and productivity performance indicators;
- Exception reports and action plans against key corporate indicators and against indicators reported in dashboards to the Board sub committees.

The Board receives reports from QAC and FIC in the months in which they meet, on clinical quality and patient safety and the finance and productivity reports from

those sub-committees. During months when QAC and FIC do not meet, those reports are considered at the Trust Board meeting. These reports have been developed with external expert advice; the new arrangements and have been in place since 2012.

10 Monitoring compliance against the Care Quality Commission (CQC) Essential Standards of Quality and Safety

10.1 To ensure the Trust remains compliant with the CQC Essential Standards of Quality and Safety, a programme of regular self -assessments and monitoring is in place. This process is being reviewed to reflect the new CQC processes.

10.2 Each Outcome has a lead Executive Director responsible for ensuring robust evidence demonstrating compliance is identified, collected and maintained. The Trust uses the Health Assure software package to record and detail the evidence collected.

10.3 There is a process in place in team meetings where evidence is assessed and compliance with the *Outcome* is rated using the CQC's framework. These meetings are followed by CQC challenge sessions, where an Executive Director not linked to the *Outcome*, will lead a challenge and scrutiny of the evidence provided and the self-assessment score given. Where the *Outcome* has been rated red, or amber an action plan to improve compliance is developed.

10.4 The Compliance & Risk Committee ensures compliance with the CQC registration is maintained and that evidence is available to support this. To ensure organisation compliance with the CQC's new monitoring processes Essential Standards of Quality and Safety is monitored at, the committee through a monthly compliance report on the latest self assessment Outcome scores, along-side the Intelligent Monitoring Report.

11 Risk management and risk registers

11.1 The Risk Management Strategy aims to ensure:

- 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;
- An 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.

11.2 The Risk Management Strategy and underpinning Risk Identification, Assessment and Risk Register Procedure set out how the Trust ensures all risks are effectively identified and managed. They provide details on key sources of risk, the risk identification, evaluation and treatment cycle, and the governance structure for risk management. They describe how risk registers are populated, managed and reviewed both at service line and corporate level.

11.3 **Service Line Risk Registers**. Following the introduction of SLM work is underway to develop risk registers for each service line and a template has been developed for discussion of risk issues at performance management meetings. The risk registers will be reviewed at the Compliance and Risk working group and any issues escalated to the Compliance and Risk Committee.

11.4 **Corporate risk Register.** The corporate risk register contains risks that score 8 or above, and other strategic risks identified from the Board Assurance Framework, and for other risks identified by corporate committees. Its purpose is to log all risk assessments in the high or extreme categories and the controls in place or planned to manage the risks to its lowest possible residual level. This process is overseen by the Compliance and Risk Working Group, and the register is discussed monthly at the Compliance and Risk Committee, which received recommendations from its working group on areas which may need to be reviewed, and quarterly at the Trust Board. The Compliance and Risk Committee is tasked with ensuring delivery of the organisation's risk management procedures and practice, ensuring that all types of risk are identified and managed, and their control mechanisms operating effectively.

12 Board Assurance Framework

12.1 The Board Assurance Framework (BAF) provides a vehicle for the Board to be assured that the systems, processes, policies and people in place are operating in a way that is effective and focused on the key risks which might prevent the Trust from achieving its objectives. It enables the Board to plan and manage the assurance they require on the effectiveness of those controls. Each year, the Board approves the BAF for the year ahead, and this is reviewed at each Board meeting particularly in relation to the top three risk themes at that time. This review enables the Board to frequently:

- Discuss and agree the current risk score in relation to each principle objective;
- Track the action being taken to close gaps in controls.

- Track the action being taken to respond to negative assurances or controls.

12.2 In addition to Board review, the BAF is monitored operationally by the Compliance and Risk Working Group. Responsibility for providing scrutiny has been divided, by principle risk, amongst the primary committees For each principal risk the following information is provided:

- Links to primary regulatory frameworks
- Key controls to manage risks
- Assurance on controls/ internal and external sources
- Gaps in control/assurance/negative assurance
- Actions plans and dates for completion

12.3 The development of the BAF is co-ordinated by the Compliance and Risk Committee under the chairmanship of the Director of Finance.

13. Standing Orders, Scheme of Delegation and Standing Financial Instructions

13.1 The three key documents setting out the Trust's Governance arrangements are the Standing Orders, the Scheme of Delegation (and reservation of powers) and the Standing Financial Instructions.

13.2 The Trust's Standing Orders set out the framework under which the Trust established, the requirement for Audit and Remuneration Committees, the procedures under which Board operates and other key governance mechanisms for the Trust. Kingston Hospital NHS Trust's Standing Orders have followed Department of Health Guidance and have been updated and reviewed each year. These will be subsumed into the constitution of the Foundation Trust.

13.3 The Scheme of reservation and delegation sets out the framework to for delegating (or not delegating) decisions within the organisation. These are also reviewed annually.

13.4 The Standing Financial Instructions (SFIs) set out the detailed operation of the Trust's financial systems and are designed to ensure that Board has appropriate control of the financial systems and mechanisms in the organisation and that there is proper monitoring and use of financial resources. The SFIs are reviewed annually by both the Audit Committee and the full Board.

14. Governance and Committee structure

14.1 The governance structure was reviewed in 2013 and the new committee structure is attached at **appendix 2**.

15. Assignment of monitoring functions to a committee

15.1 The Board may assign the monitoring of a particular performance indicator or indicators to a committee, provided that this does not conflict with the scope of the scheme of delegation. KPIs are reported monthly to the Compliance and Risk

Committee and are provided at Trust Board. Where the Board assigns monitoring of performance indicators, there are explicit criteria identifying where performance needs to be escalated through exception reporting to the Trust Board. The Trust has further developed its approach to performance reporting and has sought external expert advice to inform:

- Decisions on where key indicators should be reported;
- The format of performance reporting;
- The format of exception reports required for those indicators requiring escalation and remedial action.

16. Organisational learning and continuous improvement

16.1 The Trust is committed to continuous improvement including the sharing of learning from incidents and complaints in an open and transparent culture. A new committee has been established to lead on the improvement agenda, the Clinical Quality Improvement Committee.

16.2 The Trust's "Reporting Incidents" and "Serious Incident Identification and Management" policies and procedures describe the mechanisms for investigation and learning from incidents.

16.3 All incidents which meet the criteria for reporting as Serious Incidents (SIs) are investigated by a lead investigator using Root Cause Analysis, and staff have been provided with extensive training to undertake these investigations. Should an incident be categorised as a grade 2 SI, an independent lead investigator is appointed. The final report is presented to a Scrutiny Panel which is chaired by a non-executive director and includes two executive directors, one of whom is either the Medical Director or the Director of Nursing and Patient Experience.

16.4 All SI's are received by the SI Group, which is a sub-committee of the Clinical Quality Improvement Group, chaired by the Medical Director and escalated as appropriate to Executive Management Committee and or/Trust Board. The Trust Board receives a report on SIs at each meeting.

16.5 The process by which learning from incidents and triangulation of information is taking place in the Clinical Quality Improvement Working Group and is currently under review.

16.6 Lessons from patient stories heard at listening events are being used to develop patient promises and behaviour standards as well as to inform patient experience improvement plans. In addition, the Trust Board listens to, and considers the lessons from, a patient story at the start of each public board meeting where any further Trust wide communication is agreed

16.7 The Quality Strategy also describes the role of the Clinical Effectiveness Committee, annual Clinical Audit Seminar and departmental governance meetings in ensuring the Trust:

- Sets challenging goals;

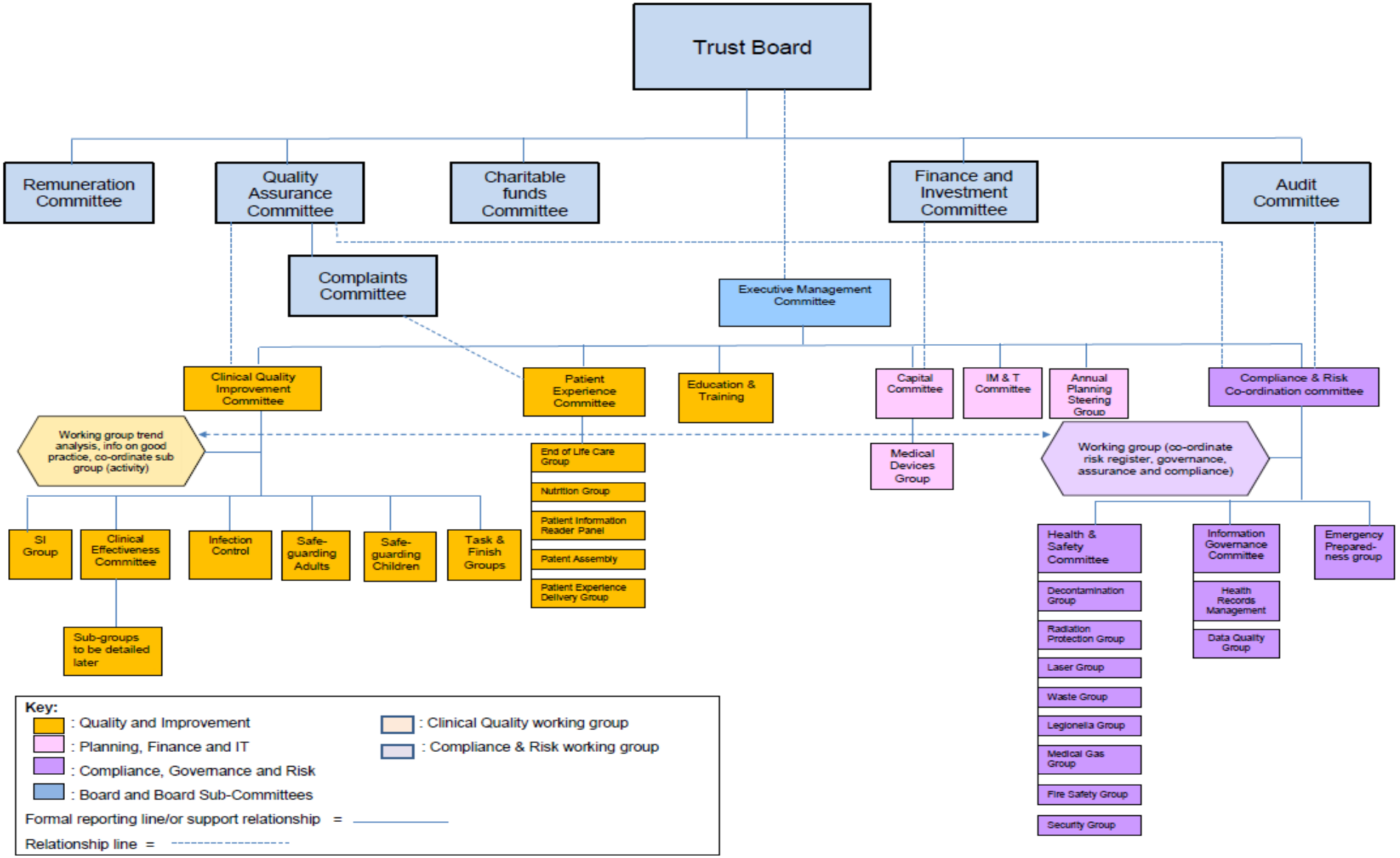
- Builds on successes;
- Evaluates achievements;
- Uses clinical audit to influence improvement processes and targets; and
- Shares lessons from quality improvements organisationally, locally and externally.

16.8 The Trust undertakes reviews of lessons learned from other Trusts to identify areas for improvement.

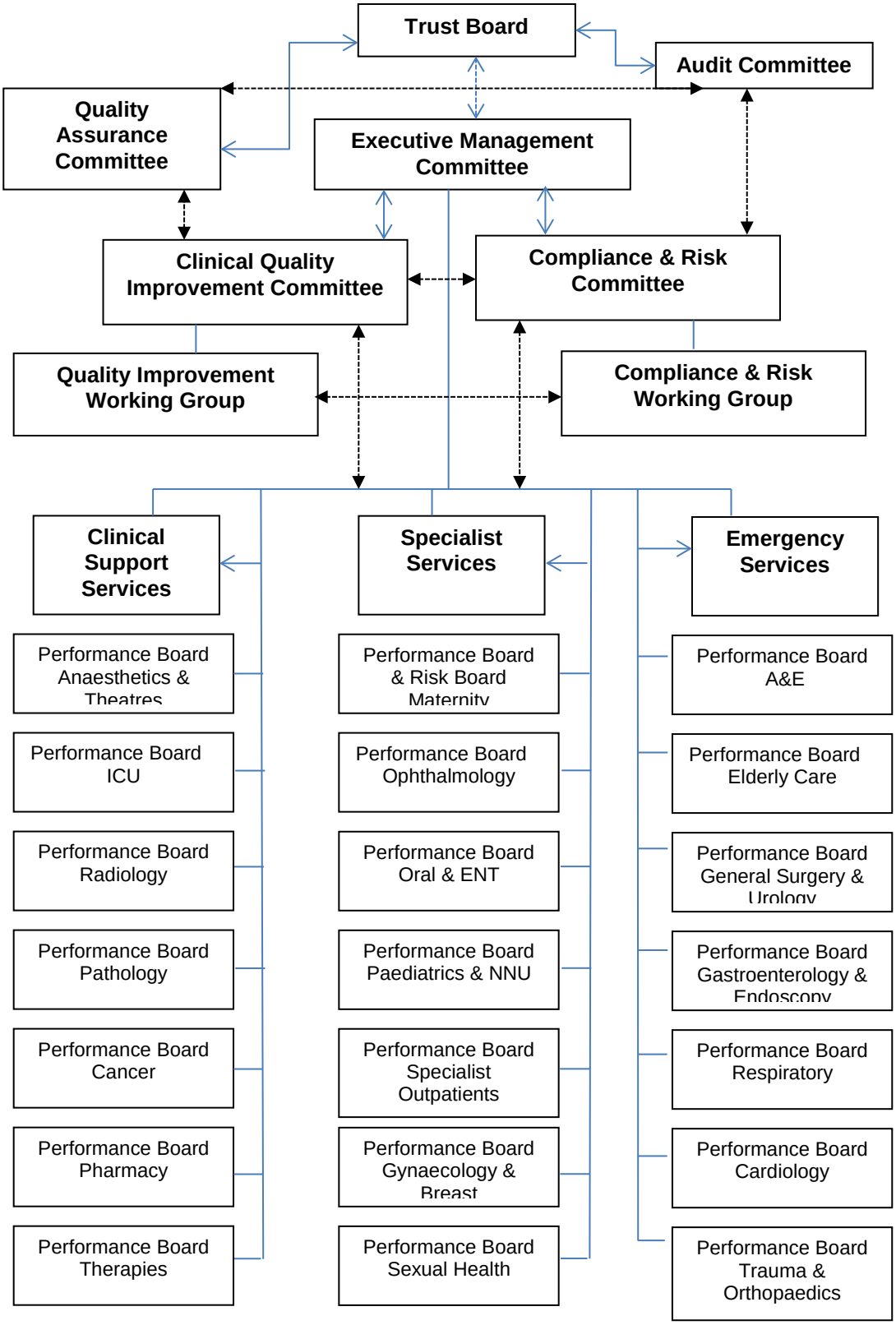
This document will be updated annually

Appendices available on request from the Head of Corporate Affairs / Company Secretary

Appendix C - Governance Committee Structure



Appendix C1 – Service Line Risk Management Structure



Appendix D - List of Trust Policies and Guidelines Relevant to Risk Management

- Code of practice on the Management of Records
- Control of Substances Hazardous to Health Policy
- Decontamination Policy
- Discharge Policy
- Display Screen Equipment Policy
- Health and Safety Policy
- Infection Control Policy
- Information Management and Technology Security Policy
- Information Governance Policy
- Major Incident Plan
- Mandatory Training Policy and Procedure (including Training Needs Analysis)
- Maternity Risk Management Strategy
- Medicines Management Policy
- Moving and Handling Policy
- NICE Implementation Policy
- Policy on Raising Concerns at Work (Whistleblowing)
- Policy on the Prevention and Management of Latex Allergy
- Policy and Procedure for Reporting, Analysis, Investigation and Learning from Incidents
- Policy And Procedure For Being Open With Patients And Their Carers
- Risk Identification, Assessment and Risk Register Procedure
- Standing Financial Instructions
- Standing Orders

A full list of policies is available on the Trust's Intranet, (Policy Management Information System)