Risk Management Strategy

2016 – 2019

Version: 6
Policy Lead/Author & position: Deputy Director of Quality
Ward / Department: Nursing Directorate
Replacing Document: Version 5
Approving Committee: Quality &Safety Committee

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Date of Next Review: February 2019

Target Audience: Trust Employees
1. Aims, Background & Scope

Risk management is the key system through which clinical, non-clinical, organisational and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. The key systems will be fully embedded at every level of our organisation and will ensure compliance with current and future risk management related standards and legislation.

2. Strategy

The most important outcome for the NHS is that it must learn lessons from every adverse incident, or untoward event/situation that occurs or is identified. It is essential that departments should review their working practices following every significant accident, incident, complaint, claim, inspection or audit; and that lessons for improving working practice are systematically learned and shared, aiming to provide and maintain high standards and continuity of service delivery. It is important that, through risk management, lessons learned are shared with other relevant areas of practice and are reported to relevant external authorities. The risk management strategy works in partnership with our trust priorities of ‘Providing excellent care for patients’ and ‘Developing out staff’, enabling them to deliver excellent patient care.

The strategic aim of our Trust is to make risk management the key system through which clinical, organisational and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders.

Our Trust Board acknowledges that:

- the services it provides, and the way it provides these services, carries with it unavoidable and inherent risk;
- the identification and recognition of these risks - together with the proactive management, mitigation, acceptance (if appropriate within its strategy) and (where possible) elimination of these risks - is essential for the efficient and effective delivery of safe and high quality services;
effective risk management is not an end in itself, but an integral part of the trust's quality, governance and performance management processes;

all staff have a role in considering risk and helping to ensure it does not prevent the delivery of safe and high quality service; and finally that

our Trust Board, with the support of its committees, has a key role:
  o in ensuring a robust risk management system is maintained and effectively resourced,
  o in encouraging a culture whereby risk management is embedded across the trust, and
  o through its plans, in setting out its risk appetite and priorities in respect of the mitigation of risk when delivering a safe and high quality service.

3. Risk Management Objectives

The purpose of the Strategy is to set out how our Trust’s risk management system will support the delivery of the trust’s overarching strategy and how it will be developed from 2016 to 2019. As such it outlines the key responsibilities for the management, reporting and escalation of risk within the trust.

The key objectives are:

• Identify and record all significant risks on ward/department, Borough and corporate risk register, via the Trust’s Risk Management Software system (Datix).
• Report all accidents, incidents and near misses on the Trust’s Risk Management Software system (Datix).
• Take action to control risks, prevent recurrence of adverse incidents and share learning with others.
• Make risk management a part of day to day activity comply, with best practice standards and maintain high standards of achievement with external requirements.
• Increase knowledge and understanding of risk management.
• Increase incident reporting
3.1 Framework for the Achievement of our Risk Management Objectives

Our Trust will use a framework that meets the relevant requirements of the Health and Social Care Act for achieving the Statutory and regulatory requirements of the Care Quality Commission, (CQC). The Framework will assist to provide evidence that our organisation is doing its best to manage, direct and control risk. We will use these processes as the Trust framework for risk management and we will be able to demonstrate that by doing so we are protecting our Trust, its employees, patients and stakeholders’ safety and interests against risks of all kinds; and provide evidence of continuously improving risk management.

The management of risk is the responsibility of everyone in the organisation and requires commitment and collaboration from all staff both clinical and non-clinical. Specific roles, accountability and responsibilities are defined later in this document.

Our Trust recognises that by its very nature, health care is an activity which involves risk, not least because some risks have to be taken in order to improve the quality of treatment and care for patients. Our Trust recognises that mistakes and errors can happen; therefore a strategy and a framework are required to deal with the hazards and risks associated with its main function of providing high quality health care to people. The level of risk tolerance is determined by our Trust Board of Directors.

Our Trust will deploy these risk management systems within a robust and effective management structure.

3.2 Risk Management System

Effective governance in the NHS is dependent on the level of integration of clinical governance, corporate governance and financial governance. Risk management is the system which underpins and integrates these three aspects of governance and
Board assurance. The primary purpose of the Risk Management System is to help staff to:

- Improve the quality of care and treatment.
- Protect patients and staff from harm.
- Eliminate or reduce unnecessary costs.

It provides the mechanism through which the Chief Executive, as the accountable officer, can assure all stakeholders that the Trust’s internal controls are effective.

Risk Management is a proactive approach that addresses every element of the organisation’s activities and comprises a four-phase cycle:

- Risk Identification
- Risk Analysis
- Risk Control
- Risk Funding

Figure 1 shows how these phases interact with each other:

Risks management starts with the systematic identification of risks which are then analysed in order to determine their relative importance. Risk control measures are taken to reduce the risk potential for harm. Some risk control measures do not require additional resources and these should be implemented. Where risk control
requires additional funding then the risk funding process determines how best to use the organisations financial resources in relation to the identified risk. Risk funding can direct funds to further risk control measures or it may decide to transfer the risk such as buying insurance or sharing the risk in the contracts drawn up with others. Finally, the risk funding process may decide that the risk should be retained. The risk process is a continual interactive process as the organisation develops a progressively more comprehensive picture of the risks it faces and what is effective control.

3.3 Risk Identification

Risks will be identified, analysed, prioritized and documented at all levels in the organisation. These risks can arise from any aspect of the organisation including:

- Clinical practice
- The environment.
- Buildings and equipment,
- Chemical or hazardous substances
- People employed by the Trust or by visitors, patients or contractors
- Procedures, systems or practices
- Financial activities
- Communication and information.
- Legislation
- Business plans
- Reputational

Risk identification involves examining all the sources of risk from the perspective of all stakeholders at all levels in the organisation. The following are a list of methods among many others which may be used to identify risks:

- Healthcare Communication
- Adverse Incidents, complaints and claims reporting
- Global Trigger tool analysis
• Audits and inspections both internal and external
• Risk identification workshops
• CQC self-assessments
• Patient and staff satisfaction surveys
• Patient Advice and Liaison Service (PALS)
• Process analysis
• Risk profiling
• SWOT analysis
• HM Coroner inquests
• Parliamentary and Health Service Commissioner (Ombudsman) reports

All identified significant risks should be recorded on the Trust's Risk Register. A risk register is:

“A log of all risks of all kinds that threaten an organisation’s success in achieving its declared aims and objectives. It is a dynamic document, which is populated through the organisation’s risk assessment process. This enables risk to be quantified and ranked, and information about risks to be collated and analysed. It therefore provides a structured approach to decision-making about whether or how risks should be treated.”

3.4 Assessing and Scoring Risks

Risks are scored using a risk scoring matrix which has been adopted by many NHS organisations based on an Australian / New Zealand standard (see Fig 2), with the risk scores taking account of the consequence and likelihood of a risk occurring.
Risk Scoring Matrix

To calculate the Risk Score the following calculation is used

**Impact x Likelihood = Risk Score**

<table>
<thead>
<tr>
<th>IMPACT should a risk occur</th>
<th>Insignificant (1)</th>
<th>Minor (2)</th>
<th>Moderate (3)</th>
<th>High (4)</th>
<th>Catastrophic (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost certain (5)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>4</td>
<td>8</td>
<td>14</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Figure 2**

The risk control objective of the Trust is to reduce risks their lowest reasonably practicable level, consistent with its mission to provide highest quality patient care and treatment, the training of future healthcare staff and increasing knowledge via research. Risk control is the means by which the risk's impact, or frequency, or both are reduced, transferred or retained. Controls include:

- Systems,
- Training,
- Contingency Plans and strategies
- Policies, Procedures, Guidelines, Protocols
- Design of equipment, buildings and materials
Figure 3, outlines how a risk will be managed and escalated from ward to Board dependent upon the risk score:

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW Between 1 and 3</td>
<td>Managed at a team/service level by the Team Risk Owner via the trust-wide Risk Register. Assurance will be provided to the Management Risk Owner on the management of this risk and managed in the local governance structures (Note – not normally escalated to Board level)</td>
</tr>
<tr>
<td>Minor Between 4 and 6</td>
<td>Managed at a service/Borough level by the Team Risk Owner via the trust-wide Risk Register. The Management Risk Lead will monitor the delivery of any actions and managed at the Borough Governance and Performance and Quality Committee (Note - not normally escalated to Board level)</td>
</tr>
<tr>
<td>HIGH Between 7 and 14</td>
<td>Managed at a service/Borough level by the Team Risk Owner via the trust-wide Risk Register. The Management Risk Lead will monitor the delivery of any actions and managed at the Borough Governance and Performance and Quality Committee (Note - not normally escalated to Board level)</td>
</tr>
<tr>
<td>High Between 15 and 19</td>
<td>Managed by the Management Risk Owner at Borough level. Actions prioritised and agreed with the Executive Risk Owner. Managed at the Performance and Quality Committee Meeting and Quality &amp; Safety Committee (Note – not normally included in the Board Assurance Framework)</td>
</tr>
<tr>
<td>EXTREME Between 20 and 25 (Strategically significant risks)</td>
<td>Managed on a day-to-day basis by the Management Risk Owner and reviewed as a minimum on a monthly basis with the Executive Risk Owner. Actions prioritised / agreed on a monthly basis and subject to scrutiny by the appropriate Board Committee / Board</td>
</tr>
</tbody>
</table>

The risk profile score determines at what level the risk needs to be managed.

Score of:

3 - 5 Minor risks which are adequately managed and may be retained if further control limits the capacity to control higher ranking risks.

Managed at team/service level.

6 and over Moderate risks which must be managed by the Borough’s governance structures.

10 and over Serious risks which must be managed and reported through the Performance Improvement Committee.
15 and over Significant risks to the Trust which must be managed and reported through the Quality and Safety Committee, report through to the Trust Board. Action plans used to manage risks must be referenced in the action plan summary section on the Risk Register together with review of progress dates.

Risks with a profile score of 15 or more will be reported to Quality & Safety Committee. The Quality & Safety Committee will review these risks and its control systems and determine what further action is needed to ensure that the risk is controlled to an acceptable level. The Quality & Safety Committee will report to the Board of Directors any risks with a profile score equal to or greater than 15 together with action planned to bring the risk into an acceptable level of control. The Board of Directors will review the actions taken and planned and may determine further action to be taken to bring the risk into an acceptable level of control.

Our Trust recognises that risk management only becomes part of an individual’s objectives by the acceptance and ownership of the approach by staff themselves.

To ensure risk management becomes integrated into all practices and procedures carried out by staff, the Trust support the implementation of practices and procedures which:

- Increase the awareness of staff to report all adverse incidents and near misses.
- Facilitate proactive self-assessment of risks throughout the Trust;
- Develop systems and processes which have the capability to reduce risk;
- Improve procedures for reporting with effective feedback mechanism;
- Continue to ensure compliance with policies and professional standards;
- Provide consistency in the management of risks;
- Ensure compliance with professional registration requirements;
- Ensure compliance with professional codes of practice;
- Promote continuing personal and professional development that meets
the needs of individuals and the business needs of the Trust.

- Enable staff appraisal to focus on improvements in performance related to adverse incidents/near misses, concerns and complaints received.

Those risks which normally score between 15 and 25 will be regarded as strategically significant risks (and will be included in the Board Assurance Framework which is considered by the Board).

Each risk will be assigned 3 risk scores:
(a) Opening Risk Score – the initial risk score, prior to any assessment of the effectiveness of the controls / mitigating actions proposed;
(b) Current Risk Score – the latest risk score, which will include a partial / complete assessment of the effectiveness of the controls / mitigating actions;
(c) Target Risk Score – the risk score which should be the objective of the trust’s controls / mitigating actions (taking account of the Board’s risk appetite).

4. Risk Acceptance (Risk Tolerance)

At times risks will be identified which cannot be eliminated or the cost of eliminating it is unreasonable and the controls outweighs the benefit of that expenditure. These residual risks should be recorded on the Risk Register. The risk profile score determines the frequency and scope required for monitoring.

5. Assurances on Controls

Assurances can be defined:-
- as the means by which the organisation, executive director, Clinical Director, Assistant Director, manager, or clinical lead responsible knows that the controls which are thought to be in place are being implemented and are effective. E.g. Monitoring reports presented to a committee or a confirmation of works completed e-mail to the responsible manager/clinician.
Our Board of Directors requires assurance that control measures are effective. Assurances associated with the control measures in place for the Principal Risks, against the Trust’s annual objectives, are monitored by the Board via the Board Assurance Framework document. Assurances associated with the control measures in place for risks, identified from within the organisation and scored at 15, are monitored by the Board via the Corporate Risk Register. These documents form one report that is presented to and reviewed by the Board at least four times per year.

The Board Assurance Framework document is a comprehensive document that sets out:

• the management of the Principal Risks to meeting the Trust’s Annual objectives.
• key evidence for the Annual Governance Statement

and which:

• covers all of the organisation’s main activities;
• identifies the objectives and targets the organisation is striving to achieve;
• identifies the risks to the achievement of objectives and targets;
• identifies and examines the system of internal control in place to manage the risks;
• identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control;
• records the actions taken by the Board to address control and assurance gaps

The Board Assurance Framework is the primary mechanism by which our Trust determines the priorities for audit of controls in place and includes both internal management audits and external independent audits. Through audit and monitoring the Trust will undertake a review of the effectiveness of the risk control measures regularly and at least on an annual basis.

Risk Control and Monitoring Measures will also include some or all of the following:

• Statistical and Trend reporting of Incidents, Complaints and Claims to our Trust Board and relevant Committees.
• Correlation between adverse incidents / near miss reporting and dates of occurrence
• Cross-tabulated reporting over a range of variances.
• Audit of the effectiveness of Adverse Incident Reporting Procedures to enable benchmarking to take place.
• Audit of Patient Records against Adverse Events / Near Miss Reporting
• Audit of the effectiveness of Trust systems and processes such as Fire Training, Fire Drills and Health and Safety Training.
• Root Cause Analysis of Adverse Incidents via Incident Management Policy.

6. Risk Financing

The funding of risk control measures is primarily through the budgets agreed annually with managers across the Trust. Financial planning and business planning should therefore include the management of identified risks.

As the financial year progresses decisions may need to be taken as to the most appropriate use of funds to manage unexpected risk control requirements and this is determined at the level of the organisation identified by the risk score.

Even when our Trust has taken reasonable measures to eliminate or reduce risks, some risks will always remain. There are three forms of financial function involved in the transfer or reduction of risk, all are carefully controlled so to minimise the amount of funds that are diverted away from direct patient care.

Equipment replacement and upgrading will need to be included and budget planning

7. Cost of Claims including Clinical Negligence

Our Trust is currently covered for the cost of clinical negligence through the NHS Litigation Authority. This covers claims arising from clinical incidents on or after 1 April 1995. A separate scheme, Existing Liabilities Scheme (ELS), also administered by the NHSLA, funds clinical negligence claims arising from incidents occurring before 1 April 1995.
8. Incident Reporting

Our Trust Management of Incident’s Policy requires that all clinical and non-clinical incidents, accidents or near miss occurrences are reported and investigated, and that lessons are appropriately shared across the organisation, within the local health economy and within the wider NHS.

Our Trust maintains an electronic reporting system (Datix) for recording all incidents. The incident reporting database provides the Trust with the ability to follow the course of an incident investigation, to monitor completion of investigations, identify remedial actions and to ensure lessons are learned to avoid future occurrence. It may provide early details of an incident that has the potential to lead to a complaint or claim and may identify multiple incidents involving the same people together with a grading of the incident’s seriousness.

The reporting system assists with the identification of departmental and corporate trends, drawing the attention of managers to areas that may require further analysis and exploration. Our Trust believes that all incidents should be openly, consistently and fairly investigated so that lessons are learned and improvements are made in the quality and standard of care we deliver. This is essential for the delivery of the clinical governance agenda. Incidents will be managed within the Boroughs with advice and support provided by the Patient Safety Team.

9. Investigation of Adverse Incidents and Near Misses

Our Trust operates a ‘Fair blame’ principle

The view of our Board of Directors is that disciplinary action does not form part of the response to a report of an incident or event, except in cases where one or more of the following applies:-

- There is at least a second occurrence involving the same individual and event;
- The incident/event results in a police action;
- The staff member was negligent in their action
• In the view of the Trust and/or any professional registration body, the action causing the incident is far removed from acceptable practice;
• There is failure to report an incident in which a member of staff was either involved or about which they were aware.

10. Authority to Investigate Adverse Events, Near Misses and Serious Untoward Incidents

The Clinical Director and their nominated staff are responsible for the area in which the incident/near miss occurs produces a report on the incident which specifies:

• The nature of the incident.
• Root causes of the incident (for serious incidents).
• Immediate action taken to protect patients, staff and the Trust from further damage.
• Action taken as a result of learning from the incident.

Managers are expected to do a causal analysis on every Adverse Incident or Near Miss at Moderate or Serious level, applying the principles of root cause analysis. A detailed root cause analysis investigation is required for all Serious Untoward Incidents, and those reported to STEIS. (Strategic Executive Incident Investigation System)

Moderate and Serious Incident reports will be reviewed and signed off by the Borough Serious Incident Review Groups and Medical Director. The Trust overview Serious Incident & Death Group meets quarterly and determines whether serious incidents and deaths have been adequately managed and all possible lessons learnt and shared. A 30 day time frame for moderate incidents and a 45 day timeline for serious incidents will be set for the investigations to be completed. A report will be provided to the Quality & Safety Committee quarterly.

11. Learning lessons from Incidents, claims and complaints

Our Trust is a learning organisation, and is committed to learning from Incidents, claims and complaints.
12. Analysis of incidents, complaint and claims

The Trust ensures a systematic approach to the analysis of incidents, complaints and claims.

On a quarterly basis it is the:
• The Head of Effectiveness responsibility is to provide all data relating to incidents.
• The Head of Patient Experience responsibility to provide all data relating to complaints.
• The Claims Manager’s responsibility to provide all data relating to claims.

The reports will be provided to the Quality & Safety Committee.

Clinical Directors are responsible for ensuring the information provided within the reports are reviewed at local Governance forums to ensure incidents, complaints and claims are analysed at Borough level and communicated to relevant individuals or groups. The Governance Facilitator for each Borough is responsible for co-ordinating analysis and learning from incidents, complaints and claims relevant to their areas.

13. Encouraging learning and promoting improvements in practice

Our Trust’s systematic approach to encourage learning and promote improvements in practice is based on analysis of incidents, complaints and claims, is a key aspect of the Risk Management Strategy.

Our Trust will ensure the risks derived from individual and aggregated information are assessed using the Trust’s approved risk assessment and risk register processes. The Quality & Safety Committee will consider individual and aggregated information and ensure the development and management of risk registers, including key controls, gaps in controls, key assurances, gaps in assurances, risk scores, action plan and review dates, where risks are considered significant. Managers responsible for the investigation of incidents, complaints and claims, supported by the relevant Governance Facilitator, will ensure significant risks from individual incidents, complaints and claims are assessed and managed using our Trust's approved risk assessment and risk register processes.
All risk assessments will have an action plan, describing how the risk will be treated e.g. staff training, awareness raising, change in practice, improved methods of communication, new initiatives, environmental improvements, guidance for staff, patients or others, clarification of roles and responsibilities.

Our Trust will ensure both local and organisational learning from incidents, complaints and claims by the following methods:

- Local ownership of incidents, complaints and claims
- Development of risk registers and action plans as appropriate, at local level
- Monitoring of action plans at agreed meetings
- Service Review process
- Review at Deep dive meetings
- STEIS reports, action plans and risk registers
- Quarterly Reports to the Quality & Safety Committee
- Patient Experience Report to the Quality & Safety and Patient Experience Committees
- Incidents, complaints and claims review at Borough level
- Quality & Safety Committee and Board of Directors review of Serious Untoward Incidents, including approval of associated action plans and monitoring to completion.

The Trust’s Head of Effectiveness and Governance Facilitators will ensure, through accountability arrangements to the Deputy Director of Quality, that any opportunity for cross-organisational learning from incidents, complaints and claims is identified and implemented.

The Quality & Safety Committee is responsible for monitoring the effectiveness of how the Trust ensures both local and organisational learning from incidents, complaints and claims and will ensure Borough level risk management objectives, which include this requirement, are reviewed and reported upon. Action plans will be developed to address any deficiencies.
The Quality & Safety Committee is responsible for ensuring lessons learnt from detailed investigation of adverse events are embedded into organisational culture and practice. The Serious Incident and Death Group will review agreed actions, following the detailed investigation of adverse events, and ensure lessons learnt are embedded into organisational culture and practice.

14. Risk Management Structure

14.1 Trust Board:

At the head of the risk management structure is our Board of Directors who are ultimately accountable for the management of risks in the organisation. The Chief Executive, as accountable officer, supported by the Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy and for ensuring adequate systems of internal control which supports the achievement of the organisation’s objectives.

14.2 Executive Director of Nursing, Quality and Governance

The Director of Nursing, Quality and Governance is designated Executive Director for risk management and has the lead responsibility for implementing the organisational and clinical risk management systems. They are responsible for ensuring that the Chief Executive and Board are advised of all high and catastrophic risks.

Director of Patient Services and Clinical Directors are responsible for ensuring the Corporate Risk Register is updated and submitted to the Board. Both the Executive Director of Nursing, Quality & Governance and Director of Patient Services have the authority to amend the Corporate Risk Register between meetings of the Quality & Safety Committee. The Quality & Safety Committee had the collective authority to re-grade risks on the Corporate Risk Register.
14.3 Director of Patient Services

The Director of Nursing, Quality and Governance delegates the oversight of our Trust risk registers to the Director of Patient Services who ensures that the boroughs have advice and guidance on the appropriate grading of risks on team, borough risk registers. The Director of Patient Services is responsible for ensuring that there are effective mechanisms for transferring information on risk through the different levels of the Trust's governance structures.

14.4 Director of Finance & Investment

The Director of Finance has specific delegated responsibility for the maintenance of financial controls, reporting all financial performance and audit risks. The Director of Finance is responsible for ensuring that the Chief Executive is advised of any High and Catastrophic Financial Risk.

14.5 Role and responsibility of Non-Executive Directors

Non-Executive Directors have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that support the achievement of the organisation's objectives. In particular, as members of the audit Committee, Non-Executive Directors will review the adequacy of the Risk Management Strategy, and receive regular monitoring information against the management of risks judged as ‘significant’ and provide verification to the Board of Directors on the systems in place for the management of risk within the Trust.

14.6 Role and responsibility of the Clinical Directors

The Clinical Directors will ensure local systems and processes are in place for the identification and management of risks within their areas of responsibility. They work at both a corporate and local level, contributing to the management and identification
of risk across the organisation and ensure staff develop and maintain safe systems of practice which is evidence based.

14.7 Trust Secretary

The Trust Secretary supports the Executive and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Board of Directors, for maintaining the Board Assurance Framework that defines the principal risks, and associated controls, assurances and action plans, to achieving the Trust’s annual objectives.

Facilitating the implementation of actions required by the Board in relation to the Board Assurance Framework and corporate governance.

14.8 Deputy Director of Quality

The Deputy Director of Quality is responsible to the Executive Director of Nursing, Quality & Governance and Medical Director for providing advice and facilitating the effective management of clinical and non-clinical risk, in addition to leading on Health and Safety aspects of risk. This responsibility includes establishing dynamic risk management systems and processes that form an integral part of routine organisational and departmental activity.

The Deputy Director of Quality provides the principal lead role in establishing clinical risk management systems in accordance with criteria described by external assurance organisations.

14.9 Quality & Safety Committee

The Quality and Safety Committee provides assurance to the Board on compliance with safety and quality standards; monitors the Corporate Risk Register; and ensures that there is effective integrated governance. The Committee obtains assurance on the delivery of programmes of work in relation to assessment and regulatory activity,
including CQC registration, the hygiene code and patient surveys. The Committee receives external review / assessment reports and monitors the implementation of action plans.

The Committee oversees the Trust’s quality governance arrangements, including arrangements for assurance on the content and publication of the Quality Account, clinical audit, never events, Serious Untoward Incidents and relevant action plans. Matters are also referred to the Trust Board for information or ratification as required

14.10 Performance Improvement Committee

Performance Improvement Committee exists to allow appropriate scrutiny and review to a level of detail that will ensure the Trust is meeting its required standard of performance in relation to Quality (patient safety and effectiveness i.e. risk and audit), Activity and productivity (including efficiency and effectiveness), Workforce (key performance indicators), Information and technology, and Statutory and Regulatory standards

14.11 Serious Incident & Death Review Group

This group meets quarterly and is chaired by the Medical Director. Serious incidents are those that harm or have the potential to cause serious harm to patients, staff or visitors to the Trust, could damage the reputation of the Trust and/or may result in significant loss of Trust's resources. Procedures are in place to ensure that incidents are reported and action taken to prevent further incidents and to learn from experience. The Serious Incident & Death Review Group monitors the implementation of these procedures and recommends actions to be taken to strengthen these procedures and ensure that they are followed.

The group meets quarterly and supports managers and clinicians in dealing appropriately with incidents and setting up systems developed out of the learning
from the incident. Serious Incidents are reported within the Serious Incidents Reports to the Quality & Safety Committee

The group will oversee the deaths within the organisation, both inpatient and community patients.

14.12 Audit Committee

The Audit Committee’s primary role is to conclude upon the adequacy and effective operation of the organisation’s overall internal control system. In performing that role, the Committee’s work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the organisation’s objectives (the Assurance Framework). As a result, the Committee has a pivotal role to play in reviewing the disclosure statements that flow from the organisation’s assurance processes. In particular this covers the Annual Governance Statement.

14.13 Health & Safety Committee

The safety committee is chaired by the Executive Director of Nursing, Quality & Governance, and has a membership of senior managers, clinicians and staff representatives and is a key part of the risk management system, reporting to the Quality & Safety Committee. Its aim is to reduce the number of accidents to people whether patients, staff or members of the public.

14.14 Internal Audit

Internal Audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas:

The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement agreed objectives of the organisation.

Internal Audit will provide an independent and objective consultancy service, specifically to help line management improve the organisation’s risk management, control and governance arrangements.
An Internal Audit Annual Plan will be completed detailing the purpose and scope of the assignments to be carried out including their prioritisation. The plan will clearly define its relationship with the Assurance Framework. Internal Audit will also review, appraise and report on matters as set out in the organisation’s Standing Financial Instructions.

15. Risk Management Strategies for all areas

The Trust’s Boroughs and Specialist Services will have systems in place to ensure risks are identified, analysed, prioritised and documented at all levels and across all areas. This will include:

- comprehensive departmental risk assessments

- specific risk assessments of service developments or changes to usual practice

- specific risk assessment of any areas of concern possibly identified from other risk management activity e.g. incident reporting trend review, complaints, claims, PALS contacts, clinical audits

- review of key risk management data including incident reporting, complaints, claims, inquests, PALS contacts, clinical audit reports

- provision and careful monitoring of effective risk management action plans including those developed following complaints, incidents, claims

- review and implementation of national guidance and warnings e.g. NPSA initiatives and Safety Alerts, MHRA Safety Notices and Hazard Alerts, NCEPOD and national enquiry reports, National Service Frameworks and NICE guidance

- Continuous review of compliance against key national standards
• Establishment and maintenance of comprehensive Risk Registers in all areas and at Team and Borough level. Risk Registers will be maintained and appropriately reviewed in accordance with the Trust’s Risk Assessment and Risk Register Policy

16. Risk Management Training

16.1 Training needs analysis

An annual training needs analysis will be conducted and coordinated through the Learning and Development Department. The Deputy Director of Quality will advise on the risk management needs for all staff groups and volunteers.

Our Trust will ensure there are systems in place to monitor that risk management training needs, identified within the training needs analysis, are addressed effectively.

The Patient Safety Team will deliver training in a variety of ways to meet the risk management learning needs of staff within our organisation.