Kingston Hospital
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

Policy Author	Melanie Whitfield Head of Patient Safety, Clinical Governance & Risk
Version	17
Impact Assessment Date	
Approving Body	Patient Safety and Risk Management Committee Audit Committee
Date Approved	
Ratifying Committee	Trust Board
Date Ratified	
Review date	October 2021

CONTENTS

1. INTRODUCTION

Kingston Hospital NHS Foundation Trust (KHFT) is committed to a strategy which aims to minimise risks to all its stakeholders through a comprehensive system of internal control.

Risk is any event, which threatens impairs / prevents an organisation from achieving its objectives. KHFT is committed to the principle that the understanding of risk involves the interplay of risk processes affecting staff, patients and the environment.

Governance is the framework within which the Trust will work to improve and assure quality of services for patients. Implementing and maintaining effective risk management is fundamental to ensuring the success of Clinical Governance. KHFT is committed to achieving best performance through the use of external and internal standards / criteria in the positive control of risk. Good risk management awareness and practice at all levels is a critical success factor for KHFT. Risk and organisational loss is inherent in everything that is done, from determining service priorities, taking decisions about future strategies, and certainly in deciding which course of action to follow. Cumulative breaches of risk thresholds may contribute to serious incidents.

Risk management is EVERY EMPLOYEE'S responsibility. This strategy will have succeeded when risk management has become embedded within the philosophy, practices and processes of the Trust, including the annual business planning cycle, and employees' mind-sets change to reflect their responsibility to be aware of risk and contribute to its minimisation. Nil risk is neither achievable nor sought. Implementation of the strategy will support a move towards an open and 'just' culture; one in which employees are increasingly risk aware with a memory of why things go wrong systemically and how they can be avoided.

The Head of Patient Safety, Governance and Risk, reports to the Director of Nursing & Quality, the Trust's lead director for risk management. Support is provided by the Patient Safety, Governance and Risk Team to the divisions and other corporate departments to meet their risk responsibilities. This includes compliance with the relevant aspects of the CQC Fundamental Standards of Quality and Safety.

This strategy is compliant with the Trust's legal responsibilities and duties under the Health and Safety at Work Act 1974.

This strategy outlines the approach KHFT will take to ensure that it develops effective risk management processes throughout the organisation, which enable the Trust to deliver its objectives and meet its statutory requirements. It also forms a key component of the Trust's overall approach to governance.

2. AIMS AND OBJECTIVES

The principal overall aims are to:

- Establish an organisational structure to manage risk at all levels.
- Ensure clarity of accountability for Risk Management in the organisation
- Produce a profile of all risks needing to be managed within the Trust by maintenance of a Trust-wide Risk Register (using the Trust Risk/Incident Reporting system), and providing mechanisms supporting logical risk management decisions being taken against this profile.

- Promote the development of a healthy open and 'just' reporting culture for the organisation.
- Strengthen implementation of clinical governance / quality arrangements.
- Promote an understanding of the Care Quality Commission's 'Fundamental Standards for Quality and Safety'.
- Provide an appropriate system for identifying and assessing levels of risk and ensuring suitable and sufficient analysis to facilitate identification of underlying factors.
- Develop and implement monitoring systems and key performance indicators that will assist the Trust to quantify changes in its risk management performance.
- Enhance the development of divisions' and corporate departments' risk registers and promote an internal framework in which divisions and corporate departments service level risks can be identified, examined and subsequently managed via the Risk Register.
- Demonstrate the leadership of, and commitment to, risk management to stakeholders and external agencies.
- Ensure that the Trust meets and, where reasonably practicable, exceeds the minimum requirements of the risk management standards indicated in paragraph 2.
- Develop improved internal control in partnership with patient safety, governance and risk management and internal audit.
- Inform best risk management practice and provide training for appropriate staff.
- Determine local targets and standards to drive quality and efficiency in the light of national frameworks, priorities and guidance, and ensure their delivery.
- Optimise the management of risk in the hospital premises.
- Draw on the knowledge and experience of other NHS or comparable organisations.

3. RISK MANAGEMENT STANDARDS

The Trust is committed to, and will be assisted in, achieving its risk management goals by reference to external regulatory authoritative bodies e.g. Care Quality Commission's "Fundamental Standards for Quality and Safety".

These cover most areas of Trust activity and generally enshrine important governance and risk management concepts, practices, and standards. In most cases these require the Trust to achieve stated levels of compliance against the various criteria with an expectation of continuous progressive improvement against national targets, and with annual external reporting of the results.

Increasingly, there is a formal independent internal/external audit to verify levels of compliance in key areas in addition to a requirement for ongoing self-assessment processes.

The Trust will incorporate the observations and recommendations arising from all such internal/external and self-assessment reviews in formulating its risk action plans.

The principal standards are as briefly described below.

3.1 Key Requirements

The need for the organisation to have effective governance/risk management systems and processes in place is governed by the following key requirements:

- Annual Governance Statement - one of the principal approaches that the Department of Health requires organisations to use as an assurance of effective governance / risk management, is to produce an Annual Governance Statement.

This statement is produced as part of the Trust's Annual Report and must be signed by the Chief Executive. It aims to demonstrate that the organisation is doing its "reasonable best" to manage its affairs efficiently and effectively through the implementation of internal controls to manage risk, through the stewardship of the Trust's governance procedures and systems.

- 1999 Health Act – following the introduction of the Health Act 1999 (and the preceding publication *A First Class Service 1998*), a statutory duty for the quality of care was imposed on all NHS organisations. For the first time since the creation of the NHS, an equal emphasis of statutory duty was placed on quality and finance.

3.2 Care Quality Commission's "Fundamental Standards for Quality and Safety"

The Fundamental Standards for Quality and Safety has been introduced to replace the older "Standards for Better Health" (SBH). These more robust requirements build upon the SBH but require ongoing evidence to support each of the 16 Outcomes.

The Provider Compliance Assessment Tool is a self-assessment document to be completed by the operational/individual leads and the ongoing evidence gathering to support each of the outcomes currently identified.

3.3 Information Governance

The Information Governance Group will ensure that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's overarching Information Governance Policy. The Group will ensure compliance with the national standards and guidance provided in the Data Security Protection Toolkit (DSPT) and further develops and monitors an annual improvement plan arising from assessment against the DSPT.

Provide a consistent and effective approach to coordinating the following components of information governance across the Trust:

- Information governance management
- Confidentiality and data protection
- Clinical information assurance
- Corporate information assurance
- Information quality assurance
- Information security assurance

3.4 Caldicott

Health Service Circular 1999/012 1999 requires trusts to appoint a Caldicott Guardian who should undertake a management audit of existing procedures for protecting and using patient identifiable information. This audit will identify the levels of performance against the prescribed indicators. From this audit an improvement plan will be developed to address any identified deficiencies.

3.5 Data Protection

The Data Protection Act 1998 includes the protection of the individual with regard to processing of personal data. Data processing systems must respect fundamental rights and freedom of people. It includes all records electronic and manual. The Human Rights Act outlines the respect for the individual's private and family life, home and correspondence.

The Freedom of Information Act encourages more open and accountable government by establishing a general statutory right of access to official records and information.

3.6 Health and Safety Legislation

There is a statutory requirement systematically to assess all workplace risks where there may be a risk to health, to record these assessments and implement suitable control measures to manage risk effectively.

4. RISK

4.1 Risk is any event which threatens impairs / prevents an organisation from achieving its objectives. Risks within the Trust can be classified by using a risk assessment methodology, which is based on an appreciation of the likelihood of risks and potential consequences, should they occur. The level of acceptable risk within an organisation is flexible and reflects financial capacity, services provided, the extent of implementation of risk management, and the Board and stakeholders' overall perception of risk.

4.2 Kingston Hospital NHS Foundation Trust (KHFT) recognises that it is neither possible nor always desirable to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources. There is indeed an exciting tension through which good risk management enables better, more reflective, practice.

Acceptable risk within KHFT is defined as:
"The risk remaining after controls have been applied to associated hazards that have been identified, quantified to the maximum practicable, analysed, communicated to the appropriate level of management and after evaluation, accepted".

5. RISK MANAGEMENT

Risk Management is having in place a corporate and systematic process for evaluating and addressing the impact of risk in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risk to arise.

6. TRUST POLICY EQUALITY STATEMENT

The Trust is committed to promoting equality, valuing diversity and protecting Human Rights. It is committed to eliminating discrimination against any individual on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation, as well as to promote positive practice and value the diversity of all individuals and communities.

7. 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, encompasses:

The process of minimising risk to an organisation by developing systems to identify and analyse 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 can be minimised.

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 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 and information governance risks.

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	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 Resolution and other regulatory or enforcement bodies. • Reputational risks for example events which may damage the credibility or reputation 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 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: • Income. • Expenditure. • Fulfillment of contracts. • The correct application of Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

8. 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.

9. INDIVIDUAL ROLES AND RESPONSIBILITIES FOR RISK MANAGEMENT

Trust Board
The Trust Board has overall responsibility for risk management and having in place effective systems of risk management and internal control covering both clinical and non-clinical risk.

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. He/she will delegate specific roles and responsibilities to the appointed Executive Directors / Senior Managers to ensure risk management is coordinated and implemented equitably to meet the Trust's objectives safely without detriment to patient care.

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 Associate Divisional Directors and the Cluster/Service Line structures.

Director of Corporate Governance
The Director of Corporate Governance has operational responsibility for corporate governance across the Trust and leads on the development of governance processes and the Board Assurance Framework.

Director of Nursing & Quality
The Director of Nursing & Quality 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. He/she is also the Caldicott Guardian and the lead for Duty of Candour. 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.

Director of Workforce & Organisational Development
The Director of Workforce & Organisational Development is responsible for delivery of the Workforce Strategy and Objectives, and is the lead for ensuring compliance with equality and diversity requirements. S/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, Facilities & Capital Development
The Director of Estates, Facilities & Capital Development 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 & Technology (IM&T) is responsible for delivery of the IM&T Strategy. S/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.

Head of Patient Safety, Governance & Risk
The Head of Patient Safety Governance & Risk has operational responsibility for quality governance and the risk management processes across the Trust including management of the Trust Risk Register.

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 coordinated, 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.

Clusters, Service Lines and Corporate Departments
Each cluster, 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's requirement for specified outcomes for each aspect of service provision.

Associate Divisional Directors, Clinical Directors, Service Managers, Service 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.

Associate 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 that systems are in place to identify, assess and manage risks through implementation and review of the Service Line Risk Register.

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.

They will adhere to the agreed governance arrangements within their areas, demonstrating annually that the meetings had been quorate, held in accordance with terms of reference, using corporate, standardised templates for minutes / agendas, etc.

Patient Safety & Risk Manager
Reporting to the Head of Patient Safety Governance & Risk, it is the responsibility of the Patient Safety & 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 Trust Risk Register as an active document and monitor mitigation plans.
- To ensure that a mechanism is in place to ensure that the risk and safety requirements of external agencies, such as the MHRA, NHS Resolution, 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-coordinating the risk management training programme.
- Service lines and corporate departments continually and regularly review their Risk Registers.
- 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 & 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.

Head of Clinical Audit & Effectiveness

The Head of Clinical Audit & 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 Patient Safety & Risk Managers to maintain an effective response to MHRA guidance.

Health & Safety Advisor

The Health & Safety Advisor, accountable to the Director of Estates 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 & PALS

The Head of Litigation, Complaints & PALS, reporting to the Director of Nursing & Quality and Director of Corporate Governance, 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-coordinating 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.

Head of Information Governance

The Head of Information Governance, reporting to the Director of Corporate Governance, 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.

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.
Risk Assessors	Perform risk assessment and report findings in accordance with the process for managing risk.
Patient Safety, Governance and Risk Team	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.
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.

10. GOVERNANCE STRUCTURE FOR RISK MANAGEMENT

The Committee Structure (Appendix B) 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 the Trust Board & Governance Structure chart.

Terms of Reference for all these Committees and the local Risk or Governance Groups are available on the Trust intranet.

10.1 High Level Committees with Overarching Responsibility for Risk Management

- **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 robust 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** (FIC) 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
  - Ensure systems are in place to support delivery of compliance with legislation, mandatory NHS Standards, NHS England/Improvement, CQC, NHS Resolution and other relevant bodies.
  - Identify risks to compliance with the various statutory bodies.
  - To support, monitor and review progress and achievements against the Trust Quality Priorities.

- **The Patient Safety and Risk Management Committee (PSRMC)** is responsible for:
  - Routinely review and oversee the Trust Risk Registers.
  - Monitor past and future external visits and any action plans in place to respond to any risks.
  - Oversee implementation of the Trust-wide policy in risk management process and review and ratify risk and non-clinical policies in accordance with the policy on Trust-wide Procedural Documents.
  - To ensure that the Trust's services deliver safe, high quality, patient-centred care.
  - Performance against internal core and specialty dashboards and external quality improvement targets:
    - ✓ Clinical outcomes
    - ✓ Patient safety
    - ✓ Patient experience
  - Key quality and patient safety risks identified from reviewing mortality data and undertaking mortality and morbidity review at both specialty and Trust level.
  - Progress in implementing action plans to address shortcomings in the quality of services, should they be identified.
  - Advise the Board on the priorities for clinical standards set by national bodies e.g., Department of Health, Care Quality Commission and the National Institute of Clinical Effectiveness.
  - Provide assurance to the Board that the most efficient and effective systems are in place and the associated assurance processes are optimal.
  - Be responsible for setting, monitoring and reviewing, on behalf of the Board of Directors, the quality improvement targets set in the quality account. It will provide assurance to the Trust Board that improvement targets are based on achievable action plans to deliver them and that quality performance issues are followed up and acted on appropriately.

10.2 Subcommittees and Groups with Specific Responsibility for Risk

The subcommittees and groups with specific responsibility for risk are summarised below. Terms of reference for all these Committees are available on the Trust intranet.

- **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 DSPT.
  - Reviewing relevant incidents, complaints and litigation, identifying any trends and action to be taken.
  - Leading and coordinating improvements in data quality.

- **The Clinical Effectiveness Committee** is responsible for:

  - To monitor that clinical care provided is evidence based, safe and effective thus supporting the Trust to meet Care Quality Commission (CQC) Good Governance Regulation 17.
  - To monitor the implementation of National Institute of Health and Care Excellence (NICE) guidelines and recommendations.
  - To approve the introduction of new procedures/techniques and obtain assurance that the procedure is relevant, safe and effective for use within the Trust.
  - To monitor participation in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies and implementation of recommendations where required.
  - To approve Trust clinical policies, guidelines, procedures and pathways.
  - To approve the Trust Annual Clinical Audit Programme that reflects national and local priorities.
  - To approve the Trust Annual Clinical Audit Report.
  - To receive regular reports from sub-groups and following examination to escalate risks where necessary, to provide advice and seek assurance where necessary.
  - To report into the Quality Improvement Committee risks and significant clinical matters.

- **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 well-being.

- **The Equality and Diversity Committee** is responsible for:

  - Overseeing the Trust's diversity processes and systems.
  - Ensuring delivery of the Annual Work Plan.

- **Service Line Performance Review Meetings/Governance 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 Group** (SIG) 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 Groups.
  - Ensuring there is a system of learning from any SIs.
  - Monitoring the SI Action Plan Tracker, HATs and PIRs.

- **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 Quality Improvement Committee or the EMC will have overall responsibility for monitoring how those risks are controlled.

11. 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**:**

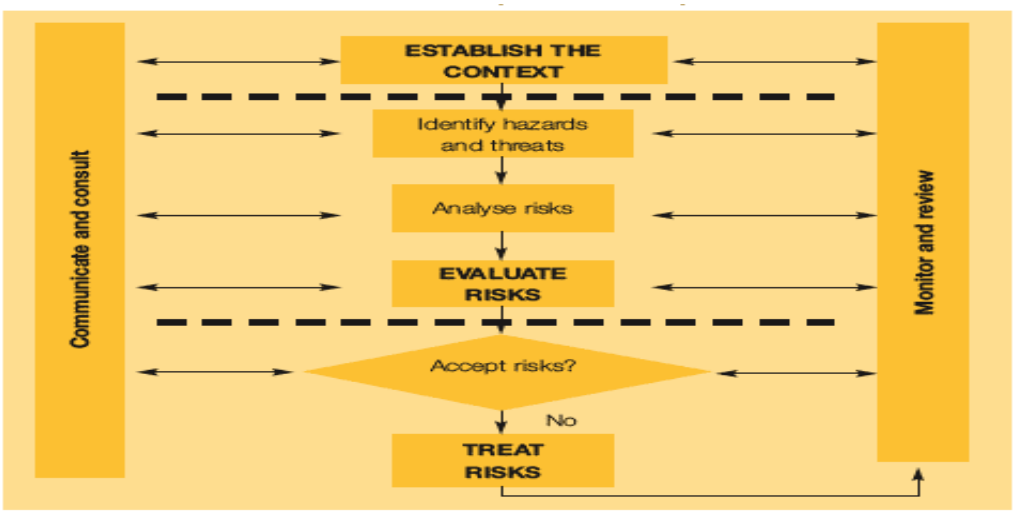
- Patients and visitors
- Staff (including contractors and volunteers)
- Finances
- The business of the Trust
- Compliance with statutory duties
- The Trust's reputation

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

11.1 Identification of Risk

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



11.2 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.

11.3 Proactive Identification of Risks

Risk Assessments should be performed on all business cases and Quality and Cost Improvements to forecast any potential risks and inform Risk Register contents.

11.4 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 minimise 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

11.5 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 controls 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.

11.6 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 that is deemed to deserve corporate visibility

11.7 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.

11.8 Timeframe for Review of Risk Registers

This Strategy recommends in line with best practice that risk registers must be reviewed and updated monthly or sooner if required. Monthly review of the Trust Risk Register with leads will occur supported by the Patient Safety, Governance and Risk Team through the Patient Safety & Risk Management Committee.

12. RECORDING RISK

The key documents that the Trust uses to record risks and the actions to mitigate the identified risks are the Board Assurance Framework, the Corporate Risk Register and the Service Line / Corporate Directorate Risk Registers.

12.1 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.

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.

The Board Assurance Framework is closely linked with the Trust Risk Register (CRR) which reflects significant risks identified at both a corporate department and divisional level. The Director of Corporate Governance 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 Director of Corporate Governance attends meetings of the Quality Assurance Committee and the Audit Committee.

12.2 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 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 - it may be appropriate to tolerate the risk without any further action, for example, due to either a limited ability to mitigate the risk or the cost of mitigation may be disproportionate to the benefit gained. The decision to tolerate would ideally be supported by a contingency plan in the event that the risk was realised.

Transfer - this option is normally taken to transfer a financial risk or pass the risk to an insurer. However, there is also the opportunity to agree to transfer risks to a partner organisation in a joint project, but it is important that all parties are clear to the exact extent of each partner's liability and responsibility for the risk.

Terminate - some risks can only be contained at an acceptable level by terminating the activity. It is the approach that should be most favoured where possible and simply involves risk elimination. In such circumstances removing the risk should be the first option considered; rather than attempting the treat, tolerate or transfer it.

Treat - treat or mitigate is in practice the most common response, achieved by taking action to reduce the probability of the risk occurring or by reducing the impact. This enables you to continue with the activity/objective but with controls and actions in place to maintain the risk at an acceptable level.

Take the opportunity – Good, effective risk management also helps organisations to explore and take opportunities. Poor risk management can lead to organisation failing to take advantage of new business opportunities or over-extending itself thus throwing away potential benefits.

The Head of Patient Safety Governance & Risk leads on the CRR process supported by the Patient Safety, Governance & Risk Management Team. The CRR is owned and reviewed by the Patient Safety & Risk Management Committee monthly 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.

12.3 Risk Tracking

A report is presented to the Audit Committee and Patient Safety & Risk Management Committee (PSRMC) to detail information on new, and closed risks contained within the Corporate Risk Register.

12.4 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 included in the CRR.

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.

Risk Escalation: risks which score 12 and above are automatically included on the CRR. Any new risk for inclusion on the CRR will be discussed by the PSRMC to ensure consistency of scoring across the Trust and appropriate mitigation.
Risk De-escalation: de-escalation from the CRR will occur automatically when the score is reduced below 12. The risk will be returned to the Service Level RR for local management. The PSRMC will receive details of risks de-escalated to ensure there is organisational oversight and have attained assurance that the risk has reduced or has been resolved.

All Service Line Risk Registers will be reviewed annually to reduce occurrence of aged risk.

12.5 Fast Track Process

Where a new risk is identified that requires ‘fast track’ approval, this should be discussed with the Matron, Clinical Director and Service Line Manager or any member of the Executive Team (follow guidance under Para 9.7 of Risk Identification Policy).

13. 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 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 level 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**.**

13.1 Risk Management Training

A programme of Risk Management Training, including Risk Assessment and Root Cause Analysis is in place and is delivered by the Patient Safety Governance & Risk Management team. Risk management is also included in 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 as necessary. 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 Core Skills Training Policy (including Training Needs Analysis).

14. COMMUNICATION / DISSEMINATION

The Risk Management Strategy will be provided to individuals with risk management responsibilities and published on the 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.

15. REVIEW

This Strategy will be reviewed by the Audit Committee at least on an annual basis to ensure its objectives remain current and relevant.

16. IDENTIFICATION AND DISSEMINATION OF LEARNING

Learning identified from thematic and service line trend reviews will be discussed at the Patient Safety and Risk Management Committee, with cascade through to service lines and staff forums. To further enhance the dissemination, learning will also be included with risk management training.

17. ARCHIVE ARRANGEMENTS

This Strategy will be archived in accordance with the Policy on Procedural Documents.

REFERENCES

- The Institute for Risk Management guidance papers (2011): 'Risk Appetite and Tolerance Guidance Paper

- HM Treasury (2004): 'The Orange Book – Management of Risk – Principles and Concepts

- NPSA (2008) : a risk matrix for risk managers National Health Service Litigation Authority (2008): Risk Grading Tool National Health Service Litigation Authority (2008): Policy for the Management of the NHSLA Assurance Framework and Risk Register Audit Commission (2009): 'Taking it on trust – National Health Report National Health Service Litigation Authority (2009): Risk Management Strategy National Health Service Litigation Authority (NHSLA) Risk Management Standards 2011-12

- Good Governance Institute (2010): 'What every healthcare board needs to understand about patient safety

- Good Governance Institute (2012): 'Risk Appetite for NHS Organisations – A matrix to support better risk sensitivity in decision taking

- Good Governance Institute (2012): ' GGI Board Briefing: Defining risk appetite and managing risk by Clinical Commissioning Groups and NHS Trusts

- Care Quality Commission essential standard of quality and safety March 2010 Health and Safety at Work etc. Act 1974 Section 2 – Duties of Employers to Employees Section 3 – Duties of Employers to Persons other than Employees Management of Health and Safety at Work Regulations 2003 Regulation 3 – Requirement to Assess Risk

APPENDIX A - Corporate Framework

Process	Action	Responsibility	Timeframe
Board Assurance Framework True North Strategy	Review of BAF Review of the True North	Board and Executive Management Committee	Every meeting
		Audit Committee	Quarterly
Trust Risk Register	Review of Register	Executive Management Committee	Quarterly
		Audit Committee and Quality Assurance Committee	Quarterly Every 2 months
		Board	Quarterly
Divisional Risk Registers	Review of Risk Registers	Performance Review Meetings	Monthly
Corporate Services Risk Registers	Review of Risk Registers	Patient Safety & Risk Management Committee	Quarterly
Annual Governance Statement	Statement written as part of annual accounts	Chief Executive Director of Corporate Governance	Annual
Risk management training and education	Delivery of targeted training program	Quality Governance Team	Monthly induction of new staff Annual programme for all staff
Risk management process	Review of Risk Management policies and associated procedures and guidance	Patient Safety, Governance & Risk Management Team	Annual
Risk Management Strategy	Review and update	Patient Safety, Governance & Risk Management Team	Annual

APPENDIX B – Trust Board & Governance Structure

The latest Trust Board and Governance Structure is available on the Trust's Intranet:

https://intranet.kht.local/our-hospital/committees/

MONITORING SHEET

Element to be Monitored	Lead	Tool	Frequency	Reporting	Lead for Actions
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.	Director of Nursing & Quality (PSRMC Chair)	Review of risk management process / audit	Annual	PSRMC	Quality Governance Team
Board Assurance Framework	Director of Corporate Governance	Review of BAF risks and actions progress / audit	Every Board meeting	Board	Director of Corporate Governance

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
V1-14	Updates from inception through to Dec 2015	Operational Manager for Risk Management and appropriate Director lead	Ratified changes	• Listed changes included within V14 of Risk Management Strategy, and archived for the purposes of version control.
V15	November 2017	Patient Safety & Risk Manager Head of Patient Safety Governance and Risk Director of Corporate Governance Deputy Director of Quality		• Individual and committee roles, titles and responsibilities updated following re-structure • Changes to reflect outcomes from Internal Audit review of Risk Management arrangements and action plan. • Strategic Objectives updated (3) p. 5 • Governance Committee structure – updated Appendix C • Service Line Risk Management Structure – updated Appendix C1 • Updated titles and structures • Updated monitoring table • Added role of Risk Management Committee • Service lines will adhere to the agreed governance arrangements, evidencing annual compliance • Added components to comply with the internal Audit.
V16	July 2019	Melanie Whitfield, Head of Patient Safety & Risk	Ratified	Reviewed as per schedule
V17	October 2020	Tori Layton, Patient Safety & Risk Manager		Reviewed as per schedule Governance Committee structure – updated Appendix B Removed QIC as reporting committee Added some of the QIC responsibilities to the PSRMC